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Health Santé Salud

European Project
Getting Evidence into Practice

The challenge of getting evidence into practice: current debates and future strategies

- Current agenda
- Technical issues
- Reviews of evidence
- Capacity building
- Future action

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Promotion & Education

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Promotion & Education

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Hans Saan

The road to evidence: the European path

Evidence without capacity is an empty shell.

Mohan Singh

This special issue of *Promotion & Education* celebrates an important step for health promotion in Europe. It disseminates the way that Europe is developing a more unified evidence-based practice arena. Issues of effectiveness and evidence have gradually emerged as a common challenge. European wide collaboration began in 1989 in Rotterdam with the organisation of an International Union in Health Promotion Education (IUHPE) special conference on effectiveness and the development of a series of effectiveness brochures, sponsored by the European Commission. The IUHPE has subsequently organised effectiveness conferences in Greece, Israel, Finland, Estonia, London, and in 2005, Sweden. The effectiveness issues covered in the early brochures were revisited in the book *The Evidence of Health Promotion Effectiveness* (IUHPE, 2000), produced with assistance from the European Commission and the Centers for Disease Control and Prevention (CDC), USA.

Over the years the focus of the debates on evidence has gradually shifted to include the political alongside the scientific. This reflects the commitment in health promotion professional spheres to advocate for equal opportunities for health by challenging priorities and decisions in many policy areas. With Governments also adopting more economically expedient positions «if you cannot prove it, we won't invest», terminology and associated processes such as evidence and best practice have been added to health promoters' professional repertoire.

In other areas of health practice the use of systematic reviews to distil the best evidence out of multiple research publications is well developed, helping to create what Speller *et al* refers to later in this journal as an evidence-industry. For several reasons health promotion has not always fitted comfortably into the expanding evidence-based culture. In particular the participatory and political nature of health promotion implied processes that did not easily conform to the controlled conditions necessary for experimental research, regarded by some as the golden standard.

As always, friction generates energy. A number of national health promotion institutes in Europe were aware that they were all struggling with the linkage between evidence-based science, policy and practice. With the support of the European Commission, the collaborative project, Getting Evidence into Practice (GEP), was established with the IUHPE and EuroHealthNet (see Molleman and Bouwers for a discussion of EuroHealthNet). The project had three strands. Firstly, in order to ensure a common evidence base, a review protocol was developed, taking into account experiences and debates in the collaborating countries. Second, from the most effective programmes lessons were learned about their critical components. Many countries have checklists of these components to ensure quality and optimal professional planning. These have now been combined into a shared standard. Finally, to demonstrate that evidence must be regularly revised, two topics were updated against the background of the developed protocol and quality standard (See Slama's article on tobacco control and Jané-Llopis' article on mental health, in the section of Reviews of evidence in this special edition).

A national Dutch joint programme between the Municipal Health Service Rotterdam and the Netherlands Institute of Health Promotion and Disease Prevention (NIGZ) has covered similar issues around evidence based practice. The catalyst for the Dutch programme came from two sources a) the criteria for distribution of research funds by the National Health Research and Development Council and b) a large scale Randomised control trial (RCT) that was stopped due to a misfit between the design and the political dynamics. With support from international colleagues, the Dutch debate took place at four conferences held for policy makers, practitioners and researchers, using *Evaluation in Health Promotion* (Rootman *et al*, 2001) as the source of inspiration. Four ideas informed the progamme:

A common frame of reference was regarded as an important interface between the diversity of health promotion activities, terminology and principles.

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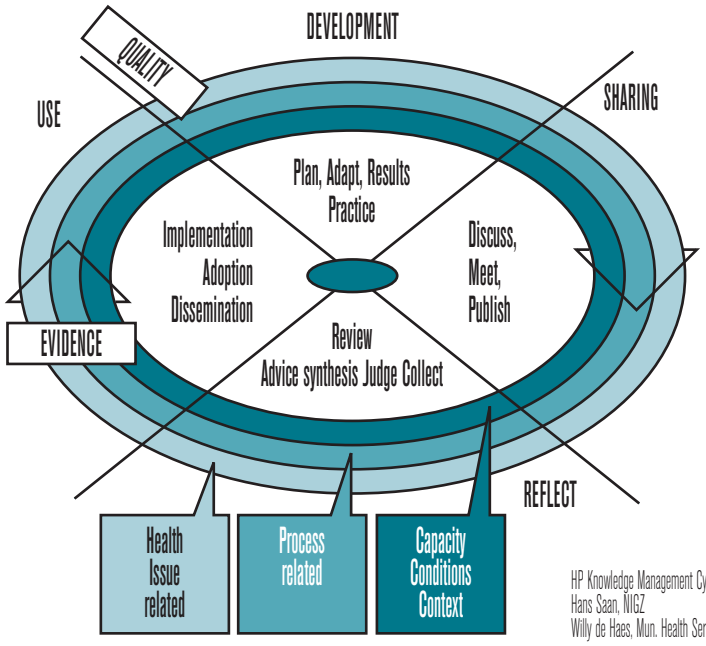
Key words

- capacity building
- effectiveness
- evidence
- partnership



HP Knowledge Management Cycle 2005
Hans Saan, NIGZ
Willy de Haes, Mun. Health Service Rotterdam eo

• If evidence is to be useful it should demonstrate a) what works b) how it works and c) under what conditions. Evidence from research, therefore, should report on results, processes and capacity. As much of the available evidence of effectiveness in health promotion does not show these three components, different research is needed.

• Health promotion research should take fundamental principles and characteristics of health promotion into account. These include people as partners, respect for the dynamics and complexity of health promotion action and a good understanding of the time it takes to produce change. A greater diversity of research efforts is needed, which includes a focus on the processes and the logistics, with capacity as an important condition.

• Evidence is not disseminated spontaneously, but like all forms of knowledge has to be managed. The model depicted here shows four stages: *Knowledge development*; *Sharing; Reviewing; Use*. The *Knowledge* stages must include results, processes and capacity, as the *Use* stage depends not only on the knowing it works, but also on an understanding of how and why it works.

This special edition showcases the Getting Evidence in to Practice (GEP) project. There are contributions on capacity (see Mittelmark *et al*), on the UK system of knowledge management designed to ensure the conditions are suitable to put evidence into practice (see Speller *et al)* on the contribution that the European region can make to the Global Programme on Health Promotion Effectiveness (GPHPE) (McQueen and Jones) and an assessment of what the future holds both for the GEP project and for evidence based practice in health promotion (Jones and Scriven). These contributions demonstrate how we are moving from a disciplinary dominance of the health and behavioural sciences to other sciences, including political, economics and management sciences. A key message is that researchers have to accept responsibility to not only focus on a different type of RCT, the Really Consolidated Truth, but also to look beyond their publications to the use their studies have for policy, practitioners and the general population.

Many countries are reconsidering how systems of linkage and exchange between research, policy and practice have to be revised to ensure a synergy. This is not only happening in Europe, but is a concern all over the world. The IUHPE-coordinated Global Programme on Health Promotion Effectiveness offers a great opportunity to share our European experiences and to gain feedback from around the globe.

So, welcome to this special issue disseminating the work of the GEP project. We trust the Stockholm conference will offer the opportunity for professional community building that will empower us as evidence-based practitioners, policy makers, researchers and advocates for health.

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Gerard R. M. Molleman and Jan G. M. Bouwens

Building the evidence base: from tool development to agenda-setting and defining a joint programme for health promotion in Europe.

Each country that develops health promotion programmes has to explore similar questions around the kinds of information available, what evidence-based interventions exist and what is the best way to implement them. Policy makers and management also demand transparency, accountability and cost-effectiveness, so there is an urgent requirement for good quality evidence of health promotion effectiveness.
Many health promotion and public health agencies in Europe and elsewhere are actively in the business of getting evidence into practice and also evidence out of practice (see Speller *et al* in this special edition for examples drawn from England, Scotland and Holland). Internationally, there is a growing interest in working collaboratively to avoid duplication of effort and to exchange ideas and methods (see Mittelmark *et al* in the Capacity building section of this journal for tangible examples of collaborative action already in place). Cooperative or multi agency action such as those outlined by Mittelmark *et al* are important because collecting and defining knowledge and a body of evidence is complex.

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The European project Getting Evidence into Practice (GEP)

Since February 2004 the European Commission has funded the project Getting Evidence into Practice (GEP). The project represents collaboration among key national agencies and international networks for health promotion in the form of a European Evidence Consortium. Currently more than 20 institutes from a wide range of European countries are involved. The project focuses on health promotion, public health and prevention interventions. There were two main outcomes from the first phase of the project. Firstly, as you will read in this special edition of *Promotion & Education*, the project updated the evidence on two selected topics and on the current position of evidence regarding effective health promotion. Secondly, a consensus review protocol for finding, collecting, defining and describing evidence and a European quality assurance tool to assess and improve health promotion were developed.

The critical point is that evidence based practice does not only involve gathering information, but also making it accessible and usable. In practice this can happen through a top-down approach that can create a disparity between the researcher and the practitioner. Moreover, the current emphasis on conducting systematic reviews often neglects valuable information from the dynamic context of health promotion and on process factors. Evidence needs to be produced from the broad spectrum of health promotion, including research, policy and practice and the systematic review procedures need to be expanded to include the collection of evidence from different sources such as grey literature, expert opinion and from non-English language sources. The use of the quality tool can help to identify promising health promotion practices, which in turn can become a focus for further research that upgrades the practice in to authentic evidence of effectiveness. This type of interaction between research and practice can contribute to the process of decision making in health promotion.

Building capacity and infrastructure

Central to the next phase of the Getting Evidence into Practice project will be establishing firm foundations for sustainable implementation and ensuring the necessary capacity. This includes a mapping exercise to assess the capacity of the national and regional organisations in the EU member states to use the review protocol to assess and support the quality of evidence based interventions and/or to supply examples of best practices. This has to be accompanied by training programmes and professional support. The review protocol and quality assurance tool will be applied on common European health topics such as obesity or health inequalities.

These kinds of activities should be part of the core business of health promoters in the EU countries and be reflected in the national and local infrastructure. As many European countries share very similar public health concerns there is clearly an added value for collaboration and for tackling these issues together. Much can be gained from sharing and exchanging experiences, insights and knowledge on evidence and by looking collaboratively for the best solutions.

Key words

- collaborative working
- evidence
- policy
- research
- systematic reviews

In the next phase the Getting Evidence into Practice projects strives to work more closely with the WHO-Health Evidence Network, so that the link between evidence based knowledge and decision-making and policy at a European level can be optimised. The collaboration with IUHPE and EuroHealthNet also makes an important contribution to the dissemination of results.

Defining together the standards and translating these standards in to concrete programmes contributes to a European wide health promotion programme of work and approach to evidence based practice, creating a strong position of health promotion within the European Centers for Disease Control infrastructure. These developments will ensure the outlines for a joint programme that offers health promotion professionals working within research, policy and practice arenas the guiding principles for shaping their projects and interventions. This will have intrinsic value for each country with respect to their own core business, the contextual dynamics of health promotion and their sense of ownership.

Catherine Jones and David V. McQueen

The European Region's contribution to the Global Programme on Health Promotion Effectiveness (GPHPE)

The Global Programme on Health Promotion Effectiveness is coordinated by the International Union for Health Promotion and Education (IUHPE) in collaboration with the World Health Organization, the US Centers for Disease Control and Prevention and many other partners including but not limited to the African Medical Research Foundation; Health Canada; the Health Development Agency, England; Health Promotion Switzerland; the Netherlands Institute for Health Promotion and Disease Prevention; and the Voluntary Health Association of India. It is a unique worldwide programme which aims to raise standards of health promoting policy-making and practice worldwide by reviewing evidence of effectiveness in terms of health, social, economic and political impact; translating evidence to policy makers, teachers, practitioners, researchers; and stimulating debate on the nature of evidence of effectiveness. The GPHPE is an overarching programme that covers a number of regional projects and related activities being conducted across the globe. The added value of the GPHPE's global vision is not only in the programme's capacity to examine and explore the differences among regions with respect to their approaches to the effectiveness of health promotion, but is concretely related to the programme's ability to recognise the common ground, distinguish the differences in context and support the strengthening of linkages and interactive sharing of this growing body of knowledge. Importantly, the GPHPE is concerned with how to best put this body of knowledge to use.

The GPHPE encompasses a range of activities, products and publications developed in order to increase the understanding of the potential impact of health promotion approaches and interventions. Given that many countries are reconsidering how systems of linkage and exchange between research, policy and practice have to be revised to ensure a synergy (for further discussion of this point see the editorial to this edition), the European project Getting Evidence into Practice has the opportunity to share the European experience with the rest of the world and contribute to the on-going reflection on how to better uncover, measure and record evidence from practice.

The project's definition of effectiveness is in concert with that held by the GPHPE. This definition recognises that evidence for effectiveness can be derived from a variety of sources beyond traditional evaluation boundaries and can not only draw upon grey literature, expert opinion and non-English language sources to expand the evidence base (see Molleman and Bowens, in this edition for further elaboration on sources of evidence), but also pull out the evidence from practice (a point which Speller *et al.,* examine in some depth).
A major challenge for the GPHPE is to develop sustainable approaches that best fit with the regional needs, whilst maintaining the high quality for which the original European work that triggered the programme is recognised. The entirety of the regional contributions serves to play a vital role in the enlarging the body of knowledge that the GPHPE aims to build (IUHPE, 2004). The interactive process between research and practice that is central to the work of the Getting Evidence into Practice project is a valuable example of how to capture the dynamic relationship between research and practice that is often ignored or discounted. The GPHPE provides opportunities for a wider dissemination of the project's consensus European review protocol and quality assurance tool, and augments the potential for an increased number of existing avenues to

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Key words

- evidence of effectiveness
- policy-making
- sources of evidence
- research

be explored and communicated with beyond European borders, which could inform and enhance the GEP work programmes now and in the second phase. The GPHPE's intention is to uncover answers and find solutions based on best practice in order to be able to advise on how interventions could be better carried out based upon the evidence, and the GEP project's contribution of guidelines and tools are designed to contribute to the implementation of evidence of health promotion effectiveness in to practice.

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Arja A. Aro, Stephan Van den Broucke and Sanna Räty

Toward European consensus tools for reviewing the evidence and enhancing the quality of health promotion practice

Over the last decade, evidence and quality have become buzzwords in health promotion. This is partly due to the growing professionalism in the sector, but also to the fact that health promotion increasingly has to prove itself as a legitimate and important part of health related services. With the growing competition for scarce resources and the increasing demand for accountability to policy makers, financers and other stakeholders, there has been a growing need for health promoters to demonstrate the quality and effectiveness of their actions (Shediac-Rizkallah and Bone, 1998).

In this regard, policy makers, health managers and researchers have attempted to apply the concept of evidence-based medicine (EBM) to health promotion, emphasising the need to base health promotion policy and practice decisions on research evidence. In a similar vein, quality assurance models and concepts used in healthcare organisations have served as a source of inspiration to enhance quality in health promotion practice. However, as health promotion and public health interventions are complex and multisectoral processes, the outcomes of which are not always visible in the short term, the concepts of EBM and quality assurance cannot be simply transferred to health promotion. Furthermore, the basic orientation of health promotion is emancipatory, and its values are rooted in fundamental human rights. Quality assurance in health promotion should reflect these fundamental and ethical values (MacDonald, 1997). So, in order to show whether health promotion is effective, which health promotion interventions work best, and under which conditions they can be successfully implemented, the existing evidence and quality frameworks need to be extended to include the contextual, multidimensional, emancipatory and ethical aspects. There is a need to develop and agree on criteria for effectiveness and quality that reflect these aspects.

Since the beginning of the nineties, much work has been done, both in the area of documenting the effectiveness of health promotion and in developing methods for quality assurance. Effectiveness and quality of health promotion are strongly interrelated, although not identical concepts. Interventions that meet quality standards are generally more effective, and using strategies and methods with proven effectiveness adds to the quality of interventions. A large number of studies documenting the effectiveness of health promotion have been published worldwide. Furthermore, organisations such as the World Health Organization

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Key words

- health promotion
- evidence
- practice
- review protocol
- quality assurance

(WHO) and the International Union for Health Promotion and Education (IUHPE) have played a key role in bringing the effectiveness of health promotion to the foreground. For example, the European division of IUHPE has organised a series of three yearly conferences focusing on the effectiveness of health promotion, and has published review documents on this issue (IUHPE, 2000). Also, a number of protocols have been created to review the information on health promotion effectiveness (CRD, 2001; Swan *et al.,* 2003; Jackson, 2004). Some of the protocols are applicable on multiple issues and in various setting, while others are more theme and context specific.

A number of European countries, including the Netherlands, Belgium (Flanders), United Kingdom, Germany, and Switzerland have developed guidelines to enhance the quality of health promotion interventions as well as tools to assess their quality. A study in Flanders has suggested that the use of such tools improves the quality of planning of health promotion projects (Van den Broucke and Lenders, 1997). Again, IUHPE has stimulated European-wide collaboration in this area, for instance by conducting a project in 1996 to build a framework for quality assurance in health promotion (IUHPE, 1996).

Despite previous efforts, however, a lot of work remains to be done. The extensive body of knowledge on effective health promotion methods for different themes and settings is not well known to practitioners and what is known is only partially implemented in practice (Jones and Donovan, 2004). A significant gap exists between the research and practice communities. As researchers debate what counts as evidence for health promotion and how it should be collected, practitioners do not always know which protocols or tools to use, for what purpose, and in what context.

The GEP project addresses the problems mentioned above. In addition to presenting a state of the art of the evidence base of health promotion and making it more easily accessible to practitioners, it strives to develop the notions of evidence and quality one step further. The project aims to cultivate consensus-based guidelines and tools on how to review sources of information concerning health promotion and implementing evidence into practice. The project is supported by the European Commission, and relies on a unique collaboration between a consortium of health promotion agencies and institutes from nearly all EU Member States.

In this paper, the work of two of the strands of this project will be presented. The first is concerned with the development of a consensus-based protocol to review research, documents and expertise reflecting the effectiveness of health promotion. The second focuses on the development of a consensus-based quality assurance tool for health promotion interventions.

Two strands with parallel aims

Strand I and II of the GEP project complement each other as they both aim to develop consensus-based tools to assist health promotion practitioners enhance the effectiveness and quality of their interventions. Strand I aims at producing a consensus-based review protocol and list of critical criteria to be used to select and review items on health promotion effectiveness as they appear in the research literature, policy papers, other documents and in practice. The target group for the detailed (full model) review protocol is mainly the researchers who produce reviews to evaluate the contents of the information that is collected. However health policy makers and practitioners can use the main steps and synthesis parts of the protocol. Strand II aims at developing a tool to enhance and assess quality in health promotion interventions. Both strands build on the current practices and experience in a number of European countries. There are 25 project team members and partners drawn from 18 countries in the GEP consortium. Project team members are from agencies that are active in this field, who have the capacity to participate fully in the project and have committed themselves to disseminating the GEP project results within their own country.

To reach the project aims, specific objectives were outlined. For Strand I these objectives are: 1) to make an inventory of the existing review instruments in health promotion; 2) to make an inventory of the main quality criteria for the review process; 3) to create a consensus-based review protocol and review criteria; and 4) to pilot test the consensus-based review protocol and criteria. The objectives for Strand II are: 1) to make an inventory of the existing quality assessment tools for health promotion projects; 2) to make an inventory of existing guidelines to increase the quality of planning and implementation of health promotion projects; 3) to reach a consensus on an assessment protocol and a set of guidelines to increase the quality of planning and implementation of health promotion projects, to be used by health promotion professionals; and 4) to pilot test the consensus-based assessment protocol and quality guidelines.

The concept of health promotion guides the evidence process

When reviewing the evidence of health promotion effectiveness on a topic, it is not uncommon to find that there are several studies yielding discrepant findings and done with varying degrees of quality (McQueen and Andersson, 2001; Rootman *et al,* 2001). The question of how to pick the most reliable evidence, and how to decide what passes for evidence arises. Similar questions arise with regard to quality in health promotion. Quality remains a subjective concept, and its definition often depends on the person defining quality. As a result, different stakeholders in a health promotion project may have different views on what has to be achieved and how. The answer is ultimately dependent on the concept of health promotion, for which no universally accepted definition exists (Tannahill, 1985). A useful distinction has been made between health promotion as an *outcome* and as a *process.* In the GEP project health promotion is seen to encompass both outcomes and processes and applies to the structured efforts to enhance health at societal level (health policy, health education through mass media campaigns), community level, and individual or group level. Furthermore, it is acknowledged that health promotion takes place in a range of settings, such as communities, workplaces and schools. In addition to health promotion GEP has also included public health and disease prevention interventions, as different agencies and countries can use these different terms to mean the same set of activities.

A broad concept of evidence

What constitutes evidence and how to

assess it are fundamental ontological and epistemological questions. Within the GEP project, scientific evidence is seen as crucial, but limited form of evidence. Scientific, professional and community groups make legitimate claims to expertise, and often these claims compete with each other (Rada *et al.,* 1999). Research evidence comprises various combinations of study types such as randomised control trials (RCT), and it has been seen as the highest and most reliable form of evidence. Expert opinion, on the other hand, has been identified as the least reliable form of evidence on the effectiveness of interventions, and is positioned at the lowest level in the hierarchy of evidence (http://www.cebm.net/levels_of_evidence.asp). It has been even stated that expert opinions are not useful or appropriate because they are qualitatively different from the forms of evidence that are derived from research (National Health and Medical Council, 2000). However, expert opinion, in the sense of the view of one person or consensus view of a group of experts, can also be regarded as a means by which research is judged and interpreted, rather than as a weaker form of evidence (Rychetnik *et al.,* 2004). In addition, experts can also function as information sources, or as a way to find additional sources. In any case, in the real life practice and functioning of health promotion, much of the work is largely based on the experience and expert opinions.

The GEP project builds on a broad definition of evidence. Evidence is not restricted to the results of hard, scientific research, but should be seen as the broader answer to the question regarding what works in health promotion and public health. In addition to randomised controlled trials and publications in peer reviewed journals, this definition also allows for the use of other valuable information sources, including the views of experts and examples of good practice. In this way evidence can encompass data derived from several sources regarding research and practice, which can be combined and compared. Besides written information, attention should be given to expert knowledge and secondary sources, including the internet.

It is not only important to establish evidence on what works in health promotion, but also to understand how things work and why they work, as well as where they work. This implies that in addition to the evaluation of outcome, the evaluation of processes is also important, providing insight into the conditions for successful implementation and replication.

How to identify the best evidence

Knowing how to use the available research literature and expertise is imperative for ensuring effective health promotion (McQueen and Andersen, 2001; Speller *et al.,* 1997; Strand *et al.,* 2003; Wong, 2002). Effective, high quality health promotion policy and practice must be based on information from the existing evaluation research, statistical and epidemiological sources and expert knowledge. Collecting this evidence requires conducting extensive cross-disciplinary literature searches, selecting the most effective programmes and applying quality appraisal criteria to determine the validity of the findings. It also requires paying attention to agreed health promotion concepts, socio-cultural and organisational factors (Rada *et al.,* 1999). In addition, health promotion also involves looking outside of the health field and including evidence from policy and social sciences research. This implies a broad understanding of how evidence is gathered (McQueen and Andersson, 2001). Furthermore, the logic of evidence-based practice identifies a cyclic relation between evaluation, evidence, practice and further evaluation (Rychetnik *et al.,* 2004; Scholten and Kremer, 2004). Thus, health promotion and public health practice should build on evidence-based practice.

In order to collect the existing evidence according to the above principles, health promotion researchers make use of systematic reviews. A systematic review is a method of identifying, appraising and synthesising research evidence (Rychetnik *et al.,* 2004; Bruce and Molison, 2004). In the context of evidence-based practice, these evidence reviews tend to be technical processes that require a good understanding of research methods and that are guided by review protocols and standard criteria. There are many systematic review initiatives internationally, several of which have focused specifically on health promotion and public health topics and interventions (Rychetnik and Wise, 2004). However, most of these initiatives have used review protocols designed for medical and clinical studies, and applied them to health promotion. Speller *et al* (1997) have cautioned that considering health promotion with the tools used in evidence-based medicine carries the risk that health promotion is designated as not effective because it is assessed with inappropriate tools. In addition, in the current EBM protocols studies are selected on the basis of their research quality, and not of the quality of the health promotion interventions.

To counter the inherent problems, attempts have been made to address scientific evidence specifically for health promotion. The most recent attempts in this regard are the development of a guideline for reviewers of health promotion and public health interventions by the Cochrane Health Promotion and Public Health field (Jackson, 2004), and the Evidence Base Initiative of the Health Development Agency in England (HDA). Also in the United Kingdom, The National Health Service Centre for Reviews and Dissemination (CRD), which have close ties with the Cochrane Collaboration, have produced a number of systematic reviews of health promotion and disease prevention interventions. All of these initiatives have their own instruction on how to find, define and summarise evidence. Most of the existing protocols concentrate on evidence from research (mostly RCTs) and from published documents, while little attention is given to evidence from practice and from expert opinions. One of the challenges of the GEP project is to broaden this scope, and to include non-research based evidence on health promotion effectiveness, as well as qualitative research and other qualitative information. The GEP project will not be limited to an inventory of existing review protocols in the field of public health and health promotion, but it will also compare and analyse these protocols, identify gaps, and consider their respective applicability in the field of health promotion. Issues like their theory base, contextual aspects, and replicability, applicability by different end users, and the value of the protocols in adding to the knowledge base of health promotion effectiveness, are of central interest.

Criteria to appraise evidence

An aspect that receives more attention than any other in existing review protocols is the criteria by which the

quality of the research or other forms of evidence are judged. These critical appraisal criteria are checklists or standards that are used to evaluate research evidence. They can be applied to assess the value of a single study, or to appraise several studies as part of the systematic review process. Critical appraisal criteria address different variables, depending on the nature and purpose of the research and the expectations and priorities of the reviewers (Rychetnik *et al.,* 2004). Quality criteria that go beyond the research area are very much in their infancy at the moment. In this regard, the GEP project aims at making a substantial contribution.

From evidence to quality

Collecting and reviewing evidence of health promotion effectiveness is not a goal in itself: the idea is to use this evidence to improve the quality and effectiveness of health promotion interventions. This aspect is the main focus of the strand II of the GEP project. Quality can be defined as the degree of achieving what one wants to achieve. This way, it can be considered as a relative and dynamic concept (Parish, 2001). The methodology to secure and improve quality can broadly be referred to as *quality assurance* (Davies and MacDonald, 1998). It indicates the process of measuring, monitoring and improving quality, but also covers other activities to prevent poor quality and ensure high quality (Øvretveit, 1998). Quality assurance is mainly a cyclic process in which current practice is diagnosed and action is taken to improve this practice where needed.

The main approaches to quality assurance in health promotion are external audits, continuous improvement and process evaluation. For the first, an external controller checks quality standards and criteria. The second approach is more process-oriented and involves efforts to improve the planning quality and implementation of health promotion projects, for which the participation of professionals is fundamental. In the third approach, (process) evaluation is used as a tool for quality assurance (Ader *et al.,* 2001; Christiansen, 1999; Øvretveit, 1996; Speller *et al.,* 1997; Kahan and Goodstadt, 1999).

There are a number of advantages to introduce quality assurance in health promotion practice. The main ones are avoiding the use of ineffective strategies and methods, promoting the systematic use of evidence-based strategies, convincing stakeholders and assuring the basic and necessary resources, and integrating the needs and wishes of participants.

Assessing quality

To help assure quality, use can be made of quality assurance instruments. These instruments or tools consist of theory driven criteria or indicators that refer to attributes that indicate good or poor quality (Ader *et al.,* 2001). Criteria are descriptive, measurable statements that are used to assess the level of performance towards meeting a certain standard, or levels of excellence of performance that should be acceptable to colleagues and service users. Quality indicators are a further elaboration of standards and criteria (MacDonald, 1997; Speller *et al.,* 1997). Criteria or indicators can be used to assess quality in a systematic way by means of questions or checklists. They can be scored by others, or used for self-assessment of quality. The latter is the cyclic, comprehensive, systematic and regular review of a project's activities against a quality standard, culminating in planned improvement actions.

The use of quality assurance tools in health promotion projects is mostly found in the context of programme management, or in the cycle of managing the actions involved in the planning, implementing, evaluating and disseminating interventions for health promotion. In this way, a number of health promotion agencies have developed guidelines to enhance the quality of health promotion interventions, as well as tools to assess the degree of this quality. While these guidelines and tools are in many ways comparable, some differences remain. For example, while all instruments are based on theories or models, the nature of these models can differ, with some tools referring to health promotion planning models (such as precede/proceed) and others to project management or quality assurance models. Further, the number of criteria differs considerably between tools, as does the format in which they are presented (a scoring form, checklists or worksheet) and the way they are scored (yes/no, 3 or 5 point scales). Finally, some instruments are mainly used to help practitioners increase the quality of their interventions, while others are intended for funding agencies to help them decide about funding. In other words, there is a range of tools available that serve very similar purposes but have their own characteristics. This is not only confusing for health promotion practitioners who want to use these tools, but also makes it difficult to compare quality of health promotion interventions across countries. In this regard, strand II of the project is aimed at reaching a consensus on which criteria and indicators are the most important ones, and on how they should be operationalised in view of elaborating a consensus-based quality assurance tool for health promotion interventions.

Progress of GEP I and II

Since its launch in April 2004, the GEP project has already taken a number of steps. Strand I started by making an inventory to describe and evaluate the existing review protocols. This was done via a data gathering process consisting of two parts. The first involved a survey on review protocols and quality criteria used by the GEP project participants, and the second a literature and web search on existing review protocols. Altogether, 16 review protocols were identified. Analysis of review protocols was based on predetermined criteria using reviving process with three discrete elements:
1) planning phase,
2) conducting the review, including sources and channels of information, selection criteria, quality assessment, data extraction and synthesis, and
3) reporting and dissemination, and challenges in summarising evidence for health promotion and public health. Two independent readers carried out the analysis and both wrote a short summary on each protocol. Based on the analysis of the existing review protocols a draft European Review protocol will be developed. The development work will be done through a Delphi process and feasibility tests carried out by participating project members.

Strand II also started with an inventory, in this case of the existing guidelines to increase the quality of planning and implementation of health promotion projects and of quality assessment tools for health promotion. Using a number of strategies, including a systematic review of

the published literature, internet search, consultation of project partners and other organisations, and snowball sampling, 27 quality assurance guidelines and 15 quality assessment tools were identified. For both guidelines and quality assessment tools, a systematic content analysis was performed yielding a description of their content, technical and scientific aspects. Further, the quality criteria of the 15 quality assessment tools were listed and grouped into 10 clusters, encompassing the different aspects of project planning, implementation, evaluation and dissemination, as well as the key points of project management and the framework of health promotion principles. The clusters served as a basis for the development of a consensus tool. The latter was achieved through a Delphi procedure involving the project team members and partners. After two Delphi rounds, consensus was reached on a set of 13 criteria and 68 indicators. On the basis of this set, a new consensus-based tool will be developed and pilot tested.

Conclusions

Getting more evidence into practice improves the quality and effectiveness of health promotion. Success is dependent to some extent on whether the gap between research and practice can be bridged. The GEP project has contributed to the debate on what counts as evidence for health promotion. In addition, review and quality assurance guidelines and tools will be made available to help health promotion practitioners make better use of existing evidence so that they can enhance and assess the quality of their projects. The participating project team members and partners from a large number of European countries provide a wide multidisciplinary and multicultural network that may been seen not only as the producer of the project results but also as a vessel of getting the results to the use by the practitioners.

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Viv Speller, Erica Wimbush and Antony Morgan

Evidence-based health promotion practice: how to make it work

This is a brief overview of some theoretical issues underpinning getting evidence of effective health promotion into practice, illustrated by some examples of exploratory work over recent years of three national agencies; the Health Development Agency in England; Health Scotland, and The Netherlands Institute of Health Promotion and Disease Prevention (NIGZ). It aims to provide some pointers about where future attention and effort should be paid to ensure the implementation of the growing body of evidence in health promotion and public health. It proposes that in order to develop evidence-based health promotion practice attention needs to be paid equally to four parallel tracks of activity:

- Systematic review of research and collation of evidence;
- Developing and disseminating evidence-based guidance;
- Developing the capacity to deliver effective evidence-based practice; and
- Learning from effective practice.

Drawing from the experience of these agencies, and from evidence about how to change practice, this paper proposes that further emphasis should be placed on capacity-building and learning from practice in order to redress the dominant focus on collating evidence. It argues that there has been limited understanding of the different disciplines, world-views, and approaches that are encapsulated within the simple phrase of getting evidence into practice, and insufficient support to resolve the tensions inherent in attempts to integrate these conflicting perspectives.

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Getting evidence into practice, or evidence-based policy and practice, has become both a mantra and a priority pursuit for the improvement of public sector delivery, especially in healthcare. Implicit in this has been the expectation that the simple identification and dissemination of evidence of effective interventions would lead directly to improvements in practice; consequently there has been considerable investment in many countries in the evidence production industry. The origins of evidence based health promotion and public health lie in the evidence-based medicine movement in healthcare. Evidence based medicine has been well defined and its processes developed in the last decade (Sackett *et al.,* 1996; Egger *et al.,* 2001; NHS Centre for Review and Dissemination [CRD], 2001). The prerogative has been to find the best and strongest evidence, with the implicit assumption that the stronger the evidence, the more powerful its influence on practice would be. This led to the bias towards systematic review synthesis of primary research based on randomised controlled trials (RCT). This has created a *de facto* hierarchy of research design, which has been substantially and carefully employed to build up an extensive body of knowledge of effective healthcare. However the pre-eminence of the RCT method has sparked considerable controversy when applied to health promotion and wider public health interventions, where it has been seen to be an inappropriate research design for evaluating complex community based public health interventions (Black, 1996; Speller *et al.,* 1997; Nutbeam, 1998). Despite these concerns the RCT is recognised to provide the best possible information of effectiveness, where the research design is appropriate to the intervention type (Oakley, 1998; MacIntyre *et al.,* 2001). The lack of information from process evaluation, both in primary studies and in reviews, about the nature and quality of the intervention, makes studies difficult to replicate in practice (Speller, 1998). Similar concerns have also been voiced about the scope of evidence based medicine and the need to include information from qualitative research (Green and Britten, 1998).

The RCT debate has dominated much of the dialogue on health promotion effectiveness. The inability of health promotion to demonstrate evidence of effectiveness using the established methodology may well have weakened its position in policy, with policy-makers taking the often but wrongly held position, that a lack of evidence of effectiveness equates to evidence of no effect.

Within health promotion there is a deeper understanding of the complex relationship between context and behaviour, and the need to influence systems and structures as well as individuals to support change. This complexity exposes the limitations of evidence based medicine. Moreover, recent debates have cautioned that the influence of research based evidence in policy is not a simple linear relationship, it depends upon understanding institutions, values and broader sources of information (Lomas, 2000; Black, 2001; Muir Gray, 2004). A recent theme issue of the British Medical Journal recognised that evidence based medicine was a necessary but not sufficient prerequisite to change

Key words

- capacity-building
- effective practice
- evidence
- knowledge management
- theory of diffusion of innovations

behaviour (Straus and Jones, 2004). Sheldon *et al.,* (2004) have also shown that guidance produced by the National Institute of Clinical Excellence (NICE) has had an uneven impact on uptake of evidence, and they call for more effort on making guidance relevant to practice, providing professional support and resources, and encouraging healthcare organisations to set up formal mechanisms to support implementation.

The theory of diffusion of innovations, first described by Rogers in 1958, has been revisited in the context of research utilisation to understand what lessons it may have for evidence based practice (Nutley *et al.,* 2002). The process of adoption of an innovation requires three distinct types of knowledge: awareness – knowing an innovation exists; how-to knowledge – the information to use it properly; and principles knowledge – understanding of how it works (Rogers, 1995). Models of process of diffusion initially emphasised innovation *push*, relying on dissemination of knowledge to achieve technology transfer. This is where much evidence based practice has concentrated to date, on the communication of guidance, or protocols for delivery. Later models have emphasised the role of *demand pull,* focussing on interpersonal communication between researchers and users, the role of organisational barriers and facilitators and the need for ongoing interaction of ideas. Rogers (1995) also considered intermediaries played an important role in adoption; both opinion leaders and change agents. Nutley *et al.,* (2002) summarise some of the lessons to be learned for evidence based practice from diffusion of innovations research as: requiring attention to the heterogeneity and technical competence of the audience; whether diffusion should be controlled by central bodies (such as NICE) or looser professional networks; and the organisational context. They caution against application of earlier linear rational models of diffusion, and also that the model has had little to say about discontinuation of ineffective practices.

Key principles for changing individual practice have been described, for example, in the NHS CRD and the Cabinet Office reviews of spreading good practice (NHSCRD, 1999; Ollerearnshaw and King, 2000). These include briefly: analysis of factors such as users' preparedness to change and external barriers; involving peers in defining and disseminating best practice; learning from others' experiences and identifying what will work in local circumstances. Successful strategies are likely to be broad based including effective elements such as use of reminders and educational outreach, with contact through networks, benchmarking or other interactive systems; while data sources need to be trustworthy, didactic instructions from the centre should be avoided.

Attempts to involve practitioners and policy-makers in both the primary research processes to make these more relevant, as in Health Scotland; and in the production of evidence-based guidance, as in HDA, aim to address some of the issues regarding relevance and practicability. However they are still based around a model of deriving and improving information about effective practice, combining explicit knowledge and the tacit knowledge held by practitioners.

Nutley *et al.,* (2004) note that there has been a shift in thinking about knowledge as an object or commodity, towards the study of knowing as 'something that people do', and hence the process of knowing is important. In the literature on knowledge management, knowledge push approaches aim to increase the flow of information through capturing, codifying and transmitting it, whereas knowledge pull approaches are concerned with engaging practitioners in searching and sharing information. It is clear that much of the effort in getting evidence into practice has been expended on knowledge push, rather than pull approaches. However surveys of best practice in knowledge management in the private sector have shown that more top performing companies used knowledge pull techniques (Kluge *et al.,* 2001). Nutley *et al.,* (2004) conclude that the creation of databases, research syntheses and prescriptions for practice may be necessary, but is probably not sufficient on its own for effective knowledge sharing and use. Work to elucidate these pull mechanisms further in the clinical field has included studies of communities of practice, defined as a collection of individuals bound by informal relationships who share a similar work role in a common context (Gamble and Blackwell, 2001) and ethnographic research on general practitioners that showed they rarely accessed explicit evidence or guidance but instead rely on mindlines, which are collectively reinforced, internalised, tacit guidelines (Gabbay and le May, 2004).

The examples described below demonstrate how agencies with similar national remits have attempted to draw on this emergent understanding and trial different approaches.

Health Development Agency, England

Producing evidence and guidance

The Health Development Agency (HDA) began its work in 2000 to maintain an up to date map of the evidence base for public health and health improvement, and to disseminate advice to practitioners, against the background of controversy about the type of evidence that might be used to inform public health and health promotion practice. At the outset, it was acknowledged that not only is the definition of evidence controversial, but also that bringing about change in policy, organisations and practice based on evidence is not straightforward. Collecting and appraising evidence, converting it into advice and guidance and supporting change within complex systems, are each complicated processes in themselves, and are based on different methods and philosophies. The HDA's challenge has been to create an evidence into practice cycle by integrating the conduct of each of the disparate processes of evidence generation, developing guidance and changing practice, to clarify their underlying assumptions and to make them as transparent as possible (Kelly *et al.,* 2004).

Building a map of the evidence base for public health interventions initially involved collating and synthesising evidence from an accumulating number of existing systematic reviews on public health topics, making this accessible and highlighting limitations of both methodology and reach. The intention was subsequently to enhance this by incorporating forms of evidence drawn from research traditions other than experimental and randomised controlled trials.

A detailed protocol for searching databases, conducting the critical appraisal of the reviews, and writing the

Evidence Briefings on a range of topics was constructed (Kelly *et al.,* 2002; Swann *et al.,* 2002). These are tertiary level research that involves reviews and syntheses of existing systematic reviews and meta-analyses. The documents are on the HDA website http://www.hda.nhs.uk/evidence, which also contains copies of the original systematic reviews they draw upon, and full bibliographical information about primary sources. It was intended that the next stage of evidence generation would involve its extension to gathering data drawn from other sources such as observational epidemiology, social scientific investigations, including those using qualitative designs, grey literature and eventually data from practice (see Dixon-Woods, 2004).

The Evidence Briefings provide a comprehensive, systematic and up to date map of the available review level evidence base for public health and health improvement. They are, however, a passive resource. In order for the evidence to be directly applicable to the field, a more active approach was required to make it accessible, contextualised and easily implemented. To determine whether an intervention, even one well founded in the evidence, would be likely to be successful, requires an understanding of local contexts and circumstances, of local professionals' knowledge bases, commitment, and engagement, and detailed assessment of the particular population at whom the intervention is aimed.

The HDA has produced a wealth of guidance to support the development of aspects of effective public health practice (see, for example, Health Development Agency, 2001; 2002), based upon traditional approaches to evaluating the evidence, assessing the policy and practice context, consultation with stakeholders and target audiences and examples of good practice. The HDA has now developed a more integrated, systematic and empirical way of involving practitioners in producing guidance. The process involved testing the research messages' strength (validity/reliability) paying attention to generalisability, transferability and the means of turning findings to action. Once the most reliable, valid and potentially useful findings were identified these were tested with practitioners. Groups of relevant practitioners and agents involved in the delivery of the service assessed the findings in the light of an appraisal of existing practice and organisation. They considered current organisational and professional barriers to change, in order to better identify drivers, triggers, opportunities and pressure points relevant to making the evidence work on the ground. This phase is critical in informing where and how the evidence can be used and the type of activities that are likely to be effective in changing practice (Kelly *et al.,* 2003). This fieldwork was undertaken around the country with different groups of practitioners, using qualitative data gathering techniques, to build up a systematic account of patterns of local issues and problems identified, as well as examples of effective (or ineffective) practice. In 2004 a number of Evidence and Guidance Collaborating Centres were established linking research expertise on specific topics in universities with the goals of maintaining the evidence base on topics and continuing to prepare practitioner informed guidance for the field (http://www.hda-online.org.uk/html/about/collaboratingcentres.html).

Capacity-building for effective practice

While evidence and guidance publications are routinely disseminated widely to policy-makers and practitioners in England, the HDA has consistently paid attention to the local needs for support for implementation and changing practice. This was built upon understanding from diffusion of innovations theory of the limitations of simple dissemination methods on widespread adoption and implementation of evidence-based practice, and on emerging understanding of the relevance of complexity theory in bringing about change in complex systems. The HDA resourced four main routes to supporting the development of effective public health practice and systems. These included nine regional development teams of the HDA based in regional government offices and health authorities around the country; central practice development staff with expertise in particular topic areas; specific national co-ordination programmes such as the National Healthy School Standard, and Practice Development Collaborating Centres established in 2004, (http://www.hda-online.org.uk/html/about/collaboratingcentres.html). Each of these activities contributes to the dissemination and adoption of effective practice, and national level co-ordination of regional delivery facilitates learning from practice and sharing between regions. The HDA development functions aim to implement effective public health actions, using evidence based methods that build on what is known about best practice in improvement techniques (NHSCRD, 1999; Ollerearnshaw and King, 2000); and, critically, engage with the field to support the detail of implementation locally using educational methods, learning networks and change methods such as Open Space Technology and visioning (see Latchem *et al.,* 2003; Burke *et al.,* 2002).

A framework the HDA found useful in understanding the different categories of potential development interventions is the capacity building framework for health promotion developed in Australia (NSW Health, 2001). Capacity building is defined by Hawe *et al.,* (2000) as the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors. The framework identifies five key dimensions for change actions: organisational development, workforce development, resource allocation, partnerships and leadership. Through its national, regional and local staff and connections the HDA aimed to support change and improvement in capacity, informed by evidence or best practice, in each of these dimensions.

The HDA set out proposals in 2004 for a *Learning from Effective Practice System and Standards* for the systematic collection, review and synthesis of effective health improvement practice. The aim has been to develop a national process to support planning, evaluating, recording and retrieving effective practice. The programme aimed to develop a system designed to work alongside and add to other types of evidence and approaches for capturing practice based learning in a way that could enhance, extend and enrich the public health evidence base and practice. This formalised process of capturing and systematically sharing the tacit knowledge about effective local interventions so that it can be combined with evidence from the published literature, to provide robust guidance about what works, completes the evidence into practice cycle. The HDA's functions transferred to NICE in

April 2005 to form the National Institute for Health and Clinical Excellence (NICE). At the time of publication, NICE is consulting on the production of public health evidence and guidance, and how regional teams can best support NICE's implementation programme, including whether they should encompass both public health andclinical topics..

Health Scotland

Political devolution in Scotland in 1999 has led to a more open and consultative policy development process with government. There are distinctive features of the policy and practice contexts in Scotland that shape the way in which evidence-based implementation is being forged. Scotland has small close-knit communities of people involved in academic public health research, and public health and health promotion practice in 15 local health boards. At national level the potential for evidence-informed policy and practice development has been strengthened through the creation of Health Scotland, incorporating the Health Education Board for Scotland with its focus on health promotion research and evaluation for programme implementation and practice development, and the Public Health Institute for Scotland which gathered and disseminated population health information and evidence, and developed a multi-disciplinary public health workforce. The establishment of three National Health Demonstration Projects has also contributed to evidence-based practice with learning from their evaluations feeding back into policy and practice development.

It is clear that an evidence based approach involves more than producing systematic reviews of evidence and improving dissemination efforts. It also requires the cultivation of new professional roles and the development of collaborative mechanisms working across research-policy-practice boundaries. These ideas drew upon the work of the Research Unit for Research Utilisation at St Andrew's University (RURU) (Nutley *et al.,* 2002; Walters *et al.,* 2003) and the Canadian Health Services Research Foundation (CHSRF) (CHSRF, 2000; Lomas, 2000), which both emphasise the importance of developing collaborative approaches that improve communication, linkage and exchange. To illustrate this, examples of effective collaborations in the development and evaluation of specific public health interventions, and examples of professional roles that have been developed at national level, are described.

Research-policy-practice collaboration

Following high rates of HIV infection in drug injectors in parts of Scotland in the mid-eighties the politically sensitive step of introducing needle exchange schemes was piloted. Initial schemes were set up without consultation or research and failed. A more collaborative process of research, service development, consultation and process evaluation was pursued over a number of years, and successful needle exchange schemes were established that provided a transferable service model that has been effective in reducing the prevalence of HIV in users and preventing a potentially catastrophic HIV epidemic (Gruer *et al.,* 1993).

The success of this evidence-based approach to public health practice was founded upon effective research-policy-practice collaborations over a period of years. It involved policy-makers, the national disease surveillance body, local public health teams, and those providing services to injecting drug users. Feedback from monitoring and evaluation research played a crucial role in ensuring that policy decisions and practice developments continued to be strongly evidence-based. This feedback reassured policy makers that the approach taken was effective and modifications to the intervention were made from evaluation evidence. For example, the number of needles and syringes that could be given on each occasion was increased after it was shown that the allowable number fell well short of what most injectors required.

A second example of successful research-policy-practice collaborations in Scotland but with less dramatic results has been in sexual health, where a school sex education programme, Sexual Health and Relationships Education (SHARE) was developed over ten years, using an interactive process of research, resource development and consultation with education and health practitioners (Wight *et al.,* 2002; 2004). SHARE was evaluated in 25 schools using an RCT design and process measures. The main outcome measure was the termination rate for women under 20. While at interim evaluation SHARE was received well, there was no impact on levels of sexual activity or contraceptive use in the target group. Despite this, and the fact that the final outcome measures were not yet available, the SHARE training was rolled out nationally as a basis for work in secondary schools across Scotland. So while there was an effective collaboration and success on process and educational measures, the absence of positive effect posed dilemmas for those involved in its dissemination.

Professional evidence-based policy and practice roles

For these collaborative processes to become mainstreamed, different structures, working practices and professional roles are required to ensure ongoing linkage and exchange. In the literature on the barriers to interaction, the role of intermediaries, such as expert or peer opinion leaders, and interpersonal contact between researchers and policy-makers is emphasised (Locock *et al.*, 2001). Lomas (2000) also stresses the importance of linkage and exchange to increase trust between the two communities. The CHSRF used the ideas of Lomas on improving linkage and exchange to develop their approach to evidence-based decision making (CHSRF, 2000). This model seeks to create direct interactions between researchers, funders, decision-makers and knowledge purveyors, and designs structures and ways of working that facilitate the exchange of ideas, problems and solutions between these groups. The role of National Learning Networks set up in association with the three National Health Demonstration Projects and the Research Specialists within the former HEBS illustrate the model in action.

In 2000, three national demonstration projects were funded in the priority areas of coronary heart disease, child health, and sexual health and well-being of young people. While being implemented at a local level, the projects were established as test beds for national policy and practice, founded upon a strong evidence base and carefully evaluated to generate lessons of wider relevance. To ensure the wider dissemination of lessons learned, in 2002 a National Learning Network was set up for each facilitated by a Network Coordinator. The networks operate in three main ways: disseminating lessons learned from the implementation and

evaluation of the projects; distilling and disseminating the published international evidence base on effective practice in these areas and drawing this together with the tacit knowledge and experience of practitioners; acting as a catalyst to support capacity-building, facilitating an interchange between policy and practice and providing feedback on workforce development needs.

HEBS was established in 1991 to develop and implement national health promotion programmes and contribute to policy, to ensure that the development and delivery of national health improvement strategies and programmes are informed by existing evidence and are evaluated appropriately. The role of developing evidence based practice lay with seven Research Specialists with a remit aligned to policy priority areas and groups. Over the last twelve years, the Research Specialist role was developed to work in three main ways: to keep up to date with published research evidence in their area and ensure evidence is available and accessible to policy-makers and programme managers; to commission and manage new research; and to maintain good linkage with practitioner networks.

The experience in Scotland has shown that moving evidence into policy and practice can be done, but it is a complex, multi-factorial process. There is often no shortage of evidence. What is crucial is finding linkage and exchange mechanisms by which researchers, research funders, policy-makers and practitioners can engage together on issues of common concern. Crucial areas include intervention development and evaluation, and how research evidence and lessons learned from programme evaluations are available and accessible to effectively inform decisions of those who have the power to make a difference, the policy-makers and practitioners. We suggest that the development of new professional roles that work across the interface between research, policy and practice can make an important contribution to getting evidence into practice.

The Netherlands Institute of Health Promotion and Disease Prevention (NIGZ)

The Netherlands has an established infrastructure for health promotion. Dedicated specialists (approximately 1500) work in a variety of regional and national institutions. The Netherlands Organisation for Health Research and Development (Zonmw) promotes quality and innovation in the field, initiating and fostering new developments, knowledge transfer and implementation. The Ministry of Health, whilst only allocating two per cent of the health budget to health promotion, has given the field a prominent place within recent policy initiatives.

A fundamental and ongoing debate has been what constitutes appropriate evidence in health promotion. The relevance of the RCT to complex health promoting interventions has been given particular attention, a point picked up earlier in this paper. As early as 1997, a conference was organised where the issue of suitable evidence was the focus of discussion between Dutch and international experts. It took a further four years before the Ministry of Health and Zonmw fully recognised that the question of establishing appropriate evidence for health promotion deserved greater national attention. A further four conferences were organised that offered free access for policy-makers and managers, researchers and practitioners to engage in a critical examination of what was adequate research for health promotion. The Ministry of Health and Zonmw were supportive of the project to improve the evidence, with a group of key stakeholders invited onto a steering committee. In all, almost a thousand delegates attended the four conferences, drawn equally from the three targeted groups; policy makers and managers, researchers and practitioners.
A book is to be published which describes three important lessons learned through these discussions:

- There is a need to develop and share a common frame of reference as an interface for exchange of experience and to build common knowledge.
- A diverse range of research needs to be drawn on and a closer link established between policy and practice. Special attention should be given to the context and organisational conditions, in combination with more comprehensive programmes that cover a variety of health promotion interventions.
- A shift should be made to active knowledge management, to ensure quick sharing and use of knowledge. To organise that dialogue new funding is already available.

The Knowledge Management Cycle (outlined in the Saan editorial in this special edition) was a concrete outcome of the four conferences, capturing the importance of balancing evidence with knowledge of effective practice and organisational support for knowledge management, to assure its implementation in practice.

Conclusion

The national examples outlined above demonstrate an inherent tension in simultaneously operating different strands of activity to get evidence into practice. These are not to be underestimated, nor their successes in balancing essentially disparate research, evidence building and practice development processes in the context of a dominant paradigm that, at least until recently, has favoured the pre-eminence of evidence. In these examples all strands of the so-called cycles or spirals of evidence into practice processes can be distinguished, including, as well as the collation of disparate forms of evidence and preparation of practice-informed guidance that values tacit knowledge, attention to the processes identified in the literature as important for change. These include: networking to share learning and foster mixed communities of research, policy and practice; the development of key posts such as, research specialist, and, practice development, acting as change agents and opinion leaders; creation of bodies of knowledge and communication to practitioners, both about the availability of information and how to use it to encourage knowledge pull; and influence on workforce and organisational development aspects to build capacity.

Space does not permit further debate on the problems faced by those in these national agencies responsible for the delivery of actually getting evidence into practice, and a further step might be to draw on this experience to explore in more detail some of the lessons learnt. This would include issues such as: the tension between the focus on what users actually want and need, rather than just producing what can be easily produced; the lack of concentration on and resourcing for developmental support for practice in tandem with evidence production; and the disruption caused to quite fragile mechanisms for collaboration across these different streams of activity by both internal and external

organisational change. Given the interdisciplinary nature of these endeavours it would also be helpful to develop agreed terminology and understanding of the different processes; evidence-based practice or evidence-informed practice; getting evidence into practice or evidenced based policy and practice; knowledge management; practice development and capacity-building, for example, all require further shared definition.

The IUHPE's Global Programme on Health Promotion Effectiveness has clearly much to contribute to furthering effective processes of getting evidence into practice. Given the ambient climate in evidence based medicine has moved much closer to the recognition of the need to consider all these dimensions for effective practice, it is now time for health promotion, with its inclusive and integrative disciplinary perspectives, to take the lead. The potential is there to demonstrate how, drawing on learning from diverse fields of literature and examples like these, to take forward both a respect for, and action on, the collation of research and practitioner informed evidence, *and* capacity-building to get it into routine practice.

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Eva Jané-Llopis

From evidence to practice: mental health promotion effectiveness

Mental health problems and mental and behavioural disorders are not exclusive to any special group, and are found in people of all regions, all countries and all societies (WHO, 2001). In Europe, mental and behavioural disorders have been estimated to cause 20 per cent of all Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries. DALYs is a methodology introduced in the Global Burden of Disease. It accounts for the disability and chronicity caused by disorders (Murray and Lopez, 1996). The DALY is a measure of health gap, which combines information on disability and other non-fatal health outcomes and premature death. One DALY is one lost year of healthy life.

Depression alone causes 6 per cent of disability, the third leading cause in Europe (Ustun *et al.*, 2004; Chisholm *et al.*, 2004). Suicide rates are the highest in the world and still 80 per cent higher in eastern than in Western Europe (Health For All [HFA] database). It is estimated that one in four persons will develop one or more mental or behavioural disorders during their lives (WHO, 2001) and projections estimate that poor mental health is increasing (Murray and Lopez, 1996; WHO, 2002).

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But it is not only the burden on the individuals that suffer from a mental illness. One in four families are likely to have at least one member with a behavioural or mental disorder (WHO, 2001). These families not only provide physical and emotional support, but also bear the negative impact of stigma and discrimination. So in most circumstances the burden of poor mental health is underestimated.

The costs of mental disorders are estimated to be between 3 and 4 per cent of Gross National Product (WHO, 2003), of which half are estimated to be healthcare costs. The rest are costs associated with lost productivity, loss of employment, social welfare or premature mortality and costs falling, for example, under labour, justice or education sectors.

Practice and policy in mental health promotion

The European World Health Organization (WHO) Ministerial Conference on Mental Health, *Facing the challenges building solutions*, held in January 2005, has put mental health promotion on the political agenda of Ministers of Health across Europe.

To support policy development, the publication *Mental Health Promotion and Mental Disorder Prevention: a Policy for Europe*, supported by the European Commission, presents a policy framework outlining areas for evidence-based action in mental health promotion (Jané-Llopis and Anderson, 2005a; 2005b). However, a list of policy options, a book reviewing the evidence, or a proposal for an action plan, although are essential contributions to move the field or mental health promotion forward, will not suffice to move evidence into practice and support implementation.

In addition to political will and the preparation of key documents, some major processes need to be addressed, developed and implemented, if an integrated evidence based action for mental health promotion is to be achieved. As outlined in other papers this issue (see the contributions from Mittelmark *et al.*, Slama, Speller *et al.*) these processes can be conceptualised in to four categories:

1. Collate, review and summarise evidence of health promotion effectiveness;
2. Disseminate the evidence in appropriate ways to policy-makers and to practitioners;
3. Assess capacity to implement evidence-based policy, programmes and practices;
4. Learn from effective practice to support further capacity building and improve the evidence base.

This paper will use these categories to structure a brief analysis of initiatives that aim to close the gaps in getting the evidence into practice for mental health promotion.

Collating the evidence of mental health promotion effectiveness

In the last decades a number of literature reviews have demonstrated that prevention of mental disorders and promotion of mental health can be effective across the lifespan (Durlak, 1995; Mrazek *et al.*, 1994; Price *et al.*, 1988; Albee *et al.*, 1997) and can provide cost-effective outcomes (Hosman and Jané-Llopis, 1999).

Key words

- mental health
- behavioural disorders
- Disability Adjusted Life Years
- mental health policy

Topic-specific literature overviews have confirmed that prevention and promotion approaches can be efficacious in reducing mental health problems and symptoms of mental disorders, including child abuse (MacMillan *et al*., 1994a; MacMillan *et al*., 1994b), conduct disorder (Reid *et al*., 1999), violence and aggression (Yoshikawa, 1994), depression (Muñoz, 1993; Muñoz *et al*., 1993; Gillham *et al.,* 2000), substance use (Gilvarry, 2000), and in different settings, including schools (Greenberg *et al*., 2001).

Meta-analyses have been undertaken to assess programme efficacy, quantifying outcome studies and identifying programme ingredients that might be responsible for programme effects. To date, meta-analyses have been relatively topic and age specific, and have been undertaken in the fields of harmful drug use for children and adolescents (Tobler, 1992; Tobler and Stratton, 1997; Tobler *et al*., 1999), mental health for children (Durlak and Wells 1997; Durlak and Wells, 1998), interventions for infants and children up to 6 years of age (Brown *et al*., 2000), programmes to prevent child sexual abuse (Davis and Gidycz, 2000) and programmes to prevent depressive symptoms (Jané-Llopis *et al*., 2003).

Finally, two recent major publications lead by the World Health Organization (WHO), and one developed by the International Union for Health Promotion and Education (IUHPE) under the Global Programme on Health Promotion Effectiveness (GPHPE), have reviewed the evidence of what works in mental health promotion and mental disorder prevention (WHO 2004 a,b; Hosman *et al*., in press; Herrman *et al.,* in press; Jané-Llopis *et al*., 2005).

Based on the evidence, the following sections provide a summary of some of the health, social and economic outcomes that have been achieved through mental health promotion and mental disorder prevention interventions.

Health and mental health outcomes
Interventions to promote mental and physical health during parenthood aim to develop personal resources, coping strategies, and parenting skills, as well as to create supportive environments for the individuals and their children. Efficacious parenting approaches, which include home-based programmes and parenting interventions, have shown increases in positive attitudes towards children, better knowledge about child behaviours, and a healthier psychosocial and physical development of children. Home-based interventions, especially for families at risk, such as those living in poor economic backgrounds or those where one parent suffers from a mental illness, have shown significant increases in subjective positive mental health and quality of life, such as life satisfaction, increased well-being, and decreases in maternal stress (Jané-Llopis *et al*., 2005). This has shown to be especially beneficial for the children because of the creation of healthy attachment from birth on, a better organised family life, and more stimulating environments throughout childhood. However a meta-analysis of 167 interventions for children from 0 to 6 years of age (Brown *et al*., 2000), whilst confirming the evidence of programme effects for health and social outcomes, indicated a large variation in outcomes across programmes, which calls for continuous evaluation of interventions and implementing those that have proven to be efficacious.

Interventions for pre-school (for example see Box 1) and school mental health promotion using a holistic school approach, that includes skills building components and environmental approaches (Weare, 2000), have shown improved psychological adjustment, competence enhancement and improvements in self-esteem, sense of mastery, and a better ability to solve personal problems. Such interventions have also shown decreases in feelings of self-blame, loneliness, learning problems, behavioural problems and aggression, depressive and anxiety symptoms and lead to more general improvements in mental well-being (Greenberg *et al*., 2001; Domitrovich *et al*., in press).

Efficacious interventions for adults include workplace mental health promotion initiatives, interventions for those out of work, and community services for retired people. These types of interventions have lead to a range of health outcomes (WHO, 2004a,b; Jané-Llopis *et al*., 2005). For example, legislation and environmental interventions at the workplace have been shown to lead to increases in mental health and well-being as well as reductions in symptoms of anxiety, depression, and stress-related problems (WHO, 2004b; Price and Kompier, 2005, in press). Exercise and social network interventions for elder populations have lead to increased physical and mental health and well being, and decreases in depression (WHO, 2004a, b).

Social outcomes
The effects of home-based interventions, pre-school programmes like the Perry Preschool (Box 1), and holistic approaches to school mental health promotion, have also resulted in short and long-term social outcomes. For

Box 1

The High Scope/Perry Preschool Project (Schweinhart and Weikart, 1998)
The High Scope/Perry Preschool Project targeted at risk 3 to 4 year old African-Americans living in poverty. It combined half a day preschool intervention using a developmentally appropriate curriculum with weekly home visits.
Health and social short term results
On the short term, the programme led to reduced mental retardation, better social adjustment, school success and academic achievement, and increased high school graduation.
Health and social long term outcomes
When results were followed through childhood and adolescence of programme participants, up to age 27 years, the programme showed to lead to increased social competence, a 40% reduction in lifetime arrests, a 40% increase in literacy and employment rates, fewer social problems and welfare dependence and improved social responsibility.
Economic outcomes
The Perry Preschool Programme cost US$1000 per child, but the benefit produced was estimated at around US$7000, due to decreased schooling costs, increased taxes paid on higher earnings, reduced welfare costs, decreased justice system costs, and decreased crime victim costs (Barnett, 1993).

example, social aspects associated with mental health effects in school-based interventions include improvement in peer sociability, adaptive social skills, tolerance and compliance with rules, and adaptive assertiveness (Greenberg *et al.*, 2001). Long term social outcomes of home-based and pre-school interventions include, for example, decreases in teenage pregnancies, divorce-related events, crime and arrests, as well as increases in employment, literacy rates and social adjustment and responsibility (Olds, 1989, 1997, 1998; Schweinhart and Weikart, 1998).

Legislation and environmental interventions at the workplace can lead to increased productivity and reductions of sick leave. Interventions such as the Jobs programme (Box 2) have led to decreases in unemployment, better jobs in terms of pay, stability and possibilities of finding a job more quickly (Price *et al.*, 1992). The Jobs programme has been adopted and proven to be efficacious when implemented in different countries, like the evaluation undertaken in Finland that replicated the USA results (Vuori, *et al.*, 2002; Vuori and Silvonen, in press). Importantly for employers, there is also evidence of decreases in the frequency of sick leave due to mental disorders, such as depression.

Economic outcomes

The cost-effectiveness studies of the Perry preschool project and the Jobs programmes have demonstrated the economic benefits of these types of interventions (Vinokur, 1991; Barnet, 1993). Unfortunately, to date, very few cost benefit and cost effectiveness studies have been attempted to quantify the economic impact of mental health promotion programmes. For example, a meta-analysis of 167 programmes only identified two percent of the trials that had any reference to the costs and benefits of the interventions (Brown *et al.*, 2000).

However, in line with the World Health Organization report for mental health (WHO, 2001), not all the related costs or benefits for society can be estimated in economic terms. There are other mental health promotion intervention outcomes that are not expressed as specific financial costs and benefits that have an indirect economic impact. Indirect benefits might include increased productivity, lowering of the prevalence and incidence of disorders and related accidents and mortality, as well as reducing individual suffering and burden to families (Hosman and Jané-Llopis, 1999).

Box 2

The Winning New Jobs Program: Promoting Reemployment and Mental Health (Price *et al.,* 1992)
The Winning New Jobs Program was developed in the United States to help unemployed workers to seek reemployment and cope with the challenges of unemployment and job-search (Price et al., 1992; Caplan, *et al.,* 1989; Price and Vinokur, 1995). The programme is based on theories of active learning process, social modelling, gradual exposure to acquiring skills, practice through role playing, and inoculation against setbacks. The five workshops focus on identifying effective job-search strategies, improving participant job-search skills, increasing self-esteem, confidence, and the motivation of participants to persist in job-search activities. The intervention is designed to achieve its goals through the creation of supportive environments and relationships between trainers and participants and among participants themselves.

Health and social outcomes

The intervention showed increased quality of re-employment, increased self-esteem and decreased psychological distress and depressive symptoms, over 2 years, particularly among those with higher risk for depression (Price *et al.,* 1992). In addition, the programme has been shown to inoculate workers against the adverse effects of subsequent job-loss because they gain an enhanced sense of mastery over the challenges of job-search.

Economic outcomes

Cost effectiveness analysis of the JOBS programme showed a three-fold return on the investment after 2 ? years, and more than a ten fold return after five years (Vinokur et al., 1991).

Dissemination of evidence on mental health promotion in Europe

Information on efficacious mental health promotion could be of use across countries with different cultural and economic backgrounds. Evidence-based practices should be adapted to be culturally sensitive, tailored to different population groups, and developed according to the principles of effective implementation (Barry *et al.*, 2005). Unfortunately the evidence does not always reach countries and regions that are most in need of this information (WHO, 2002), and only a small number of countries have access to, and implement, effective programmes. For example two European directories on mental health promotion and mental disorder prevention for children and adolescents demonstrated that about 80-85 per cent of the collected programmes that were being implemented across Europe could not be considered as evidence-based approaches (Mental Health Europe, 2000, 2001).

A European initiative co-sponsored by the European Commission, aims to close this information-dissemination gap. An Internet database systematically describes mental health promotion and mental disorder prevention programmes, policies, their outcomes and their implementation essentials (www.imhpa.net). The provision of information on what works and what are the critical conditions for implementation (how, what and by whom should an action be undertaken) are pre-requisites for the translation of evidence into practice. However, in some cases programmes are already implemented and sustained in a country or region, although no formal evaluation has been undertaken. In those situations, guidelines for evaluation and programme improvement, such as those proposed by the Preffi instrument (Molleman *et al.*, 2004) can facilitate the use of evidence in practice.

Assessing the capacity for implementation

Unfortunately, the evidence base for mental health promotion and its dissemination across countries alone will not suffice to achieve action and to improve the populations'mental health. Along with information on what works, it is crucial to have insight on, for example:

what training is in place to develop capacity, what infrastructures are available to lead on implementation, what workforce in health and other sectors can be engaged, who will be responsible to implement what, or what are the support mechanisms for programme and policy implementation. Lack of information on these issues creates serious barriers to successful development and implementation of mental health promotion.

An initiative to map capacity in mental health promotion is the Mental Health module of HP-Source.net, a tool for health promotion (for further information see www.hp-source.net under the European mental health promotion module and the contribution by Mittelmark *et al*., in this edition). This speciality module aims to assess and provide an overview of the available infrastructures, policies and resources for mental health promotion and mental disorder prevention at the country or regional level. Information includes, for example, availability of training programmes for professionals, identification of key stakeholders, evaluation initiatives. This information is translated into country profile descriptions, and can be used as a tool for the further development of infrastructures, as a baseline for monitoring development at the country level, or as a supporting document to develop an action plan or a specific policy for prevention or promotion in mental health.

The questionnaire has been piloted in four countries, Poland, Norway, England and Scotland. To ensure a reliable collection of data, groups of experts from different professional backgrounds in the fields of public and mental health were invited to provide the information and to support it with the relevant documents and references. The sections below present a brief summary of some of the information captured during this first pilot around the issues of training, infrastructures and implementation of mental health promotion and mental disorder prevention.

Policy priority and funding
Mental health promotion seems to be considered a priority area across the four countries in which the questionnaire was piloted, as evidenced in speeches from politicians and policy makers and reflected in country policy documents. However, when respondents were asked whether mental health promotion is a real priority, respondents concluded across all four countries that mental health promotion is less of a real priority than seems to be indicated in the policy documents. This also seems to be reflected in the low level of resources allocated to promotion and prevention in Poland and in England during the last four years. Conversely, the current Scottish budget of £24 million for improving mental health and well being for the years 2003-2006, provided through the Scottish Executive's Health Improvement Fund, is impressive and illustrates that resources can be made available and priorities put into practice. As for where resources are allocated, in both Poland and Norway, governmental funding for prevention and promotion in mental health is available for national centers and institutes. In Norway the funding is also dedicated to research, screening and early detection, health professional education and specific events such as conferences and seminars.

Infrastructures for implementation and available programmes
Across the four countries different organisations are involved in developing the knowledge base and implementing mental health promotion and mental disorder prevention, including Mental Health centres, non-governmental organisations, universities, and other semi-governmental organisations. Across countries, the home, the schools and the workplace are the settings with larger availability of programmes for mental health promotion and mental disorder prevention. Identified settings with lesser availability of implementation include hospitals and elder care facilities. Interestingly programmes on the Internet are widely available in Scotland whereas they are not available in Poland. This highlights the potential and possible barriers to using existing new technologies to close information gaps across Europe.

Training
Training on mental health promotion and prevention of mental disorders is integrated in existing curricula in the UK and Norway, whereas in Poland no trainings for mental health promotion are available. In the training of primary and secondary healthcare professionals, teaching practical strategies for promotion of mental health and well-being (as distinct from treatment of mental disorders) does not seem to receive attention or be considered as a high priority.

Some barriers for implementation
In Poland, for example, the lack of non-governmental organisations, the lack of political will to implement the policies stated in governmental documents, the lack of training in the curricula of university studies, and the lack of cooperation between state agencies that get some funds for mental health promotion, have been identified as key barriers for the development of mental health promotion and mental disorder prevention. These barriers, among others, will apply to many different countries across Europe, and strategies need to be developed to facilitate overcoming these problems and translating evidence into practice.

Developing capacity through training

Mental health promotion requires a broad based professional workforce and strategies to build capacity are urgently needed across Europe. This could involve embedding mental health promotion and mental disorder prevention components in existing training initiatives for health promotion, public health, primary healthcare, mental healthcare and related disciplines; by ensuring that the practicing health workforce has access to continuing education programmes; and that the education of professionals in other sectors prepares them to recognise the importance and benefit of their policies and actions for the population's mental health (Jané-Llopis and Anderson, 2005a,b). Interdisciplinary research training programmes should also be made available to develop research skills to conduct evaluations, to improve the quality and effectiveness of practice (Mittelmark, 2003) and to stimulate the evaluation and improvement of implemented programmes through the creation of partnerships between research and practice organisations.

The WHO recommends that, since not all countries have the current opportunities for training for prevention and promotion

in mental health, international training initiatives should be undertaken in collaboration with organisations that already have the capacity for and the experience to support these countries (WHO, 2004a; 2004b).

One of such initiatives is the newly created training network for promotion and prevention in mental health, developed under the European Platform for Mental Health Promotion and Mental Disorder Prevention. The training modules are based on the cascade model of training the trainers'and aim to stimulate the development of capacity for promotion in mental health at the country level. Training modules include problem solving skills in primary healthcare, programme development and evaluation, programme implementation, and advocacy in mental health. The aim of the training modules is to translate the evidence into usable practice based skills that can be applied across different situations and countries. For example, a first pilot in the Netherlands, training general practitioners mental health promotion, showed the possibility of using problem solving skills in primary healthcare daily practice. Some of the problems identified in getting the intervention into practice included the lack of confidence of the general practitioners in delivering problem solving skills because of limited training, how to overcome the resistance of patients, or how to deal with the time restrictions of real life consultations. Training modules should adopt their core components in the light of the barriers that are identified in practice, translating practice into evidence, so that the circle of intervention development, implementation, and improvement can be completed (for a more detailed discussion of how to make evidence based practice in health promotion work, see Speller *et al.* in this edition of the journal).

From evidence to practice in mental health promotion

Assisting policy development

To move from evidence to practice, policy approaches to mental health promotion need to be developed. One of the key barriers identified by the four countries is that, although there is interest in mental health across political audiences, as evidenced in political speeches, still little action is undertaken. Therefore it is crucial to facilitate the translation of knowledge into practice, through policy guidelines and frameworks for action that make sense to policy makers and that respond to their needs. All policies need a firm knowledge base and decisions should be based on scientifically sound and socially relevant and feasible bases. The publication Mental Health Promotion and Mental Disorder Prevention: a Policy for Europe (Jané-Llopis and Anderson, 2005a) is based on the available evidence and provides such a policy framework for action. Prevention and promotion in some situations are included in larger mental health policies or plans, such as the recently published WHO Mental Health Action Plan (WHO, 2005) that has been endorsed by all European ministers of health.

However high-level documents only serve as frameworks and guidelines on which to base action and indicate how mental health problems could be tackled across European countries. The need is that action plans with support for implementation are developed in each European country, which fit its culture and needs. Efforts should be dedicated to compile evidence that not only makes sense to policy makers, but will also stimulate either the development of country based action plans for mental health promotion, or the integration of specific prevention and promotion components in existing general action plans for mental health.

Increasing efficiency: links between physical and mental health

In spite of the evidence for the efficacy of prevention and promotion in mental health, the challenge remains to increase efficiency of interventions, to implement effective strategies in the real world and to ensure their sustainability while simultaneously monitoring their impacts. Mental health and physical health are interrelated and their links are bidirectional. Physical ill health is detrimental to mental health as much as poor mental health contributes to poor physical health. For example, malnourishment in infants can increase the risk of cognitive deficits; heart disease and cancer can increase the risk of depression (Marmot *et al.*, 1999; Blane *et al.*, 1996); mood disorders can lead to an increased risk of accidents, injuries and poor physical and role function (Wells *et al* 1989); learned helplessness, hopelessness and depression are associated with decreased immunological activity and an increased risk of tumour growth and infections (Kopp, 2000). Because of this interrelationship, often outcomes of interventions to improve physical health lead to improved mental health and vice versa (Herman and Jané-Llopis, 2005). For example, interventions promoting a healthy start of life have led over time to reductions in crime, violence, harmful substance use, birth weight, child abuse, psychological distress, and increased employment (Olds, 1997; Schweinhart and Weikart, 1998).

These relationships between mental and physical health provide an opportunity to increase efficiency of interventions (Herrman and Jané-Llopis, 2005; Jané-Llopis and Barry, 2005). Especially in those cases where resources are scarce for mental health promotion, multi-component interventions that tackle generic determinants of mental and physical health can lead to multiple outcomes including the reduction of negative consequences such as unemployment and the increase of mental well-being and quality of life. An efficient strategy is to embed mental health promotion components in existing health promotion programmes, such as those that are already implemented in the community making use of existing available resources in every situation (Jané-Llopis, Saxena and Hosman, 2004). In the field of mental health promotion the case is made to strongly mainstream mental health promotion activities within health promotion, while the advocacy for mental health should remain distinct (Herrman and Jané-Llopis, 2005).

Conclusions

In the continuous efforts to put evidence into practice, key stakeholders should continue collating, reviewing and summarising the evidence of health promotion effectiveness; disseminating the evidence efficiently to key stakeholders, assessing capacity for implementation; and continuously learning from effective practice to support further capacity-building and improve the evidence base. In these processes it is therefore crucial to pay attention to the levels of evidence for

effectiveness, the cultural appropriateness and acceptability of practice across implementation areas, the financial, personnel, technical and infrastructural requirements needed, along with estimating the overall benefits and potential for large scale and efficient application. The barriers in implementing effective programmes, especially in countries with low level of resources, call for collective efforts of all organisations, sectors and professionals with responsibility for mental health (WHO, 2002) to work together and support development at the country and European levels.

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Karen Slama

From evidence to practice: tobacco control effectiveness

If we look at the prevalence of tobacco use in a population over time, we see the image of a social epidemic – it is highly contagious at various times to various groups and some population groups abandon it (Lopez *et al.*, 1994; Lund *et al.*, 1995; Slama, 1998). If we look at the pharmacokinetics of nicotine we see evidence of psychoactive effects on the central nervous system and specific receptors (mhGAP, 2004), and these effects are important in understanding the difficulties individuals encounter when they attempt to stop using tobacco. If we look at personality differences and risk-taking behaviours, we see variation in the appeal of using a psychoactive substance such as tobacco (US National Academy of Sciences, 2000). If we look at twins' behaviours we see coherent genetic links to uptake and maintenance of tobacco use (Johnson *et al.*, 2002). If we measure the prevalence of tobacco use before and after the introduction of international tobacco company marketing strategies in a country, we find a rapid and measurable increase in prevalence (Hammond, 1998).

Social norms do not totally explain the phenomenon of tobacco use, but nor do nicotine addiction, personality traits, psychological needs, genetics, history and economic structure of the community or the latitude for marketing tactics by the tobacco industry. They are all interacting factors behind the phenomenon, which good health promotion for tobacco control must take into account. But because of the multiple levels of influence, the standards for assessing best practice in tobacco control must be flexible. Measuring the impact of advocacy or health information on social norms is not as clear-cut as measuring the impact of a cessation product among a discrete sample of individuals. Although many programmes make selective use of tobacco control strategies, the best evidence for tobacco control points to comprehensive, global approaches (Slama, 2004a).

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Health promotion for tobacco control

Tobacco control effectiveness is a major example of the outcome of persistent, comprehensive and long-term health promotion. The ultimate goal for tobacco control is to promote better health for longer in a population. This can be achieved if cultural, social and individual values support tobacco control measures and a highly regulated tobacco industry, and non-smoking or non-tobacco use is the normal behaviour. Following the IUHPE criteria for best practice (IUHPE, 2000), this paper examines outcomes in health, economics, social factors and political actions, and proposes action in terms of public policy, practice, research and communications. This enters into the Getting Evidence in to Practice (GEP) project action framework consisting of four categories, including collating, reviewing, summarising evidence of health promotion effectiveness and finally disseminating the evidence in appropriate ways to policy-makers and to practitioners (other papers in this special edition also use these four categories, see Mittelmark *et al.*, Speller *et al.,* and Jane- Lopis).

Tobacco use outcomes

Health outcomes

Tobacco use is killing almost 5 million people per year (WHO TFI, 2005) and rates are rising (Gajalakshmi, 2000). Over 20 different fatal diseases are now causally related to tobacco use (U.S. DHHS, 2004). Unless dramatic changes occur in world prevalence trends, tobacco is estimated to become the world's largest cause of premature death and debilitating illness by 2020 (Murray and Lopez, 1996). Effective tobacco control actions that both increase the number of current users who quit and prevent a larger number of new users from taking up tobacco use could cut estimated rates by up to one third (Guindon and Boisclair, 2003).

Economic outcomes

Even though consideration of quality of life and health status of the population should be essential to the determination of health policy in relation to prevention, usually the determining factor is evidence that future savings in health and other social costs will offset the investments (McGinnis *et al.*, 2002). For tobacco control, that evidence is available. A growing body of health economists calculate that societies would experience net benefits if tobacco use decreased in line with increased taxation (Jha & Chaloupka, 1999).

In addition, economists point out that money not spent on tobacco does not disappear from the economy, but is spent or invested in other products or services (Lightwood *et al.*, 2000). There would be few economic incentives to grow tobacco in the European Union if it was not subsidised. Tobacco manufacturing is capital intensive, that is, it does not need a large work force or create jobs. Tobacco distributors and retailers are often counted as working in a tobacco economy, but they distribute and sell other items as well, so their jobs are not entirely dependent on tobacco products. Costs to society of decreased tobacco use would be transferred from tobacco-related health care costs to costs related to a population living longer.

Key words

- Framework Convention for Tobacco Control (FCTC)
- tobacco cessation
- tobacco control
- tobacco policy
- tobacco prevention

Social outcomes
Tobacco control is not usually evaluated in terms of many of the important social outcomes that are the goals of health promotion, such as social equality, enhanced quality of life, health literacy, mastery and self-efficacy. Social outcomes are reported as positively affected, however, when they are part of an evaluation of tobacco control. Increased quality of life and a sensation of mastery or more control over life events have been found among those who stop smoking (Nusselder et al, 2000). Conversely, not succeeding in stopping tobacco use is known to have a negative impact on self-efficacy and a sense of mastery (Grémy *et al.*, 2002; O'Loughlin *et al.*, 2002).

A major factor in effective tobacco control efforts is the de-normalisation or de-legitimisation of tobacco use, which provides a social climate that encourages cessation, enhances prevention and provides public support for strict enforcement of clean air regulations, which in turn facilitate cessation and prevention.

Political outcomes
The role of government includes protecting its population. Because of the massive harm caused by active and passive exposure, laws and regulations for tobacco control can be considered a requirement of good governance. Evidence shows that a political response is the only effective tool for preventing the uptake of tobacco use directly, by increasing the price of tobacco products through taxation, and by limiting the appeal of tobacco use by prohibiting advertising for, promotions of and sponsorship by tobacco companies or their products (WHO, 1999). The government also has a role to play in funding investigation and dissemination of the causes, consequences and costs (U.S. CDC, 1999) of tobacco use, and the operational and applied research necessary to determine the best programmes and campaigns. Today, in some countries, the tobacco industry is so powerful, with key figures on various boards and commissions, that undertaking tobacco control is politically risky. The development of international standards, particularly in light of the recently created International Framework Convention on Tobacco Control (FCTC) (http://www.who.int/tobacco/framework/en/), should make anti-tobacco activity an easier political stance to take in some areas, or the only stance in more advanced tobacco control areas. As tobacco control grows around the world, the example of limiting corporate behaviour and influence can be a valuable model for other lifestyle issues that involve corporations (Chopra and Darnton-Hill, 2004).

Tobacco control best practices
Policy

Legislative strategies
Legislation and regulations can be measured in terms of either existing or not existing, and in the degree of commitment to their enforcement. But the processes behind the legislation are complex and often require sociological or political case studies or, over the long term, time-trend, behavioural epidemiological or econometric studies (Chapman, 1999; Chapman 2001). The evidence for assessment cannot distinguish effective from ineffective efforts in health promotion or advocacy in the short-term. Another issue is what outcome is to be measured: changed perceptions and motivations, public support or demand for a new law, media attention, presentation of a text to a legislative body, enactment or non-enactment of a tobacco control law, public support for the new law, degree of enforcement of the provisions of the law? Certainly laws have been voted that do not have public support, just as overwhelming public demand does not always lead to corresponding laws. The short-term responses may indicate that a campaign was unsuccessful, but health promotion may lay a foundation for action in the long-term. For example, in the past, the WHO World No Tobacco Day was an alibi for inaction throughout the rest of the year, and could be ignored in a list of best practices. However, when tobacco is a hot media topic, and there are many activities being promoted, World No Tobacco Days may provide some of the impetus for enacting legislation or, more recently, signing or ratifying the FCTC.

Best practice can be determined by looking at the legislation in those countries that have experienced significant and sustained decreases in prevalence over time. The criteria for efficacy of each kind of legislation is the degree to which it protects the public from harm, increases the normative value of not smoking and/or limits the access of the tobacco industry to marketing strategies (price, product, promotions, distribution) to increase consumption. A number of legislative actions in different parts of the world have been shown to be effective in tobacco control. The major categories of legislation concern increasing prices through taxation policy; banning all forms of tobacco advertising, sponsorship and promotions; regulating tobacco product characteristics and tobacco product packaging and labelling; smoke-free air requirements; health education; limiting access by regulating sales and controlling smuggling; and facilitating access to cessation programmes (Shibuya *et al.*, 2003).

International policy and the FCTC
Actions of individuals in key positions can radically alter the effects of advocacy and mobilisation of civil society. When the idea was first launched for an international treaty to deal with the global burden of tobacco deaths in the resolutions of the 9th World Conference on Tobacco and Health in 1994, people felt that it might take decades for such a treaty to evolve. In 1995, the WHO did not have even one full-time position for tobacco control (despite 3 million estimated deaths per year at that time) and the tobacco industry was successfully undermining projects (Zeltner *et al.*, 2000). But in 1998, the new director of the World Health Organisation, Dr. Gro Harlem Brundtland, put tobacco control on the top page of the public agenda by creating a cabinet-level tobacco control programme, the Tobacco-Free Initiative, and by creating the mechanism to develop an international framework convention for tobacco control. The text of the FCTC was unanimously adopted in May 2003 at the 56th World Health Assembly (http://www.who.int/features/2003/08/en/). It has since been ratified by more than the needed minimum of 40 nations to enter into force for ratifying nations on 27 February 2005.

The availability of globally negotiated standards of protection for the population in the articles of the FCTC now gives added impetus to the urgency of tobacco control legislation. The FCTC includes provisions that represent the world consensus on minimum standards for a national tobacco control programme (Shibuya *et al.*, 2003). As such, they can

serve as a model for national laws, even for nations that do not ratify the treaty.

Although we do not know the extent to which the FCTC will lead to stronger tobacco control around the world, the negotiation and accession periods have produced greater activity in the legislative domain. NGOs mobilised to create an umbrella organisation (the Framework Convention Alliance) whose presence as observers and advocates for tobacco control during the process had a striking impact on the official delegations. Advocacy will need to continue as civil society monitors the development of the FCTC's ruling body, the Conference of Parties (COP), which will be responsible for designing the orientations in application of the FCTC. Lobbying the public, the media and the government is necessary so that a large number of countries ratify the treaty, so that the COP has the strength to impose strong interpretation of the standards of practice, and so that countries collaborate and develop stronger national tobacco control programmes.

Tobacco industry behaviours
In opposition to tobacco control at any level, tobacco industry activities can negate or reduce the impact of any campaign. The tobacco industry works to ensure that the operating environment remains as favourably disposed as possible towards their marketing strategies (Hastings *et al.*, 1997), applying pressure on governments around the world to stave off any limits on their profit making. One of the most troubling aspects of tobacco industry strategies involves current initiatives on intellectual property and trade treaties. A recent report (Weissman, 2003) from Essential Action, a Non Government Organisation (NGO) that monitors corporate behaviour, notes that some trade agreements restrict government adoption of health and safety measures concerning tobacco, and give the right to investors, including the major tobacco trans-national companies, to defy government regulations and to obtain compensation for lost profits due to restrictions on their products that are not compatible with the rules of investment agreements. If tobacco is maintained within normal trade agreements and tobacco trademarks within intellectual property rights, some nations may be frightened away from putting in place tobacco control measures that limit tobacco marketing strategies. Unfortunately, the FCTC does not cover the issue of public health taking precedence over trade. The only real solution here would be to remove tobacco from all trade agreements.

Practice

Normative strategies
Normative strategies are the actions that enhance and accompany change in social norms. This involves moving from a society that defines tobacco use as a normal, acceptable behaviour, to one that values a tobacco-free norm, encouraging and helping individuals to quit and demanding clean air. The growth of social value for being tobacco-free in countries such as Australia, Canada or Sweden came about when the specific components of tobacco control legislation, health education, research and political commitment all existed and functioned together.

Even in countries that have growing anti-tobacco social norms, the battle for hearts and minds is still raging between tobacco control advocates and pro-tobacco forces. Tobacco use is still supported by large proportions of the population. Tobacco products are traded as normal products that fall within the definition of a commodity. Currently, no politician or agency director is accountable for tobacco use prevalence trends, or cessation rates, or for death rates associated with tobacco use. It is worth noting that the report on the Millennium Development Goals for building sustainable development in low-income countries does not evoke the issue of tobacco use (or having a chronic disease of non-infectious origin). Tobacco company abuses are not currently included in human rights surveillance. Laws on corporate accountability do not require compensation from tobacco companies for health damages or environmental impacts. These are all issues to come in the area of normative measures.

Mass media campaigns can build up public attention and adherence to tobacco-free norms, but any one campaign is usually only able to be evaluated on proximal measures such as penetration and audience recall, measure that are not in themselves indications of enduring effect. For the evidence, it is necessary to go back in time to an era when communities could be compared on the presence or absence of a campaign without contamination or concomitant activity between groups. Studies from the 1980s in Australia and Finland (Slama, 1994) show the potential of mass media campaigns prior to a legislative framework for tobacco control. It is unlikely that controlled trials of such campaigns can ever again be undertaken.

Programmes
Programmes are interventions provided for specific groups or individuals in the population that have defined outcomes that can be measured. This includes studies of cessation programmes for help-seekers or large community studies with multiple, simultaneous or consecutive activities. Evaluations of programmes can monitor behaviour or attitude change.

Interventions aimed at preventing uptake or to motivate cessation within a school setting are a particularly difficult and sensitive subject. The evidence for school programmes is not supportive of an independent effect. Nonetheless, claims can be made for such programmes' effects in the general social climate for tobacco use when adult behaviour and attitudes are coherent and complementary to messages in the school. However, if such coherence is not available, the evidence does not show long-term effects of such programmes. Many in the tobacco control field see no use for school programmes, and indeed, in the absence of any other tobacco control activity, they are ineffective at best (U.S. CDC, 2000). The CDC recommends that best evidence indicates that only increased taxation and mass media campaigns show successful prevention outcomes. However, children, like adults, have the right to be informed and health education about tobacco falls into this category. For best practice, it may be that school-based cessation programmes for young people rather than prevention programmes provide better overall results (Lawrance, 2001).

Before voluntarily trying to change behaviour, a person has to believe that there are greater advantages than disadvantages to doing so. A smoker stops smoking when the perceived reasons for quitting are stronger than fear, withdrawal, doubt, craving and so on. For smokers who are not yet mentally prepared to stop, the greatest service for them is to be offered information and dialogue to

increase motivation and confidence in stopping. The treatments available for smokers who are ready to stop fall into two categories. First, there is medication to reduce the physical symptoms of withdrawal so that the smoker can concentrate on other impediments of cessation. The other type of treatment tries to extinguish the conditioned associations that are a part of addiction. If the larger environment is favourable, treatments have a much greater chance of success. For both adults and adolescents, the stronger the anti-tobacco environment, the more cessation attempts occur, the greater the desire to quit and the more people seek treatment. Societies with weak or no anti-tobacco measures have smaller proportions of smokers ready to stop and they also subvert treatment success.

Cessation clinics can prove that providing help is better than not providing help, that offering quitters a product that lessens the physical discomfort of stopping is better than not offering it (Lancaster *et al.*, 2000). These are examples of best practice in programmes. The advent of medications, such as nicotine replacement therapy (NRT) and bupropion (Zyban), for aiding cessation may have had an impact on the perception of the possibility of stopping. But some studies have found that the use of NRT is not a significant factor in population prevalence (Slama, 2004b). Surveys that track changes over time in attitudes about tobacco of both users and non-users have shown that differences can be achieved at a societal level, but attributing that change to any one factor is no longer possible. Among cessation programmes, opportunistic brief advice appears to have the best potential to produce a population effect in raising the proportion of people who do not smoke in a population, and in creating a social climate that encourages smokers to stop. The WHO suggests that community approaches such as telephone quitlines and Quit and Win programmes also have the potential to respond to population demand for aid in cessation (Da Costa e Silva, 2003).

Research

Epidemiological research data on the health outcomes of tobacco use and quitting have accumulated for over 50 years, and quantitative and qualitative medical, pharmacological and behavioural research concerning programmes for prevention or cessation has been going on for almost as long. More recent trends include econometric studies and evaluation of social trends. New research on enhancing social support systems and other behaviour change elements to work at the population level is needed (Park *et al.*, 2004). Behavioural epidemiology may be a good research approach to assess the way society changes and how those changes influence individual behaviour change. Assessment of advocacy is difficult. If a law is voted, advocates have a visible quantifiable outcome. But other measures are needed for the process, when the law is not voted or is not enforced. Currently, in the absence of successful change, we have few tools except time trend studies for measuring whether advocacy has produced incremental effects, transitory effects or none at all, and this area of research needs innovative thinking.

Communications

One of the most interesting developments over the past decade is the effort to inform the public about the internal strategies and world view of the major tobacco companies, made possible initially by whistle-blowers who were personally unwilling to see certain practices remain unknown (Glantz *et al.*, 1996), followed by court-mandated disclosure as a result of legal action in the US. The result has fed into a vast programme of debunking much of the social image that the tobacco industry previously had been able to maintain. In essence, the industry was *not* earnestly looking to find the truth about the health effects or addictiveness of its products, its products were *not* designed to be as safe as possible, legislative controls would *not* be illegal, unnecessary or economically disastrous. These and other themes can still be seen in communications strategies from the industry. The documents have also provided information about delaying or counteracting legislative initiatives, suborning researchers, facilitating smuggling, outright lying to governments and deceiving their own consumers, to name some of the reasons behind the now steadily growing number of legal suits being brought in many countries around the world.

Communications of the tactics of the tobacco industry and its manipulation of information has proved to be a pertinent and memorable message for health promotion campaigns. Other themes that have shown relevance for the populations receiving them include those that graphically demonstrate the idea of health damage. The Australian campaign *Every cigarette does you damage* not only found resonance with the Australian population, but with other populations in Asia and Europe.

Conclusions

Health promotion has the goal of enabling people to understand and change the determinants of health so that they are able to improve their own health. Health promotion for tobacco control should include:

1. Building healthy public policy with taxation, clean air, advertising bans, other legislative controls on tobacco industry activity, tobacco cessation facilitation and funding for mass campaigns
2. Creating supportive environments that encourage non-smoking and cessation, building on the legislative framework, with evidence-based intervention support for cessation at the worksite or school, comprehensive programmes that motivate and supply support for behaviour change, encouraging public health issues on the public agenda through advocacy and information, including disclosure of tobacco industry tactics
3. Strengthening community action through facilitated cessation advice and treatments, enforcement of smoke-free regulations and local manifestations of anti-tobacco social norms
4. Developing personal skills and self-efficacy in not starting or stopping smoking
5. Reorienting health services to include cessation and motivation for change practices at all levels of contact with the population.

Effective tobacco control health promotion should be available at all population levels, using knowledge and strategies about the diverse aspects of the tobacco epidemic: genetics, pharmacology, medicine, behaviour, health systems, health education, rules of commerce and trade, economics, law, public health, public policy. Investment in best practices for tobacco control is an obligation for better population health.

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Mapping European Capacity to Engage in Health Promotion at the National Level: HP-Source.net

Speller *et al.* present elsewhere in this issue a simple four stage framework for a systematic approach to getting evidence about health promotion effectiveness into practice. This paper examines the third stage of this framework, which is centred on capacity. The underlying premise is that systematic data collection is required to fill the knowledge gap surrounding capacity for health promotion in the countries of Europe. It is recognised that mapping capacity of a country to undertake health promotion is a complex task, but that a proven model for doing so is now available (IUHPE, 2004). Importantly, the process of capacity mapping provides not only needed information but also serves as a catalyst for action. The challenge is to expand capacity mapping to eventually include all European countries, using approaches that permit comparisons between countries and mutual learning about how to increase capacity.

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The need for capacity mapping

Capacity mapping is vital as an ongoing accountability mechanism that can strengthen the case for health promotion across Europe. Evidence based practice requires essential tools, including trained people, well-founded policies, financial resources, proven intervention methods, research capacity and productivity, the capacity to generate public enthusiasm and participation, and monitoring, evaluation and feedback capabilities. If health promotion evidence based practice is not up to standard in Europe, the reason is usually not lack of good intentions, but lack of good tools, including workforce capacity.

In the present context, capacity is defined as the ability to carry out stated objectives (Goodman *et al.,* 1998). Having the capacity to perform a task is an essential but not entirely sufficient condition for performance to take place. The matching of capacity to a desired level of action is the point at which many enterprises succeed or fail. It is a serious mismatch if the objective is to produce Porsches, with the capacity to produce Fords, and vice-versa. The wide spread interest in measuring capacity arises from the desire to adjust capacity to achieve the intended level of action. In public services delivery there is little reporting of over capacity. Mapping capacity for health promotion is controversial, because measuring capacity is fundamentally a political process surrounding how limited resources can be allocated to unlimited needs.

As a consequence of the above, health promotion capacity mapping is approached in various ways. No single model for capacity mapping dominates, and no gold standard measure of capacity is feasible (Ebbesen *et al.*, 2004). The approach to mapping may vary depending on the level that the analysis takes place: person, organisation, community, regional, national, and international (Brown *et al.*, 2001). At the organisational level (an NGO for example), the task is often to learn what the level of capacity is for accomplishing critical functions (Morgan, 1997). At the community level and in settings in communities such as schools and work places, the task may be to catalogue the resources the community has, to guide decisions to strengthen the delivery of local health promotion action (Bensgerg, 2000; Kotellos *et al.*, 1998, Gibbon *et al.*, 2002). At the national level, the objective is usually to learn the extent to which essential policies, institutions, programmes and practices are in place, to guide recommendations about what remedial measures are desirable (Wise and Signal, 2000; WHO, 2001; National Health and Medical Research Council, 1997).

Depending on the level of analysis and the objective of the exercise, capacity mapping might concentrate on:

- inputs – resources including people, money, space, policy, services;
- process – activities through which inputs are used in pursuit of expected results;
- output – products anticipated through the execution of activities that use inputs;
- intermediate outcomes – short term performance at a system level following from outputs;
- impact – long term results and achievements related to the organisation's mission (Brown *et al.*, 2001).

Key words

- capacity mapping
- infrastructure
- policy
- health promotion programmes
- HP-Source.net

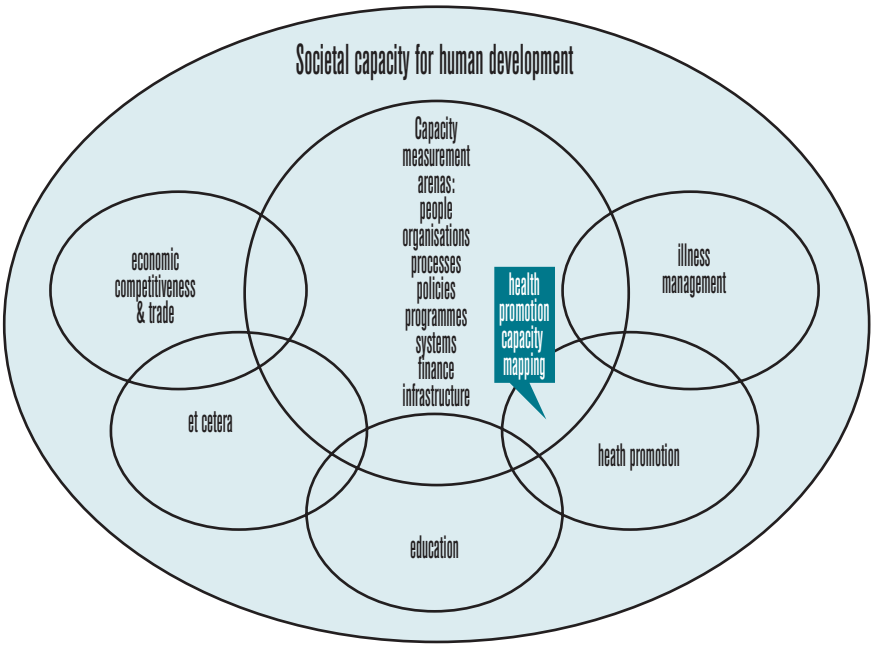

Figure 1. Venn diagram illustrating the context of health promotion capacity mapping

The points above indicate the possibilities and illustrate that capacity mapping is a complex process. No single capacity mapping exercise could possibly claim to be comprehensive. As the title of this paper specifies, it is concerned with national level capacity with foci on policy, infrastructure and programmes. These delimitations serve notice that much of what is of interest related to health promotion capacity is not addressed here (see Figure 1).

National level health promotion policy, infrastructure and practices

For at least the past decade, national capacity for health promotion has been the subject of conferences, scholarly dialogue and political debate (French Committee for Health Education, 1995; Wise, 1998; Wise and Signal, 2000). At the Fifth Global Conference on Health Promotion in Mexico City in 2000, national investment for health and the need to build infrastructure for health promotion were dominant themes (Ziglio *et al.*, 2000a; Moodie *et al.*, 2000). However, the published literature on capacity mapping at the national level is scant, confined mostly to calls for mapping, and reports of mapping exercises. Little scholarly exchange is published about theory and principles of mapping, and related methodology issues. One of the few academic treatments of the subject is the work of Rütten and colleagues in Europe, who provide a conceptual and empirical framework for comparative public health policy analysis and evaluation (Rütten *et al.*, 2000). A consortium including researchers from Belgium, Finland, Germany, The Netherlands, Spain and Switzerland used a policy-making model to guide the design of a policy-maker survey, in which 719 respondents provided data on a wide range of dimensions of policy. As one might guess, the data provide a rich source from which to study policy processes, but critical aspects of national capacity besides policy are not included. A few other international capacity mapping projects have broader scope, but tend to be concerned with healthcare delivery systems in general, or with particular diseases or conditions. An example of the former is the large series of country studies done by the European Observatory on Healthcare Systems, which examines country capacity in five areas, including organisational structure and management; healthcare financing and expenditure; healthcare delivery system; financial resource allocation; and healthcare reforms. For an illustration of this approach, see the report on Azerbaijan by Holly *et al.*, (2004). An example of disease specific capacity mapping that allows international comparison is the global mapping of national capacity for non-communicable disease prevention and control undertaken by WHO (2001).

More typical in health promotion are isolated case studies, which range from brief overviews to extraordinarily detailed analyses. Examples of the former are the series of cases published for the 1994 International Seminar on National Health Promoting Policies, Strategies and Structures (see for example Demeulemeester and Baudier (1995), Eskola (1995) and Hagard (1995). A particularly rich example of a detailed case study is that undertaken in Australia by the National Health and Medical Research Council (1997). This multi-stage, multi-method study culminated in a work that arguably defines the highest state-of-art in health promotion infrastructure mapping. The approach taken, however, is so costly and requires so much expertise that very few countries would invest the needed resources to follow this model.

In Europe, there are two large scale health promotion capacity mapping exercises which lend themselves to country comparisons: the country audit approach of the WHO's Investment for Health initiative, and a researcher/practitioner collaboration called HP-Source.net, developed to meet data collection needs that were brought to light by WHO country audit exercises in the mid and late 1990s.

The capacity mapping model developed by the WHO Regional Office for Europe, and used as part of its Investment for Health initiative (Ziglio *et al.,* 2000a; 2000b; 2001), has at its core National Health Promotion Infrastructure Appraisals. As an example of this approach, WHO undertook an appraisal in the Republic of Slovenia originating from a request for assistance from the President of the Parliament of Slovenia (WHO, undated). A team of six experts prepared for a site visit by studying a wide range of documents about

Slovenian geography, political system and laws, economic situation, demographic, social health and sickness profiles, and structures and institutions. During a six day site visit in March 1996, they conducted interviews, participated in semi-structured discussions and a workshop. Based on the information garnered from documents and meetings, the team composed a report with two elements. The first was an assessment of Slovenia's strengths, weaknesses and opportunities for investment in health; and the second an Investment for Health Strategy for Slovenia, based on the conclusions of the assessment. The analysis was qualitative, as illustrated by this conclusion of the team:

"Potential strength is demonstrated by the blossoming of activities which has taken place at national and local levels. Noteworthy are the growth of NGO's in the health field, the expanding Healthy Cities movement which looks set to cover about 50% of the Slovenian population by 1997, and the Health for All coordinators'network. However, weaknesses with the infrastructure greatly outweigh its strengths. Strong village communal traditions are in serious decline. Many municipalities are too small to be viable for the professional, administrative and financial roles which local government needs to play in Investment for Health." (WHO, undated: pp. 22).

The report concluded with five recommendations:

1. produce an Investment for Health strategy for Slovenia with a strongly articulated vision;
2. establish a national level Intersectoral Board for Investment for Health at the level of the Council of Ministers;
3. create health promotion incentives in the healthcare system;
4. encourage NGO participation;
5. devise a human resource strategy to develop and deploy a skilled workforce. The final report was submitted to the Slovenian Parliament for discussion and resolution, intended to be used as a key advocacy document in legislative and policy making aimed at improving Slovenia's level of investment in health.

Similar processes have been mounted in other European countries (see as examples Hagard *et al.,* 2000; Hagard *et al.,* 2002). The WHO capacity mapping approach is characterised by its use of site visit teams, the combination of document analysis and in-person data collection and the production of advocacy documents backed by the authority of the WHO. Although there appears to be no formal evaluation of this mapping strategy, much practical experience in capacity mapping has been generated and professionals who were members of several of the appraisal teams gained important insight into the critical aspects of policies, infrastructure and programmes that were required for health promotion to flourish.

One of these team members was Professor Spencer Hagard, the then President of the International Union for Health Promotion and Education. Hagard appreciated the usefulness of the WHO approach, but understood also that the personnel and time required for country audits limited the generalisability of the WHO method. Needed also was a system for a streamlined, yet professional appraisal that would produce country profiles with both qualitative and quantitative data, permitting country comparisons, useful to inform policy processes and as an applied research tool.

HP-Source.net – The Health Promotion Discovery Tool

Moving from the foundation of experience he acquired while on WHO Appraisal teams, Hagard conceived of an Internet-based capacity mapping system called HP-Source.net (see www.hp-source.net)

With funding from the European Commission in the period 2002-3, a team was assembled to develop a new approach to health promotion capacity mapping. HP-Source.net aimed to meet the need for a system of data collection and data dissemination on essential policy, infrastructure and practice that would be useful to policy makers, service planners and deliverers, educators and researchers and others. Starting from the network funded originally by the European Commission, with researchers from 24 European countries, HP-Source.net has evolved into a voluntary, global collaboration of researchers, practitioners and policy makers, having the common goal to maximise the efficiency and effectiveness of health promotion by:

- Developing a uniform system for collecting information on health promotion policies, infrastructures and practices;
- Creating databases and an access strategy so that information can be accessed at inter-country, country and intra-country levels, by policy makers, international public health organisations and researchers;
- Analysing the databases to support the generation of models for optimum effectiveness and efficiency of health promotion policy, infrastructure and practice;
- Actively imparting this information and knowledge, and actively advocating the adoption of models of proven effectiveness and efficiency, by means of publications, seminars, conferences and briefings, among other means.

HP-Source.net collects quantitative and qualitative data in nine categories:

- Politics, policies and priorities
- Evaluation
- Monitoring and/or surveillance
- Knowledge development
- Implementation
- Information dissemination for healthcare professionals
- Programmes and strategies
- Professional workforce
- Funding

Data may be collected with reference to national health promotion capacity in general, but also with regard to specific subject areas. For example, HP-Source.net and other partners have launched specialty data sets on European mental health promotion capacity and on European alcohol policy. As the HP-Source.net project expands, other specialty data sets will be established in Europe and elsewhere. HP-Source.net also offers reports and summaries related to various aspects of health promotion capacity building (see for example Fosse, 2003).

Data validity

In capacity mapping exercises, it is a particular challenge to ensure the validity of the data on capacity. Often, capacity mappers have vested interest in their work that may wittingly or unwittingly influence their perception of how much capacity exists. To increase the validity of capacity data, HP-

Source.net uses the concept of pedigree to both allow for verification of the accuracy of the data, and to provide links to key documents. In the common meaning of the term, a pedigree is a formal, usually written, record of the history of an ancestral line. In the present sense, pedigree refers to written and publicly available records that substantiate the health promotion and/or disease prevention origins of infrastructures, policies and practices that are entered into the HP-Source.net databases. Researchers are provided with sole access to the data entry website (located within the overall HP-Source.net website) and are guided through the data entry process by prompts, supplemented by definitions and explanations and opportunities to contact the HP-Source.net Coordinating Centre for further consultation. The completeness, validity and reliability of the data are all dependent on the national researchers'ability to identify all the correct data and to enter them correctly. Data analysis reveals quality improvement opportunities, and regular training sessions improve researchers'ability to provide data with good validity. The HP-Source.net approach to validity emphasises constant quality improvement. Users of HP-Source.net are encouraged to contact the Coordinating Centre with suggestions for updating data and improving the accuracy of data entered previously. Updates are made on a continuous basis using the online data entry system.

Using HP-Source.net data

HP.Source.net is a useful tool for discovery and communication, as it provides links to health promotion institutions throughout Europe and the rest of the world. However, the database can also serve an additional purpose, as a research tool. The HP-Source.net databases may serve as research objects in and of themselves. For example, data on national health promotion policies can be used to compare and contrast policy along a number of dimensions: policies in place, types of monitoring and reporting systems, implementation strategies, professional workforce development and so forth.

A second approach to research with HP-Source.net is to use it to gain access to national documents, organisations, databases and monitoring systems. For example, by clicking the Monitoring and/or Surveillance link at the HP-Source.net web site and following the associated links, a researcher quickly has direct access to national documents describing monitoring and surveillance systems in all countries reporting that they have such systems.
Not only policy researchers, but practitioners as well can make use of HP-Source.net as a knowledge portal, as these two examples illustrate:

Example 1
A Ministry of Health policy planner wishes to summarise health promotion policy systems in different countries. In HP-Source.net, the Politics, Policies and Priorities link reveals which countries have written documents pertaining to these topics. By clicking further links, the titles and status of supporting national documents are displayed. By clicking on the document links, the planner moves to each document itself, to find more information including policy recommendations and suggestions for action. Additional links take the planner to the institutions responsible for the documents, via website- and email addresses. The HP-Source.net site itself displays summaries of the documents. In this way, the planner uses HP-Source.net as a discovery tool, quickly gaining access to knowledge about health promotion systems in various countries, including information about who to contact and how to get in touch, for further information.

Example 2
The director of a new master's degree programme in health promotion wants to find out what master's courses exist in heath promotion in Europe, and uses Hp-Source's Professional Workforce link to get started. By clicking this link, an overview of academic health promotion courses in Europe is displayed. To make an inquiry about courses offered at the master's level in the Netherlands, the educator follows links to discover three Dutch universities offering such courses. A link away is the connection to the websites of each of the universities, so that study programme descriptions can be accessed, and their key staff can be contacted.

The kinds of policy and applied research illustrated above are feasible without the assistance of a tool like HP-Source.net, but using such a tool systematises and speeds research greatly, compressing what might otherwise be months of research into an afternoon of work.

From capacity mapping to policy and practice

Capacity mapping, in order to provide a useful picture as to how health promotion is implemented in a country, needs to cover a range of activities and resources. For example, a capacity map should include policies that impact health, and health promotion policy, infrastructure and resources, including human, institutional and financial. A capacity map must be sensitive to the fact that the levels of governance and decision making differ between countries. In some countries, such as England and Norway, strong national policy is dominant, while in others, such as Germany and Italy, policy making is more a responsibility of regions. In addition, a model of effective health promotion policy and practice developed in one culture may not be fully relevant in another culture. It is a great temptation when trying to develop a new system with limited resources to import a model that has been shown to work elsewhere. However, it is important that a capacity map is seen mainly as a way of raising ideas and suggested solutions to problems, which can be tested locally. An understanding of this dynamic is needed to counter a one-size-fits-all mentality.

On the path from capacity mapping to policy and practice, a capacity map may offer benchmarks of sound international practice for countries wishing to improve. Countries identified through capacity mapping as having an advanced health promotion system might well feel pleased, perhaps stimulating continuing investment to maintain a leading position.

At the supra-national level, international agencies and donor organisations wishing to stimulate health promotion development may find capacity maps useful both to identify where investment is needed and to facilitate the sharing of good practice. Related to all these uses is the question of how up to date the capacity map is. Capacity maps can be static, snapshots of a moment in time, or

they can be constructed to map change in capacity over time, permitting analysis of cause and effect relationships between outputs and outcomes.

Returning to the example of capacity mapping as a stimulus for improved health promotion education and workforce development, two trends are evident. First, capacity globally to train health promotion professions is not keeping up with growing demand. Effective and efficient health promotion relies on the capacity and capability of a large workforce in a wide range of roles, organisations and sectors, including health, housing, environment, transport and education. Second, a competencies approach is increasingly being used to provide a baseline from which to plan and deliver improved education and training programmes in health promotion. Capacity mapping has the role of providing information on existing education programmes and educational practices, and information on competency standards that are emerging in various parts of Europe and elsewhere (Davies, 2003).

Capacity mapping and advocacy for health promotion

Data from capacity mapping is not only useful to inform professional activities, as exemplified above, but can also be valuable in health promotion advocacy. Data collected on existing national capacity allows countries to advocate for better, more thoughtful investments in the construction and support of health promotion infrastructure. Such data are indispensable to support advocacy for the development of health promotion in countries or regions that have little or nothing in terms of existing systems and programmes. In this light, the use of data from capacity mapping for advocacy serves a dual purpose, as do most health promotion related advocacy initiatives and campaigns: they aim to reach policy and decision makers to demonstrate the effectiveness of health promotion, and aim to develop the field of health promotion itself.

Whilst advocacy methods are diverse, one particularly innovative means of reaching policy and decision-makers is to go to them and demonstrate health promotion effectiveness in a meaningful way. This kind of advocacy, supported by data from capacity mapping, is informed, rational, evidence-based advocacy that has the potential to stimulate logical, politically defendable decisions (Mittelmark, 2003). For example, when HP-Source.net was launched publicly in 2003, the International Union for Health Promotion and Education (IUHPE) organised a session at the European Parliament in Strasbourg to introduce parliamentarians to health promotion capacity mapping as a policy tool. Attended by representatives from the European Commission, WHO officials, Members of the European Parliament, representatives from other European NGOs, project partners and national research counterparts who contributed to the data collection, the event was an ideal opportunity to advocate for the development and implementation of health promotion policies to European decision-makers (IUHPE, 2003). Following hands-on interaction with the HP-Source.net database, the parliamentarians were left in no doubt that by mapping the capacity that exists, rational decisions can be made about how to improve and extend the resources that are needed (Jones, 2004).

Implications for the future

Despite evidence of effectiveness, formidable barriers continue to stand in the way of health promotion, and many of these barriers are structural. No information system spanning all of Europe is yet available that effectively and accurately pools experience and knowledge about what approaches to health improvement work best in various parts of the continent. There are too few opportunities for advanced training in health promotion, to produce the necessary capacity to assist communities with their health promotion efforts. Few countries in the region have established a coherent, well articulated and forceful policy that positions health promotion as a vital adjunct to the healthcare services. Health NGO's and health professionals in the region are still not well enough linked. The synergies that could arise from a connected-up system of services, training and outreach are not realised. The basic information systems that are essential to identify health promotion priorities and chart progress are disjointed.

Of course, examples of excellence can be found in many places, but fragmentation and the cultural, economic and political complexities of Europe make it difficult to illuminate these exemplars, learn from them, and link up the pieces into a strong system of supports for health promotion practice. Thus, there is need for systematically collected information, initially at the country level, about the state of health promotion infrastructure, policies and programmes that is easily accessible by policy makers, advocates for health promotion, NGO's, researchers, educational and training institutions and communities.

The potential benefits of mapping health promotion capacity are many. Were it possible to quickly and efficiently access information about the current national and regional health promotion policies, they could be used in advocacy work, to encourage such policies where they are not yet in place. If it was clear what the various health promotion research centres in Europe were working on and what areas of expertise they had, more rational research priorities could be set, ensuring that critical gaps were identified and filled. If training programmes were surveyed and teaching resources shared, the cadre of community health workers might be efficiently expanded. If there was an inventory of public and professional education opportunities, people could be alerted to the possibilities, and identify the gaps in opportunity.

In essence, capacity maps are vital for health promotion in Europe, to support more rational and efficient priority-setting, and improve decision-making at all levels. Such maps would reveal gaps by identifying what exists and where. The maps would have coordinates, making it possible to quickly link up with key documents, organisations and people in ways and at speeds that are currently unavailable.

The issues outlined above have been the subject of discussion for several years in Europe, and pan-European networks of health promotion specialists have formed to deal with the challenge of developing the capacity to move from evidence to practice. One of these networks discussed in this paper, HP-Source.net, has the task of mapping health promotion capacity, ultimately in every European country. However, one of the main points of this paper is that no single approach to capacity mapping can meet

all the needs for capacity data. The various approaches to capacity mapping that have been described here offer a menu of possibilities and the opportunity to mix and match methodological approaches to meet various needs. In this connection an important recent development was the establishment of the European Community Health Promotion Indicator Development (EUHPID) Project, funded by the European Commission (DG SANCO) Health Monitoring Programme (Davies *et al.,* 2004). EUPHID is part of a comprehensive European Union Public Health Knowledge and Information System intended to underpin its programme of Community action in the field of public health in the period 2003-2008. The System will generate information concerning the health status of the population to improve the health status of European citizens (Kramers, 2003).

This mixed method approach advocated above has been adopted by WHO-EURO, which is currently undertaking comprehensive mapping of European health promotion capacity. The mapping consists of several orchestrated activities, including:

- Summarisation of existing data on capacity for health promotion, for example from WHO-EURO's Venice Office's 'National Appraisals of Health Promotion Policy, Infrastructures and Capacity'carried out in collaboration with a number of European member states between 1996 and 2004;
- Analysis of social and economic trends affecting population health at various levels from country level to Europe as a whole (WHO, 2002);
- Consultation with member states'ministries of health, finance, welfare, labour, social affairs, etc., and non-governmental organisations, regarding health promotion system

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investments, policies and programmes needed to tackle health issues arising from social and economic trends;
- Summarisation of present country-level health promotion policy, infrastructure and programmes, from HP-Source.net data.

European progress will be reported in August 2005 at the WHO's 6th Global Conference on Health Promotion in Bangkok, Thailand (For further information contact Chris Brown, Program Manager, Investment for Health & Health Promotion, WHO/European Office for Investment for Health & Health Development, chb@ihd.euro.who.int). In Bangkok, other WHO regions will also contribute data and experience with health promotion capacity mapping. Efforts to improve the quality and usefulness of capacity mapping will be stimulated, and continued as a conference theme at the IUHPE World Conference on Health Promotion and Health Education in Canada in June 2007.

Conclusion

With its diverse research and practice networks working on capacity mapping, health promotion has the potential to develop sophisticated capacity mapping systems. The central challenge, raised in the first paragraph of this paper, will be to ensure that capacity mapping is an effective catalyst for action to improve capacity, and not simply results in repositories of unused data. To this end, conferences and professional journals play a vital role in informing potential users about where and how to access data from capacity mapping exercises. HP-Source's contribution to this is the establishment of a Dissemination Centre at the IUHPE, which has as its main task the expansion of the HP-Source model beyond Europe.

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Professor Spencer Hagard conceived HP-Source.net and led its development during 2003-4. We are grateful to him for bringing us together to address the challenge of developing a practical approach to mapping national capacity for health promotion. Jackie Robinson managed HP-Source.net with great skill during its first two years of operation and made significant contributions to the practical and the technical aspects of the project. HP-Source.net expresses gratitude to Research Director Dr. Hege Randi Eriksen of the HALOS Division of UNIFOB (University of Bergen) for providing core funding in the period 2004-5.

Catherine Jones and Angela Scriven

Where are we headed? The next frontier for the evidence of effectiveness in the European Region

This special edition of *Promotion & Education* examines the contemporary debates and actions around getting evidence in to health promotion practice, focusing mainly on the Getting Evidence into Practice Project (GEP). The contributors have gone further than just discussing the current position. There is much in the journal that points to what needs to happen next. The purpose of this final paper is to synthesise some of the arguments and ideas presented by the authors. Key issues in terms of the present situation will be identified, followed by an assessment of efforts required in the future to further develop the mechanisms of getting appropriate evidence in to (and out of) health promotion practice.

Current position

There are five key issues that dominate this edition and indicate the current position of the evidence based practice movement in health promotion. These are: the nature of evidence; the need for a common framework for getting evidence in to practice; workforce capacity and capability; linkage between research, policy and practice; collaborative action and the need for a unified terminology.

A fundamentally important and ongoing debate is what constitutes appropriate evidence of effectiveness in health promotion. The value of the RCT has been given particular attention by a number of authors, with the general view that the complexity of health promoting interventions requires different types of evidence. The nature of health promotion outcomes and processes is seen as critical to how the evidence is located, defined and summarised (see, for example, the section in Aro *et al* on how the concept of health promotion guides the evidence process). Slama also offers practical examples from tobacco control that illustrate the need for flexible and comprehensive standards for assessing best practice, supporting the general view that evidence of effectiveness in health promotion must be gathered from a diverse range of sources. Moreover, there is a consensus that generating evidence on what works in health promotion is insufficient on its own. Evidence must also point to how it works, under what conditions and in what context.

There is strong commitment to the common framework for a systematic approach to getting evidence about health promotion effectiveness into practice, centred on four equally important components:
- Collate, review and summarise evidence of health promotion effectiveness;
- Disseminate the evidence in appropriate ways, to policy-makers and to practitioners;
- Assess capacity to implement evidence-based policy, programmes and

practices;
- Learn from effective practice to support further capacity building and improve evidence base.

The mapping and the development of workforce capacity for the effective implementation of the growing body of evidence in health promotion is seen as an important (and complex) element of this framework and has been advocated by all authors.

The importance of an effective link between research, policy and practice is powerfully presented. The notion of knowledge *push* and knowledge *pull* provides a strong visual representation of the dynamic forces at play between research and practice and the need for balance in this evidence tug of war (detailed description of these processes can be found in Speller *et al.*).

Finally, whilst all contributors agree that it is essential to work collaboratively to progress the evidenced based movement within Europe and globally, there is a divergence of terminology. A wide range of terms are used within this special edition, from evidence-based policy and practice to evidence-informed policy and practice, from knowledge management to capacity building, from best practice to best evidence to evidence of effectiveness, and from practice development to getting evidence into practice. The variety of terms and the need to incorporate the evidence processes rapidly into the field requires a common unambiguous language with which health promotion professionals can communicate effectively through their collaborative networks.

Some of the five issues outlined above are unresolved and will continue to dominate the future agendas of those working in the evidence in to practice arena.

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Future action

The work of the Global Programme on Health Promotion Effectiveness (GPHPE) lies at the core of this issue. Its unique mission is not only to examine and explore the differences among regions with respect to their approaches to the effectiveness of health promotion, but its global vision is related to the programme's capacity to recognise the common ground, distinguish the differences in context and support the strengthening of linkages and interactive sharing of this growing body of knowledge (as described by Jones and McQueen when examining the European Region's contribution).

The Getting Evidence into Practice project (GEP) is moving into a second phase, and the project members and partners are determined to enlarge and expand its reach and dissemination to a wider audience. Building upon the foundations for sustainable implementation and ensuring the necessary capacity are both central to the next phase, which also includes training programmes and opportunities for technical support (see Molleman and Bouwens for an outline).

Activities in phase two will involve a mapping exercise to assess the capacity of organisations in the EU member states to use the European review protocol and support and improve the quality of evidence-based interventions. However, as Mittelmark *et al.* argue, there is a need to map the capacity for health promotion beyond these parameters and to ensure that the information from the mapping exercise is a valuable asset and mechanism to those who advocate for health promotion across Europe. Capacity mapping is not only a key element for implementation strategies but has a variety of uses in communications, knowledge development and education, professional workforce development, advocacy, and policy development. The next challenge remains to increase capacity to use evidence in practice, and to produce it from practice (for further elaboration and case studies see Speller, *et al.*).

There are clear and consistent recommendations being made by all of the authors in this special edition about the future direction for evidence based approaches to health promotion, which GEP and GPHPE can take forward.

Strengthening the networks within and between countries to share learning and to foster mixed communities of research, policy and practice is seen as crucial. Along side this, it is suggested that new professional roles need to be established that have a strategic remit for working across the interface and making effective links between research, policy and practice. Other key posts might be usefully established to work within the research and practice development communities to act as change agents and opinion leaders in the evidence based arena. These posts would have responsibility for the creation of bodies of knowledge and communication to practitioners about the availability of information and how to use it in practice.

Collaborative efforts need to continue to assess both the current capacity (in its broadest sense) and the training initiatives for increasing capacity (see the discussion by Jané-Llopis on building capacity through training). What is crucial to the future is establishing strong linkage and exchange mechanisms by which researchers, research funders, policy-makers and practitioners can engage in productive exchanges on issues of common concern. There are, however, barriers to developing a more fluid interaction between the key stakeholders in the evidence based movement. The most significant challenge for the future therefore, for both GEP and GPHPE, will be how to overcome the infrastructure, organisational and political barriers to progress. Health promotion, with its inclusive and integrative disciplinary perspectives, must take the lead in finding ways to develop capacity, so that knowing the evidence and knowing how to measure the evidence is accompanied by the structural, human and material resources to use and build on the evidence.

Key words
- framework
- evidence
- capacity for implementation

Hans Saan

En route vers l'évidence : le chemin parcouru en Europe

Si on a les preuves mais on se sait ni les trouver ni les mettre en évidence, on est devant une coquille vide.

Mohan Singh

Ce numéro spécial de *Promotion & Education* marque un pas important pour la promotion de la santé en Europe. Il diffuse la manière dont la Région développe un champ plus unifié de pratiques fondées sur les preuves. Les questions sur l'efficacité et les preuves ont commencé à émerger comme un défi commun à relever. La collaboration à l'échelle européenne a fait ses premiers pas en 1989 à Rotterdam, avec l'organisation d'une conférence spéciale de l'Union Internationale de Promotion de la Santé et d'Education pour la Santé (UIPES) sur l'efficacité et la publication d'une série de brochures sur ce même thème, avec le soutien de la Commission Européenne. L'UIPES a ensuite organisé des conférences spécialement sur l'efficacité et la qualité de la promotion de la santé en Grèce, en Israël, en Finlande, en Estonie, à Londres et en 2005, en Suède. Les sujets traités dans les premières brochures ont été revisités dans la publication *The Evidence of Health Promotion Effectiveness – Shaping Public Health in a New Europe* (IUHPE, 2000), élaborée avec l'aide de la Commission européenne et des Centres américains de Contrôle et de Prévention des Maladies (CDC).

Au fil des années, le centre des débats sur les preuves d'efficacité s'est progressivement déplacé de la sphère scientifique pour inclure la dimension politique. Cela reflète l'engagement des milieux professionnels de la promotion de la santé à plaider en faveur de l'égalité des chances devant la santé, en discutant des priorités et des décisions prises dans de nombreux domaines politiques. Les gouvernements adoptant eux aussi des positions opportunes d'un point de vue économique du genre « si vous n'êtes pas en mesure d'apporter des preuves d'efficacité, nous n'avons aucune raison d'investir dans votre champ », la terminologie et les processus comme *données probantes* et *bonne pratique* ont été ajoutés au répertoire professionnel des promoteurs de santé.

Dans d'autres secteurs de la pratique sanitaire, le recours aux analyses systématiques pour extraire les meilleures données probantes, à partir de multiples publications de recherche est bien développée, aidant à créer ce que Speller *et al.* appellent une « industrie des preuves » dans l'article qu'elle publie dans cette revue. Pour plusieurs raisons, la promotion de la santé ne s'est pas toujours sentie confortablement installée dans cette culture des preuves. En particulier, la nature participative et politique de la promotion de la santé suppose des procédés qui ne correspondent pas tellement aux conditions contrôlées nécessaires à la recherche expérimentale, considérées par certains comme la panacée universelle.

Comme toujours, les frictions génèrent de l'énergie. De nombreux instituts nationaux de promotion de la santé en Europe avaient conscience de batailler avec la même question des rapports et des liens entre science, politique et pratique. Ils ont donc décidé de joindre leurs efforts à ceux de l'UIPES et d'EuroHealthNet dans un projet européen soutenu cette fois encore par la Commission européenne, le GEP ou « *Getting Evidence into Practice* » (voir Molleman et Bouwens). Le projet a trois composantes. Premièrement : pour garantir une base commune de données probantes, un protocole d'analyse été développé, prenant en compte les expériences et les discussions menées dans les pays collaborateurs. Deuxièmement, on peut tirer des enseignements à partir des éléments essentiels des programmes les plus efficaces. De nombreux pays disposent de listes de ces éléments et critères de contrôle de qualité pour une planification professionnelle optimale. Ces listes ont servi à l'élaboration d'un cadre commun d'évaluation de la qualité et de l'efficacité des interventions. Enfin pour prouver que les preuves doivent être mises à jour régulièrement, deux sujets préalablement étudiés dans les publications de l'UIPES sur l'efficacité, ont été réactualisés, en utilisant le protocole et les critères de qualité en développement (voir l'article de Slama sur le contrôle du tabac dans la partie « Analyse des preuves » de ce numéro hors-série et celui de Jané-Llopis sur la santé mentale, dans cette même partie de la revue.

Un programme national aux Pays-Bas entre le Service de Santé municipal de Rotterdam et l'Institut néerlandais de Promotion de la Santé et de Prévention des Maladies (NIGZ) a couvert des points similaires autour des pratiques fondées sur les preuves. Le catalyseur pour le programme néerlandais est venu de deux sources : a) les critères de répartition des fonds alloués à la recherche par le Conseil national de la Recherche et du Développement pour la Santé et b) un essai randomisé contrôlé (RCT) à grande échelle qui a dû être arrêté en raison d'un décalage entre la conception de l'outil et la dynamique politique. Avec un petit coup de pouce

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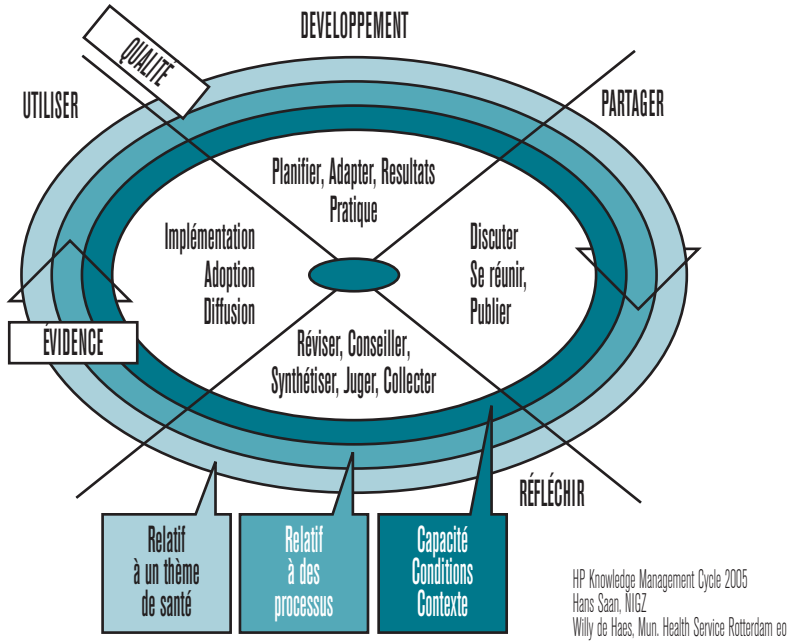
Mots-clés

- développement des capacités
- efficacité
- données probantes
- partenariat



de collègues internationaux, le débat néerlandais a eu lieu dans le cadre de quatre conférences destinées aux responsables politiques, aux praticiens et aux chercheurs, s'appuyant sur *« Evaluation in Health Promotion »* (Rootman *et al.*, 2001) comme source d'inspiration. Quatre idées sous-tendent le programme :

1. On considère qu'un système de référence commun représente l'interface importante entre diverses activités, terminologies et principes, propres à la promotion de la santé.
2. Pour que les données probantes soient utiles, il ne faut pas seulement montrer ce qui marche, mais aussi comment ça marche et sous quelles conditions, ce qui implique de faire des recherches et des rapports sur les résultats, les méthodes et les capacités indispensables. Comme les données actuellement disponibles ne mettent pas en évidence ces trois éléments, il faut entreprendre d'autres recherches.
3. La recherche en promotion de la santé devrait prendre en compte les caractéristiques et principes fondamentaux de ce champ d'intervention, à savoir le partenariat avec la population, le respect des dynamiques et de la complexité de l'action en promotion de la santé ainsi qu'une bonne compréhension du temps qu'il faut pour changer les choses. Une plus grande diversité des efforts de recherche est donc nécessaire, qui mette l'accent sur les méthodes et la logistique, en reconnaissant que les capacités sont une condition importante parfois sous-estimée.
4. Les données probantes ne sont pas partagées spontanément, mais comme toutes les formes de savoirs, elles doivent être gérées. Le modèle décrit ici montre quatre étapes : le développement des connaissances, le partage, l'analyse et l'évaluation et finalement l'utilisation des connaissances. L'étape de développement des connaissances sous-entend qu'elle inclut les capacités, les processus et les résultats, alors que l'étape d'utilisation ne repose pas seulement sur le fait de savoir que cela marche mais sur la compréhension de comment et pourquoi cela marche.

Ce numéro hors-série sert de vitrine au projet *« Getting Evidence into Practice »* (GEP). On y trouve des articles sur le développement des capacités (voir Mittelmark *et al.),* sur le système de gestion des connaissances au Royaume Uni conçu pour avoir les meilleures conditions de mise en pratique des preuves d'efficacité (voir Speller *et al.),* sur la contribution que la région européenne peut apporter au Programme mondial sur l'Efficacité de la Promotion de la Santé (GPHPE) (McQueen et Jones) et une évaluation des prochaînes étapes du projet GEP et de la pratique fondée sur les preuves en promotion de la santé (Jones et Scriven). Ces différents articles démontrent comment nous passons dans notre discipline d'une dominance de la santé et des sciences comportementales à d'autres sciences (politiques, économiques et de la gestion).
Un message clé est que les chercheurs doivent accepter la responsabilité de non seulement se concentrer sur un autre type de RCT, les « Réalités Complètement Tangibles », mais aussi de voir au-delà de leurs publications l'utilité que leurs études auront pour la politique, la pratique et le public en général.

De nombreux pays sont en train de reconsidérer la façon dont les systèmes de lien et d'échange entre la recherche, la politique et la pratique doivent être revus pour garantir une synergie. Il ne s'agit pas seulement des Pays-Bas, ni de l'Europe, mais c'est le cas partout dans le monde. Le Programme mondial sur l'Efficacité de la Promotion de la Santé coordonné par l'UIPES nous offre la chance de pouvoir partager nos expériences européennes et de bénéficier d'informations du monde entier.

Alors bienvenue dans ce numéro hors-série qui diffuse les travaux du projet GEP. Nous sommes convaincus que la conférence de Stockholm sera l'occasion de développer notre communauté professionnelle, et de nous donner des moyens d'agir en tant que professionnels, décideurs, chercheurs et avocats de la santé, informés des preuves de l'efficacité de la promotion de la santé.

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Gerard R. M. Molleman et Jan G. M. Bouwens

Elaborer la base des données probantes : développer un outil, fixer un ordre du jour et définir un programme commun pour la promotion de la santé en Europe

Tous les pays qui développent des programmes de promotion de la santé ont à répondre aux mêmes questions : quelles informations sont disponibles, quelles interventions basées sur des données probantes existent effectivement et quelle est la meilleure manière de les mettre en place ? Les politiques et la gestion de la santé demandent transparence, responsabilité et rentabilité (cette fameuse question des coûts-efficacité) ; on a donc un besoin urgent de preuves de qualité de l'efficacité de la promotion de la santé.

De nombreuses institutions de santé publique et de promotion de la santé en Europe et ailleurs sont actives pour essayer de déterminer comment mettre en pratique les données probantes et comment recueillir les preuves d'efficacité à partir de la pratique (voir l'article de Speller *et al.* dans ce numéro hors-série et les exemples qu'ils apportent tirés de l'expérience de l'Angleterre, de l'Ecosse et des Pays-Bas). Au niveau international, on cherche de plus en plus à travailler plus étroitement ensemble, pour éviter la duplication inutile des initiatives et pour échanger des idées et des méthodes (voir l'article de Mittelmark *et al.* dans la rubrique « Développement des capacités » de cette revue pour des exemples tangibles d'actions en collaboration déjà en place). Les actions en multi-partenariat et en collaboration telles que celles décrites par Mittelmark *et al.* sont importantes car recueillir et analyser ces savoirs et cette masse de données n'est pas une tâche facile.

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Le projet européen « *Getting Evidence into Practice* »

Depuis février 2004, le projet « *Getting Evidence into Practice* » (« Mise en pratique des données probantes »), financé par la Commission européenne (DG SANCO), représente la collaboration entre des partenaires clé (agences nationales et internationales de promotion de la santé) sous la forme d'un consortium européen (l'Évidence Consortium). Actuellement, plus de 20 institutions de différents pays européens sont impliquées. Le projet est axé sur la promotion de la santé, la santé publique et les interventions de prévention. Deux principaux résultats apparaissent de la première phase. Tout d'abord, comme vous allez le lire dans cette édition de *Promotion & Education*, ce projet a permis de réactualiser les données probantes relatives à deux sujets choisis, et de faire l'état des lieux des preuves dont on dispose actuellement sur l'efficacité de la promotion de la santé. Deuxièmement, un protocole d'analyse consensuel pour trouver, recueillir, analyser et présenter les données, et un outil européen d'assurance qualité pour évaluer et améliorer la promotion de la santé, ont été mis au point.

Lorsqu'on évoque cette question des preuves, il ne s'agit pas simplement de rassembler des informations mais aussi de les rendre accessibles et utilisables. On est trop souvent face à une stratégie directive de haut en bas et il existe toujours un fossé entre la recherche et la pratique. Par ailleurs, la manière actuelle de procéder aux analyses des données et à l'évaluation néglige souvent des informations très utiles issues du contexte dynamique de la promotion de la santé et sur les éléments de processus. Les preuves doivent être produites à partir du large éventail qu'offre la promotion de la santé : recherche, politique et pratique. Les procédures d'analyse doivent être élargies par des procédures de collecte d'informations issues de différentes sources telles que la littérature grise, les avis de spécialistes et les ressources non anglophones. Utiliser l'outil qualité peut aider à identifier les pratiques prometteuses pour donner l'impulsion à plus de recherche et permettre de promouvoir telle ou telle expérience au rang de 'réelles'données probantes. Ce type d'interaction entre la recherche et la pratique peut contribuer à une prise de décision pertinente en promotion de la santé.

Développer les capacités et les infrastructures

Un enjeu capital de la phase suivante du projet sur la mise en pratique des données probantes *(« Getting Evidence into Practice »)* sera de renforcer les fondations pour une implémentation durable et de garantir les capacités nécessaires. Cela implique un exercice d'analyse afin de déterminer les capacités des organisations nationales et régionales des pays membres de l'Union Européenne pour pouvoir utiliser le protocole d'analyse pour l'évaluation, pour apprécier et soutenir la qualité des interventions basées sur les données probantes et/ou proposer de bonnes pratiques et des exemples. Tout cela doit être orienté par des programmes de formation et un soutien professionnel. Le

Mots-clés

- collaboration
- données probantes
- politiques
- recherche
- analyses systématiques

protocole d'évaluation et l'outil d'assurance qualité seront appliqués à certains problèmes de santé publique qui se posent en Europe comme l'obésité, ou les inégalités de santé.

Idéalement, on devrait trouver ce type d'activités au cœur des actions de promotion de la santé dans les pays de l'Union Européenne, reflété au niveau des infrastructures locales et nationales. De nombreux pays européens faisant face aux mêmes problèmes de santé publique, comme l'obésité par exemple, on voit clairement la valeur ajoutée d'une collaboration pour s'attaquer à ces questions ensemble. Il y a beaucoup à gagner à partager et échanger les expériences, les points de vue et les savoirs sur les preuves d'efficacité et en cherchant ensemble les meilleures solutions.

Dans la phase suivante, les projets de *« Getting Evidence into Practice »* s'attachent à travailler plus étroitement avec le Réseau de l'OMS (HEN), de façon à optimiser le lien entre les connaissances basées sur les données probantes, la prise de décisions et les politiques au niveau européen. La collaboration avec l'UIPES et EuroHealthNet contribue aussi de façon importante à la diffusion des résultats.

Définir ensemble les critères et traduire ces critères en programmes concrets contribuent à développer un programme de travail européen en promotion de la santé (et une pratique fondée sur les preuves) et permettent d'asseoir solidement la promotion de la santé au sein des centres européens de contrôle des maladies (ECDC). Ces avancées vont garantir les grandes lignes d'un programme commun de travail qui offre aux professionnels de la promotion de la santé (qu'il fassent partie de la recherche, des sphères politiques ou de la pratique) des principes directeurs pour les aider à donner forme à leurs projets et à leurs interventions. Cela va avoir une valeur intrinsèque pour chaque pays, par rapport à leurs propres priorités et la dynamique contextuelle dans laquelle s'exerce la promotion de la santé et leur donner un sentiment d'appropriation.

Catherine Jones et David McQueen

La contribution européenne au Programme mondial sur l'Efficacité de la Promotion de la Santé (GPHPE)

Le Programme mondial sur l'Efficacité de la Promotion de la Santé est coordonné par l'Union Internationale de Promotion de la Santé et d'Education pour la Santé (UIPES) en collaboration avec l'Organisation mondiale de la Santé, les Centres américains de Contrôle et de Prévention des Maladies (CDC) et de nombreux autres partenaires parmi lesquels la Fondation africaine de Recherche médicale (AMREF) ; Santé Canada ; l'Agence anglaise de Développement de la Santé ; Promotion Santé Suisse ; l'Institut néerlandais de Promotion de la Santé et de Prévention des Maladies (NIGZ) ; et l'Association volontaire indienne pour la Santé (VHAI). Il s'agit d'un programme mondial unique qui vise à améliorer la qualité des prises de décisions et des interventions promotrices de santé à travers le monde en évaluant les preuves de leur efficacité en terme d'impact sanitaire, social, économique et politique ; en traduisant les données probantes pour les décideurs, les enseignants, les praticiens et les chercheurs ; et en stimulant le débat sur la nature des preuves de l'efficacité.

Le GPHPE est un programme global qui comprend différents projets régionaux ainsi que de nombreuses activités menées à travers le monde qui leur sont liées. La valeur ajoutée de la perspective mondiale qu'offre le GPHPE réside non seulement dans la capacité des programmes à examiner et à explorer les différences entre les régions quant à leurs approches de l'efficacité de la promotion de la santé, mais est aussi concrètement liée à la capacité de ce programme d'identifier les points communs, distinguer les différences de contexte et soutenir le renforcement des liens et le partage interactif de cette masse croissante de savoirs. Le GPHPE s'interroge particulièrement sur la meilleure manière d'utiliser ces savoirs.

Le GPHPE englobe une gamme d'activités, de produits et de publications développés dans le but de mieux faire comprendre l'impact potentiel des approches et des interventions promotrices de santé. Comme de nombreux pays sont en train de reconsidérer la façon dont les systèmes de liens et d'échange entre la recherche, la politique et la pratique doivent être revus pour garantir une synergie (Saan, 2005), le projet européen *« Getting Evidence into Practice »* a ici l'occasion de partager l'expérience européenne avec le reste du monde et de contribuer à la réflexion actuelle sur la meilleure façon de découvrir les données probantes à partir de la pratique, de les mesurer et de les enregistrer. La définition que ce projet donne de l'efficacité est en accord avec celle du

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GPHPE, reconnaissant que les preuves de l'efficacité peuvent être tirées de diverses sources au-delà des limites traditionnelles d'évaluation et faire appel à la littérature grise, aux avis des spécialistes et aux ressources non anglophones pour développer la base des données probantes (Molleman et Bouwens, 2005) et extraire les preuves de la pratique, en privilégiant une approche active (Speller *et al.*, 2005).

Pour le GPHPE, un défi majeur est de développer des approches durables qui correspondent mieux aux besoins régionaux, tout en conservant la qualité élevée que l'on reconnaît au travail européen original à l'initiative du programme. L'ensemble des contributions régionales permet de jouer un rôle essentiel dans l'élargissement des connaissances que le GPHPE vise à renforcer (UIPES, 2004). La méthode interactive entre la recherche et la pratique, centrale dans le travail du projet 'Getting Evidence into Pratice', constitue un exemple précieux sur la manière d'exploiter la relation dynamique souvent ignorée ou négligée entre la recherche et la pratique. Le GPHPE donne l'occasion de diffuser plus largement le protocole d'évaluation et l'outil d'assurance qualité, tous deux mis au point par le consensus européen GEP, et accroît les possibilités d'explorer et de communiquer avec ce qui se fait au-delà des frontières de l'Europe, ce qui pourrait influencer et améliorer les programmes de travail du GEP, tant dans l'immédiat que dans la seconde phase.

Le but du GPHPE est d'apporter des réponses et des solutions fondées sur de bonnes pratiques afin de pouvoir renseigner et conseiller sur la manière dont les interventions peuvent être mieux réalisées en se fondant sur des données probantes. Les directives et outils apportés par le projet GEP, en complément des connaissances dont on dispose, sont conçus pour contribuer à l'utilisation des preuves de l'efficacité de la promotion de la santé dans la pratique.

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Questions techniques

A. A. Aro, S. Van den Broucke et S. Räty, p. 10

Un consensus européen pour développer des outils d'évaluation et d'analyse des données probantes et améliorer la qualité de la pratique en promotion de la santé

Les notions de données probantes et de qualité prennent de l'importance dans la promotion de la santé. Alors qu'on attend de plus en plus des spécialistes de la promotion de la santé qu'ils démontrent et qu'ils améliorent la qualité de leurs actions, ceux-ci ne devraient pas se contenter d'adopter les concepts existants et les outils fournis par la médecine fondée sur les preuves et par l'assurance qualité telle qu'elle est appliquée dans la pratique médicale, et cela en raison de la nature complexe, dynamique et multisectorielle de la promotion de la santé. Afin de montrer si la promotion de la santé est efficace, quelles interventions marchent le mieux, et sous quelles conditions elles peuvent être mises en œuvre, le cadre actuel de la pratique basée sur les données probantes et sur la qualité a besoin d'être élargi. Il est nécessaire de développer et de s'accorder sur des critères d'efficacité qui respectent la nature contextuelle, multidimensionnelle, émancipatrice et éthique de la promotion de la santé. De plus, un écart important subsiste entre la recherche et la pratique, dans le sens où l'état actuel des connaissances sur les méthodes efficaces de promotion de la santé pour différents thèmes et lieux de vie est méconnu des professionnels, et donc pas toujours appliqué.
Pour faire face à ces questions, les chercheurs et les praticiens de la promotion de la santé peuvent utiliser des protocoles et des directives pour examiner et analyser les données probantes et améliorer la qualité des interventions. A cet égard, de nombreux protocoles existent qui aident à analyser les informations recueillies sur l'efficacité de la promotion de la santé. Certains d'entre eux sont applicables à des questions multiples et dans divers lieux de vie, tandis que d'autres sont plus spécifiquement thématiques et contextuels. De même, de nombreuses directives ont été mises à disposition pour améliorer la qualité des interventions de promotion de la santé, et des outils ont été développés pour évaluer leur qualité.
Le projet européen GEP, « *Getting Evidence into Practice* » (Mettre en pratique les données probantes) part des directives et des outils existants pour faire avancer tout ce qui touche aux preuves d'efficacité et à la qualité. Outre le fait de présenter un état des lieux des données probantes de la promotion de la santé et de les rendre plus accessibles aux praticiens, ce projet a pour but de créer un consensus entre spécialistes européens de la promotion de la santé sur le contenu et la forme à donner aux directives et aux outils d'analyse de la littérature, des documents et de la pratique pertinents pour la promotion de la santé, et d'utiliser les données probantes dans la

pratique. Ce projet puise dans l'expérience acquise dans plus de 25 pays quant à la 'mise en pratique des données probantes'. Il s'agit de renforcer l'utilisation d'une large base de données probantes, en analysant et établissant des critères d'efficacité de la promotion de la santé fondée sur les preuves, et en en soutenant l'application par les praticiens. Pour mettre en commun cette expérience, un consortium a été formé qui regroupe des agences et des instituts de promotion de la santé de presque tous les Etats membres de l'Union Européenne.

V. Speller, E. Wimbush et A. Morgan, p. 15

Pratique basée sur les données probantes en promotion de la santé : comment faire pour que ça marche

Cette vue d'ensemble des questions théoriques qui sous-tendent la mise en pratique des données probantes, est illustrée par les exemples tirés du travail exploratoire de certaines agences nationales : l'Agence anglaise de Développement de la Santé (*Health Development Agency* (HDA) ; Santé, Ecosse (*Health Scotland*) ; et l'Institut néerlandais de Promotion de la Santé et de Prévention des Maladies (NIGZ) aux Pays-Bas. Elle indique où les efforts devront être consentis à l'avenir pour mettre à profit la masse croissante de données probantes en promotion de la santé. Elle suggère qu'afin de développer la pratique basée sur les données probantes en promotion de la santé, quatre pistes parallèles d'activité soient prises en considération à parts égales :

- L'évaluation systématique de la recherche et la collecte des données probantes
- Le développement et la diffusion de directives basées sur les données probantes
- Le développement des capacités pour une pratique efficace basée sur les données probantes
- Tirer les leçons de la pratique efficace.

À partir de leurs expériences, et des preuves accumulées sur la manière de changer la pratique, cet article propose que l'on mette l'accent sur le développement des capacités et les leçons que l'on peut tirer de la pratique afin de replacer l'objectif principal sur le recueil des données probantes à partir de la recherche. Il soutient la nécessité d'une meilleure compréhension de différentes disciplines, visions du monde, et approches contenues sous l'étiquette *« getting evidence into pratice »* (mise en pratique des données probantes), et propose de résoudre les tensions inhérentes en intégrant ces perspectives contradictoires.

L'impact du contexte sur le comportement est important, de même que la nécessité d'influencer tant les systèmes et les structures que les individus pour qu'ils soutiennent le changement. La théorie de la diffusion des innovations est revisitée dans le cadre de l'utilisation de la recherche afin de comprendre quelles leçons pourraient en être tirées pour une pratique basée sur les données probantes. Initialement, les modèles de processus de diffusion mettaient l'accent sur la diffusion passive *(« push »),* reposant sur la dissémination des connaissances pour parvenir au transfert de technologie – c'est sur quoi la pratique basée sur les données probantes s'est concentrée principalement jusqu'à aujourd'hui, c'est-à-dire sur la communication de conseils apportés par des spécialistes. Les modèles plus récents insistent sur les rôles de la diffusion active *(« pull »),* qui se concentre sur la communication chercheur/utilisateur, les barrières organisationnelles et les facilitateurs, la nécessité d'une interaction suivie entre les idées, et le rôle des leaders d'opinion et des agents du changement. Les approches passives de diffusion des connaissances visent à augmenter le flux d'informations à travers leur obtention, leur codification et leur transmission, tandis que les approches actives se préoccupent d'impliquer les praticiens dans la recherche et le partage d'informations. Nous soutenons que les efforts de mise en pratique des données probantes doivent être dirigés vers des approches de diffusion active plutôt que passive.

Les exemples décrits démontrent comment des agences ayant des missions similaires ont entrepris d'exploiter cette compréhension émergente et de tester différentes approches. La HDA a créé un « cycle de mise en pratique des données probantes » en s'efforçant d'intégrer chacun des processus disparates de production des preuves d'efficacité, en développant des guides et en changeant les pratiques, pour clarifier leurs hypothèses sous-jacentes et les rendre aussi transparentes que possible. *Health Scotland* montre qu'une approche fondée sur des données probantes nécessite que l'on cultive de nouveaux rôles professionnels et que l'on développe des mécanismes de collaboration qui traversent les frontières qui séparent la recherche, les politiques et la pratique. Quant au travail réalisé aux Pays-Bas pour dépasser les essais randomisés, il souligne la nécessité de passer du paradigme de la Recherche et du Développement à une gestion active des connaissances, pour garantir un partage et une utilisation des connaissances plus rapides. Chacune de ces quatre pistes de mise en pratique des données probantes peut être vue de différentes façons dans ces exemples, et l'on devrait tirer des leçons de leurs expériences sur la manière de développer les capacités pour une mise en œuvre de la promotion de la santé basée sur les données probantes.

E. Jané-Llopis, p. 21

Des données probantes à la pratique : efficacité de la promotion de la santé mentale

La santé mentale est un bien public partout dans le monde, est essentielle à l'individu et à la société, et est un droit fondamental de l'être humain. Cependant, toutes les tranches d'âge, tous les pays et les sociétés connaissent des manques en termes de santé mentale et font l'expériences de troubles mentaux. Pour soutenir une approche globale de mise en œuvre d'actions de promotion de la santé mentale, comme le demande le Plan d'Action européen de l'OMS sur la Santé Mentale, quatre dimensions peuvent être soulignées pour mettre en pratique les données probantes ; à savoir, poursuivre :
1) la collecte, l'analyse et la synthèse des données probantes sur l'efficacité de la promotion de la santé mentale ;
2) la diffusion efficace des données probantes auprès des principaux acteurs ;
3) l'estimation des capacités de réalisation ; et
4) n'avoir de cesse de tirer les leçons de la pratique efficace pour continuer à soutenir le développement des capacités et améliorer la base des données. Cet article vise à illustrer par quelques exemples comment l'action menée dans ces quatre dimensions peut soutenir le secteur de la promotion de la santé mentale. Premièrement, les preuves démontrent que la promotion de la santé mentale peut être efficace et amener le développement économique, social et sanitaire à la société. Deuxièmement, un registre sur Internet des pratiques de promotion de la santé mentale peut aider à la diffusion des preuves de ce qui marche dans les pays et régions, en apportant différents outils pour l'implémentation. Troisièmement, les capacités de mise en œuvre de la promotion de la santé mentale peuvent être estimées au niveau national et servir à définir les domaines-clés dans lesquels l'action est possible et les barrières qui doivent être surmontées pour améliorer l'implémentation future. Quatrièmement, l'implémentation peut être soutenue par un développement des capacités continu au travers d'initiatives de formation, pour développer, par exemple, des ressources humaines pour la promotion de la santé mentale. Agir dans ces quatre dimensions s'avère crucial pour faciliter la traduction des données probantes en pratique, et améliore la qualité de la pratique qui peut à son tour être traduite en nouvelles preuves d'efficacité. De plus, le lien étroit entre santé physique et santé mentale, et les points communs de leurs stratégies, sont une occasion d'accroître l'efficacité des interventions. Ces lignes d'action qui soutiennent la mise en pratique des données probantes fournissent des outils pour améliorer la qualité de la promotion de la santé mentale et soutenir les politiques pour favoriser le développement d'une stratégie globale d'amélioration de la santé mentale de la population.

K. Slama, p. 28

Des données probantes à la pratique : efficacité de la lutte antitabac

Une promotion de la santé globale, continue, et durable a un impact sur les comportements à risques pour la santé : c'est ce que nous montre la lutte efficace contre le tabac. L'épidémie de tabagisme est générée et entretenue par l'interaction de facteurs individuels, sociaux, économiques et politiques ; déterminer de bonnes pratiques en promotion de la santé nécessite de les prendre tous en compte. Tandis que les divers éléments d'un programme peuvent être testés par des essais contrôlés, d'autres aspects de la lutte antitabac, comme le changement organisationnel et social, un plaidoyer efficace ainsi que de nouvelles définitions culturelles du tabagisme et de la non légitimité des stratégies de marketing de l'industrie du tabac, nécessitent des mesures différentes de bonne pratique. Les bonnes pratiques en politique sont actuellement contenues dans la Convention-cadre pour la Lutte Antitabac, qui définit les normes minima du contrôle du tabac sur le plan national et international et pour la restriction du champ d'action de l'industrie du tabac. Les données probantes pour les pratiques sont recueillies à partir des stratégies qui modifient la valeur sociale de l'usage du tabac. Un changement qui, au-delà des politiques que cela peut inclure, touche à la définition même du tabagisme : aujourd'hui, fumer n'est plus un comportement normal et raisonnable ; éducation pour la santé et plaidoyer jouent ici un rôle-clé en influençant à leur tour les choix politiques. Les meilleures preuves d'efficacité des programmes peuvent s'évaluer par des essais randomisés contrôlés, bien que l'influence du contexte rende difficile la mesure du changement à un niveau autre qu'individuel. Des études montrent que les programmes scolaires ou d'autres programmes qui s'adressent exclusivement aux jeunes sont inadéquats, et que la communauté plus large doit être impliquée. La thérapie d'aide au sevrage tabagique et les médicaments peuvent aider les individus ; la prévalence au sein d'une population est influencée par les programmes qui touchent le plus grand nombre : une large diffusion de l'éducation pour la santé dans les médias, des conseils ponctuels dispensés lors des contacts avec les services de santé, et la divulgation des informations contenues dans les documents internes de l'industrie du tabac. En somme, la lutte antitabac marche le mieux lorsque les politiques, les pratiques et les programmes travaillent de concert.

M. B. Mittelmark et al, p. 33

Répertorier les capacités européennes à s'engager dans la promotion de la santé au niveau national : HP-Source.net

Il n'existe encore aucun système d'information recouvrant l'ensemble de l'Europe qui rassemble de manière efficace et précise l'expérience et les connaissances acquises sur les approches pour améliorer la santé qui marchent le mieux dans diverses parties du continent. Peu de pays dans la région disposent d'une politique cohérente, bien articulée et énergique qui fasse valoir la promotion de la santé comme un complément essentiel des services de soins de santé. Les ONGs et les professionnels de santé dans la région ne sont pas encore suffisamment liés. On est encore loin des synergies qui pourraient résulter d'un système mieux coordonné de services, formations et actions préventives de proximité. Les systèmes d'information de base, essentiels pour déterminer les priorités en promotion de la santé et les progrès réalisés sont disjoints. De nombreux exemples d'excellence existent, mais étant donné la fragmentation et les complexités culturelles, économiques et politiques de l'Europe, il est difficile de mettre en avant les modèles, d'en tirer un enseignement, et d'assembler les pièces dans un système solide qui soutienne la pratique en promotion de la santé. Ainsi, on a besoin d'informations collectées de manière systématique sur l'état des infrastructures, des politiques et des programmes de promotion de la santé en Europe. Ces informations devraient être facilement accessibles aux responsables politiques, aux défenseurs de la promotion de la santé, aux ONGs, aux chercheurs, aux institutions d'enseignement et de formation et aux communautés.

En Europe, HP-Source.net a pour but de répondre en partie à ce besoin d'un système de collecte et de diffusion pour faire face aux problèmes mentionnés ci-dessus. Partant d'un réseau fondé à l'origine par la Commission européenne, et regroupant des chercheurs de 24 pays européens, HP-Source.net a évolué vers une collaboration internationale et bénévole entre des chercheurs, des praticiens et des responsables politiques dont le but commun est de maximiser l'efficience et l'efficacité des politiques, des infrastructures et des pratiques en promotion de la santé, et cela : (1) en développant un système uniforme de collecte d'informations sur les politiques, les infrastructures et les pratiques ; (2) en créant des bases de données et une stratégie d'accès de façon à ce que les responsables politiques, les organisations de santé publique et les chercheurs puissent accéder aux informations tant d'un pays à un autre qu'à l'intérieur même des pays ; (3) en analysant les bases de données pour soutenir la production de modèles permettant un fonctionnement et une efficacité optimum des politiques, infrastructures et pratiques de promotion de la santé ; (4) en communiquant activement ces informations et ces connaissances, et en plaidant non moins activement en faveur de l'adoption de modèles dont l'efficacité et l'efficience sont prouvées, par le biais de publications, séminaires, conférences et briefings, entre autres moyens. HP-Source.net collecte des données quantitatives et qualitatives dans neuf domaines différents : politiques et priorités ; évaluation ; contrôle et/ou surveillance ; développement des connaissances ; implémentation ; diffusion de l'information pour les professionnels des soins de santé ; programmes et stratégies ; ressources humaines professionnelles ; financement. Les données sont collectées en faisant référence aux capacités nationales de promotion de la santé en général, mais aussi par rapport à des domaines spécifiques tels que les capacités de promotion de la santé mentale et les politiques liées à l'alcool.

HP-source.net démontre qu'il est possible de développer des systèmes paneuropéens coordonnés qui permettent de répertorier les capacités de la promotion de la santé. D'autres travaux européens d'inventaire méthodique des capacités, en particulier ceux du Bureau européen de l'OMS, démontrent qu'en Europe, plusieurs approches sont possibles, dans une approche triangulaire, pour fournir les données nécessaires permettant de passer des données probantes sur l'efficacité de la promotion de la santé à l'amélioration des politiques, des infrastructures et des pratiques.

Catherine Jones et Angela Scriven

Où nous dirigeons-nous ? Prochaines étapes dans le recueil et la mise en pratique des preuves de l'efficacité de la promotion de la santé en Europe

Cette édition spéciale de *Promotion & Education* examine les débats et les actions qui entourent aujourd'hui la mise en pratique des données probantes en promotion de la santé, et en particulier le projet 'Getting Evidence into Practice'(GEP). Les auteurs ne se sont pas contentés de traiter la situation actuelle. A de nombreuses reprises dans la revue, ils ont attiré l'attention sur ce qui doit se développer par la suite. Ce dernier article a pour but de synthétiser certains des arguments et des idées présentés justement par les auteurs. Il définit dans un premier temps les questions centrales par rapport à la situation présente, puis décrit les efforts qu'il faudra fournir à l'avenir pour développer les systèmes qui permettront à la promotion de la santé de mettre en pratique (et de recueillir à partir de la pratique) des preuves appropriées.

Situation actuelle

Cinq questions sont prédominantes dans ce numéro et représentent la situation actuelle du mouvement pour une pratique basée sur les données probantes en promotion de la santé. Elles concernent : la nature des preuves ; la nécessité d'un cadre de travail commun pour mettre en pratique les données probantes ; les capacités et les compétences professionnelles ; le lien entre la recherche, la politique et la pratique ; l'action en collaboration et la nécessité d'une terminologie unifiée.

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L'un des débats actuels particulièrement important s'attache à déterminer ce qui constitue des preuves pertinentes d'efficacité en promotion de la santé. L'utilité des RCT a été soulignée par de nombreux auteurs, tous partageant l'opinion selon laquelle la complexité des interventions promotrices de santé nécessite différents types de preuves. La nature des résultats et des méthodes en promotion de la santé est considérée comme capitale pour la manière dont les données probantes sont localisées, analysées et synthétisées (voir, par exemple, le passage dans l'article d'Arja *et al.* sur la manière dont le concept de promotion de la santé oriente le processus de recueil des données probantes). Slama nous offre également des exemples concrets tirés de la lutte contre le tabac pour illustrer le besoin de critères globaux et souples pour évaluer les bonnes pratiques, soutenant l'opinion générale selon laquelle les preuves d'efficacité en promotion de la santé doivent être recueillies de sources multiples et variées. De plus, tout le monde s'accorde pour dire que le recueil des preuves de ce qui marche en promotion de la santé est insuffisant en soi. Les données probantes doivent aussi indiquer comment ça marche, sous quelles conditions et dans quel contexte.

Il existe un fort engagement par rapport au cadre de travail commun pour une approche systématique de la mise en pratique des preuves de l'efficacité de la promotion de la santé, centrée sur quatre éléments d'égale importance :

- Recueillir, évaluer et synthétiser les données probantes sur l'efficacité de la promotion de la santé ;
- Diffuser ces données par des moyens appropriés, auprès des décideurs et des praticiens.
- Évaluer les capacités nécessaires à l'implémentation de politiques, programmes et pratiques basés sur les preuves ;
- Apprendre de la pratique efficace pour soutenir davantage le développement des capacités et améliorer la base des données probantes

L'identification, l'analyse et le développement des capacités professionnelles pour permettre l'implémentation efficace de la masse croissante de données probantes en promotion de la santé sont considérés comme des éléments importants (et complexes) de ce cadre de travail et tous les auteurs ont plaidé dans ce sens.

L'importance d'un lien efficace entre recherche, politique et pratique est fortement soulignée. Les notions de connaissances *passives (« push »)* et de connaissances *actives (« pull »)* fournissent une représentation visuelle éloquente des forces dynamiques en présence entre la recherche et la pratique et de la nécessité d'un équilibre entre les deux (on peut trouver la description détaillée de ces méthodes dans l'article de Speller *et al.*).

Enfin, si tous nos collaborateurs s'accordent pour dire qu'il est essentiel de travailler en collaboration afin de faire progresser le mouvement en faveur d'une promotion de la santé basée sur des données probantes en Europe et dans le monde, il existe néanmoins une divergence terminologique. L'éventail des termes utilisés dans cette édition est large allant des politiques et pratiques basées sur des données probantes aux politiques et pratiques informées par des preuves, de la gestion des connaissances au développement des capacités, des bonnes pratiques aux bonnes preuves d'efficacité en passant par les bonnes données probantes, et du développement de la pratique à la mise en pratique des données probantes. La diversité des expressions et la nécessité d'intégrer rapidement les méthodes de recueil et d'utilisation des preuves dans le domaine requièrent que l'on ait une terminologie commune sans ambiguïtés

Mots-clés
- cadre de travail
- données probantes
- capacité d'implémentation

avec laquelle les professionnels de la promotion de la santé peuvent communiquer efficacement à travers leurs réseaux de collaboration.

Certaines des cinq questions exposées plus haut n'ont pas été résolues et resteront centrales dans l'ordre du jour de ceux qui œuvrent pour la mise en pratique des données probantes.

Actions à venir

Le travail du Programme mondial sur l'Efficacité de la Promotion de la Santé (GPHPE) est au cœur de cette question. Sa mission unique ne se limite pas à examiner et explorer les différences entre les régions quant à leurs approches de l'efficacité de la promotion de la santé, mais l'intérêt de sa perspective mondiale est lié à son habileté à identifier les points communs, distinguer les différences de contexte et soutenir le renforcement des liens et le partage interactif de cette masse croissante de savoirs (comme l'ont décrit Jones et McQueen en examinant la contribution européenne).

Le projet « *Getting Evidence into Practice* » (GEP) entre dans une seconde phase, et les membres et partenaires du projet sont déterminés à étendre sa portée et sa diffusion vers un public plus large. Il sera capital dans cette nouvelle phase de renforcer les fondations pour une implémentation durable et de garantir les capacités nécessaires, ce qui implique également des programmes de formation et un soutien technique (voir Molleman et Bouwens pour les grandes lignes).

La deuxième phase impliquera un exercice d'identification et d'analyse des capacités des organisations des pays membres de l'UE à utiliser le protocole d'analyse et d'évaluation européen, et à soutenir et améliorer la qualité des interventions basées sur les données probantes. Cependant, comme l'ont développé Mittelmark *et al.*, il est nécessaire d'analyser les capacités de promotion de la santé au-delà de ces paramètres et de garantir que les informations obtenues par l'exercice d'analyse constituent un réel bénéfice et un outil pour ceux qui plaident en faveur de la promotion de la santé à travers l'Europe. L'analyse des capacités n'est pas seulement un élément clé pour l'implémentation de stratégies, mais présente une diversité d'utilisations en communication, développement des connaissances et éducation, développement des ressources professionnelles, plaidoyer et développement de politiques. Le prochain défi reste l'augmentation des capacités d'utilisation des données probantes dans la pratique, et le recueil de ces données à partir de la pratique (pour plus de détails, voir Speller *et al.*).

Les recommandations que nous adressent les auteurs dans ce numéro hors-série sont claires et constantes à propos de la direction à donner aux approches basées sur les données probantes en promotion de la santé ; celles-ci peuvent progresser dans le cadre du projet GEP et du programme GPHPE.

Le renforcement des réseaux intra et internationaux pour partager les enseignements et favoriser des communautés mixtes de recherche, politique et pratique est considéré comme essentiel. Parallèlement, on suggère que de nouveaux rôles professionnels soient définis avec des attributions stratégiques pour travailler au travers de cette interface et rendre efficace les liens entre la recherche, la politique et la pratique. D'autres postes clés seraient très utiles au sein des communautés qui développent la recherche et la pratique pour jouer le rôle d'agents du changement et de leaders d'opinion dans ce domaine des preuves de l'efficacité de la promotion de la santé. Ces postes auraient la responsabilité de constituer des corpus de connaissances et de communiquer aux praticiens les informations disponibles et la façon de les utiliser dans la pratique.

Les efforts en collaboration doivent se poursuivre pour évaluer à la fois les capacités actuelles (au sens le plus large) et les initiatives de formations destinées à accroître ces capacités (voir l'exposé de Jané-Llopis sur le développement des capacités à travers la formation). L'essentiel pour l'avenir sera d'établir un lien solide et des mécanismes d'échange par lesquels les chercheurs, les financeurs de la recherche, les responsables politiques et les praticiens pourront s'engager dans des échanges productifs sur les questions d'intérêt commun. Cependant, il existe des barrières au développement d'une interaction plus fluide entre les principales parties prenantes du mouvement pour une promotion de la santé basée sur les preuves. Ainsi, le défi futur le plus significatif, pour le projet GEP comme pour le programme GPHPE, sera de parvenir à surmonter les barrières politiques, organisationnelles et infrastructurelles, pour progresser. La promotion de la santé, qui a comme principe d'inclure et d'intégrer, doit être la première à trouver les moyens de développer les capacités, de façon à ce que la connaissance des preuves et de la manière de les mesurer s'accompagne des ressources matérielles, humaines et structurelles pour les utiliser et les produire.

Hans Saan

El camino hacia la evidencia: la trayectoria europea

La evidencia sin capacidad es una concha vacía.

Mohan Singh

Esta edición especial de *Promotion & Education* celebra un paso importante en la promoción de la salud en Europa. Comparte la manera en la cual Europa esta desarrollando el terreno de la práctica basada en la evidencia de una forma unificada. Las cuestiones de la efectividad y la evidencia han adquirido cada vez mayor importancia a modo de desafío común. La colaboración a nivel europeo dio sus primeros pasos en esta dirección en 1989 en Rótterdam con la organización de una conferencia especial de la UIPES en torno a la efectividad, donde se desarrollaron en una serie de folletos bajo el patrocinio de la Comisión Europea. La UIPES siguió manteniendo este tema en la agenda, celebrando conferencias especiales en Grecia, Israel, Finlandia, Estonia, Londres y ahora, en el 2005, en Suecia. Los temas que abordaron los primeros folletos fueron recapitulados en el libro "La evidencia de la eficacia de la promoción de la salud" (*The evidence of health promotion effectiveness)* (IUHPE, 2000)[1], elaborado con ayuda de la Comisión Europea y los Centros para el control y la prevención de enfermedades, CDC, de Estados Unidos.

Con los años, la orientación de los debates ha ido desviándose lentamente de lo científico para incluir lo político. Esto refleja el compromiso de las esferas de profesionales que trabajan en la promoción de la salud de abogar por la igualdad de oportunidades para la salud desafiando las prioridades y decisiones en diferentes áreas políticas. A medida que también los gobiernos han ido adoptando posiciones económicas más convenientes, la respuesta ha sido: "Si no puedes probarlo, no vamos a invertir". Palabras como *evidencia* y *buenas prácticas* tuvieron que ser añadidas a la jerga profesional.

En otros ámbitos de la práctica de la salud, la estrategia de utilizar revisiones para destilar la mejor evidencia de numerosas publicaciones de investigación se ha desarrollado bien, ayudando a crear lo que Speller *et al.* Por varias razones, la promoción de la salud no siempre ha encajado con facilidad en la creciente cultura de la evidencia. Su naturaleza participativa y política supone procesos que no se compaginan suficientemente bien con las condiciones controladas que requiere la investigación experimental, vista por algunos como el patrón de oro.
Como siempre, la fricción genera energía. Cierto número de institutos nacionales de promoción de la salud de Europa eran conscientes de que todos ellos luchaban para vincular la ciencia basada en la evidencia, la política y la práctica. denominan "industria de la evidencia". Con la ayuda de la Comisión Europea, el proyecto en colaboración "Poniendo la evidencia en práctica" (*Getting evidence into practice)*, fue establecido por la UIPES y EuroHealthNet (véase Molleman y Bouwens para mas información entorno a EuroHealthNet.) Se trabajaron tres líneas para el proyecto. La primera pretendía asegurar una base común de evidencia, por lo cual se desarrolló un protocolo común que consideraba las experiencias y debates en los paises participantes. En la segunda línea fue posible extraer lecciones sobre los componentes críticos de los programas más eficaces. Muchos países disponen de listas de comprobación de estos componentes para garantizar la calidad y la óptima planificación profesional. Estas listas están ahora combinadas en una norma compartida. Finalmente, a fin de demostrar que la evidencia debe ser frecuentemente revisada, dos temas del libro recopilatorio de la UIPES han sido nuevamente actualizados (véase el articulo de Slama sobre el control del tabaco y el de Jane-Llopis sobre la salud mental, ambos en el capítulo "Análisis de la evidencia" de esta edición) con el desarrollo del protocolo y la norma de calidad como telón de fondo.

Un programa nacional holandés desarrollado con el Servicio municipal de la salud de Rótterdam y el Instituto holandés de promoción de la salud y la prevención de enfermedades (*The Netherlands Institute of Health Promotion and Disease Prevention,* NIGZ) ha abordado temas similares entorno a la practica basada en la evidencia. El impulso de este programa provino de dos fuentes a) los criterios de distribución de los fondos que dedica a la investigación el Consejo holandés sobre la investigación y el desarrollo de la salud y b) un RCT (*Randomized Controlled Trials*-ensayo aleatorio controlado) a gran escala, que fue interrumpido debido a una falta de adaptación entre el diseño y la dinámica política. Con un poco de ayuda de nuestros colegas internacionales, pusimos en marcha un debate holandés en cuatro conferencias que reunieron a responsables de la toma de decisiones, profesionales de la promoción de la salud e investigadores, utilizando la publicación *Evaluation in health promotion* (Rootman *et al.*, 2001) como fuente de inspiración. Extrajimos cuatro lecciones de dicho programa:

Tenemos que trabajar dentro de un marco común de referencia que sirva de interfaz entre la diversidad de actividades, jergas y principios de promoción de la salud.

Para que la evidencia sea útil, debe mostrar a) qué funciona b) cómo

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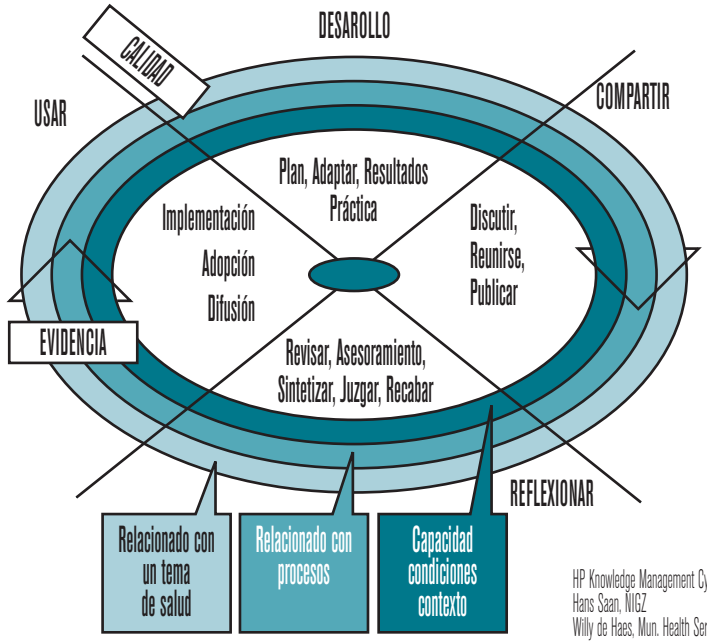
Palabras clave

- creación de capacidad
- efectividad
- evidencia
- colaboración



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funciona y c) en qué condiciones. La evidencia basada en la investigación, por lo tanto, deberá informar sobre los resultados, los procesos y la capacidad. Debido a que la evidencia de la que disponemos actualmente no muestra estos tres elementos, se necesita una investigación diferente.

Una investigación adecuada de la promoción de la salud debe tener en cuenta las características principales del campo. Estas incluyen personas en calidad de asociados, respeto de las dinámicas y la complejidad y una buena comprensión del tiempo que requiere el cambio. Igualmente necesaria es una mayor diversidad de esfuerzos de investigación, que incluya un enfoque en los procesos y en la logística, con la capacidad como condición fundamental.

La evidencia, como todo conocimiento, no se comparte espontáneamente, sino que, necesita ser gestionada. El modelo aquí descrito refleja cuatro fases: *desarrollo de conocimientos; compartir; revisar; usar*. La etapa del *conocimiento* debe incluir resultados, procesos y capacidad, al igual que la etapa de *usar* no sólo depende de saber qué funciona, sino también un entendimiento de cómo y por qué funciona.

Esta edición especial describe el proyecto "Poniendo la evidencia en práctica". Incluye contribuciones sobre capacidad (véase Mittelmark *et al.*), el sistema británico de gestión del conocimiento para garantizar que las condiciones son optimas para poner la evidencia en practica (véase Speller *et al.*), la contribución que la región europea puede aportar al Programa mundial de efectividad de la promoción de la salud (GPHPE, en sus siglas en ingles) (Jones y McQueen) y la valoración de lo que depara el futuro para este proyecto y la practica de la promoción de la salud basada en la evidencia (Jones y Scriven). Estas contribuciones demuestran con gran acierto de qué manera avanzamos desde el dominio disciplinario de la salud y las ciencias conductuales a otras ciencias, incluyendo la política, la economía y la gestión. Uno de los mensajes clave es que los investigadores tienen que aceptar responsabilidad y focalizarse, no solo en un tipo diferente de *RCT*, la *Really Consolidated Truth* (*RTC*, en este caso, 'verdad realmente verídica'), sino también mirar más allá de sus publicaciones, hacia el uso que sus estudios tienen para la política, los profesionales de la promoción de la salud y el público general.

Muchos países están reconsiderando revisar los sistemas de relación e intercambio entre investigación, política y práctica, con vistas a garantizar una sinergia. Esto no solamente está teniendo lugar en Europa, sino que también es una inquietud en todo el mundo. El Programa mundial de efectividad de la promoción de la salud que la UIPES coordina, brinda una magnífica oportunidad para compartir nuestras experiencias europeas y recibir retroalimentación de todo el mundo.

Le damos la bienvenida a esta publicación que difunde el trabajo del proyecto 'Poniendo la evidencia en práctica'. Confiamos en que la conferencia de Estocolmo sea una buena oportunidad para crear una comunidad profesional que nos faculte como profesionales, investigadores y personas que abogan por la salud basada en la evidencia.

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Gerard R. M. Molleman y Jan G. M. Bouwens

Creando la base de la evidencia: del desarrollo de herramientas al establecimiento de un orden del dia y la definición de un programa de acción de la promoción de la salud en Europa

Cada país que desarrolla programas de promoción de la salud debe enfrentarse a preguntas como las siguientes: ¿qué clase de información está disponible?, ¿qué intervenciones basadas en evidencia existen realmente? y ¿cuál es la mejor manera de aplicarlas? A esto se añade que la política y la gestión sanitarias exigen transparencia, obligación de rendir cuentas y rentabilidad; de allí que también la evidencia de efectividad en promoción de la salud sea urgente.

Muchos organismos de Salud Publica / Promoción de la Salud ejercen su actividad en el campo de cómo poner la "evidencia en práctica" y de cómo obtener "evidencia a partir de la práctica" (véase Speller *et al.* en esta edición especial para ejemplos en Inglaterra, Escocia y Holanda). A nivel internacional, existe un interés creciente por trabajar más estrechamente, es decir, por aunar fuerzas, con el fin de evitar la duplicación e intercambiar métodos de trabajo (véase Mittelmark *et al.* en la sección "Desarrollar las capacidades" de esta edición para ejemplos tangibles de colaboración ya establecidos). Acción colaboradora o en partenariado con diferentes organizaciones, tal y como explica Mittelmark *et al.* es importante debido a que no es fácil recoger y definir este conocimiento y volumen de evidencia.

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El proyecto europeo "Poniendo la Evidencia en Práctica"

Desde febrero de 2004, el proyecto "Poniendo la Evidencia en Práctica", financiado por la Comisión Europea (DG SANCO) es el fruto de la colaboración entre organismos nacionales de promocion de la salud reunidos en un Consorcio de Evidencia Europea. Actualmente, participan mas de 20 instituciones europeas. Este proyecto se concentra en la promoción de la salud, la salud pública y las intervenciones preventivas. Existen dos resultados de la primera fase del proyecto. En primer lugar, tal como van a leer en esta edición de *Promotion & Education*, este proyecto actualizo dos temas seleccionados en materia de evidencia de la efectividad de la promoción de la salud. En segundo lugar, también se logró diseñar un protocolo consensuado para la revisión de los hallazgos, la recogida, la definición y la descripción de la evidencia, conjuntamente con una herramienta europea de control de calidad destinada a evaluar y a mejorar la promoción de la salud.

Basarse en evidencia no significa solamente reunir información, sino también posibilitar su acceso y utilización. Ésta es con frecuencia una estrategia arriba-abajo, y sigue existiendo una brecha entre investigación y práctica. La práctica actual de realizar revisiones pasa por alto con frecuencia información valiosa para el dinámico contexto de la promoción de la salud y en relación con factores de proceso. Debemos encontrar medios de producir evidencia a partir del amplio espectro de la promoción de la salud: investigación, política y práctica. Necesitamos ampliar los procedimientos de revisión con procedimientos que recojan información de diferentes fuentes, como literatura no convencional, opiniones expertas e información de habla no inglesa. La utilización de la herramienta de calidad puede ayudarnos a identificar prácticas prometedoras que sirvan para aportar nueva investigación, contribuyendo así a valorizar dicha experiencia convirtiéndola en evidencia «real». Este proceso de interacción entre investigación y práctica puede contribuir a una toma de decisiones adecuada en materia de promoción de la salud.

Desarrollando la capacidad y la infraestructura

Un elemento fundamental de la siguiente fase del proyecto «Poniendo la Evidencia en Práctica» va a residir en seguir consolidando las bases para una aplicación sostenible, al tiempo que se garantiza la capacidad necesaria. Esto incluye un ejercicio prospectivo que permita evaluar la capacidad de las organizaciones nacionales y regionales de los Estados miembros de la UE para utilizar el protocolo de revisión y evaluar y apoyar la calidad de las intervenciones basadas de evidencia y/o para aportar mejores prácticas y ejemplos. Programas de formación y apoyo deberán impartir orientación. El protocolo de revisión y la herramienta de control de calidad se aplicarán a temas sanitarios europeos relevantes, como la obesidad o las desigualdades en salud.

Actividades de esta clase debieran formar parte de las actividades básicas de la promoción de la salud en los países de la UE, reflejándose en la infraestructura nacional y local. Debido a que numerosos países europeos comparten los mismos temas sanitarios, la colaboración y el tratamiento conjunto de estas cuestiones representan ciertamente un valor añadido. Mucho se puede ganar compartiendo e intercambiando las experiencias, las nuevas percepciones y el conocimiento en materia de evidencia, y también estudiando conjuntamente las mejores soluciones.
En la fase siguiente, el proyecto "Poniendo la Evidencia en Practica" se esforzará por trabajar más estrechamente con la OMS-Red de Evidencia Sanitaria *(Health Evidence Network)*, de manera que el conocimiento, la toma de decisiones y la política basados en la evidencia se puedan optimizar a escala europea. La colaboración con la UIPES y con EuroHealthNet contribuirá asimismo de manera importante a la difusión de los resultados.

La definición conjunta de normas y la traducción de dichas normas en programas de acción concretos contribuyen a un programa de trabajo europeo en materia de promoción de la salud y a la práctica basada en la evidencia, fortaleciendo la posición de la promoción de la salud en el seno de la infraestructura del Centro para la prevención y control de enfermedades europeo. Debemos actuar en estos avances a tiempo para garantizar grandes líneas de un programa de trabajo conjunto que ofrezca a los profesionales de promoción de la salud dedicados a la investigación, la política o la práctica, principios directrices para configurar sus proyectos e intervenciones. Esto ofrecerá un valor intrínseco para cada país en relación a sus propias actividades básicas, la dinámica contextual de la promoción de la salud y su sentido de la propiedad.

Catherine Jones y David McQueen

La contribución de la región europea al Programa Mundial de Efectividad de la Promoción de la Salud (GPHPE)

El Programa Mundial de Efectividad de la Promoción de la Salud (*Global Programme on Health Promotion Effectiveness* - GPHPE) es coordinado por la Unión Internacional de Promoción y Educación para la Salud (IUHPE), en colaboración con la Organización Mundial de la Salud, los Centros para el Control y la Prevención de Enfermedades de Estados Unidos y muchos otros organismos asociados, incluidos, sin que esta enumeración sea exhaustiva, los siguientes: Fundación Africana para la Investigación Médica, *Health Canada,* de Canadá, *Health Development Agency*, de Inglaterra, *Health Promotion*, de Suiza, *The Netherlands Institute for Health Promotion and Disease Prevention*, de Holanda, y *Voluntary Health Association*, de India. Se trata de un programa mundial único que tiene como finalidad mejorar las normas de formulación de las políticas y la práctica de promoción de la salud en todo el mundo, revisando para ello la evidencia de la efectividad en términos de su impacto sanitario, social, económico y político, trasladando la evidencia a los responsables de las políticas, los educadores, los investigadores y aquellos que practican la promoción de la salud, y estimulando el debate acerca de la naturaleza de la evidencia de la efectividad.

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El GPHPE es un programa de amplio alcance que abarca determinado número de proyectos regionales y actividades afines que tienen lugar en todo el mundo. El valor añadido de la visión global del GPHPE reside no solamente en su capacidad para explorar y examinar las diferencias entre las regiones en materia de enfoques de la efectividad de la promoción de la salud, sino también en que está relacionado de forma concreta con su capacidad para reconocer los puntos en común, distinguir las diferencias de contexto y apoyar el fortalecimiento de las vinculaciones y la puesta en común interactiva de este creciente volumen de conocimiento. Como factor importante cabe mencionar el interés del GPHPE en encontrar la mejor manera de dar uso a este volumen de conocimiento.

El GPHPE engloba un abanico de actividades, productos y publicaciones que han sido concebidos con el fin de incrementar la comprensión del impacto potencial de los enfoques de la promoción de la salud y las intervenciones en este campo. Debido a que muchos países están reconsiderando el modo como los sistemas de conexión e intercambio entre investigación, política y práctica tienen que ser revisados para garantizar una sinergia (Saan, 2005), el proyecto europeo «Poniendo la Evidencia en Práctica» tiene la oportunidad de compartir la experiencia europea con el resto del mundo y contribuir a la reflexión continuada acerca del mejor modo de

descubrir, medir y registrar la evidencia a partir de la práctica. La definición que este proyecto tiene de la efectividad está en consonancia con aquella del GPHPE, que reconoce que la evidencia de la efectividad se puede derivar de una variedad de fuentes que trascienden las fronteras de la evaluación tradicional, e inspirarse en la literatura no convencional, las opiniones expertas y las fuentes de habla no inglesa, ampliando así la base de evidencia (Molleman y Bowens, 2005) y "tirando" o extrayendo (enfoque *pull*) la evidencia de la práctica (Speller *et al.,* 2005).

Un importante desafío para el GPHPE consiste en concebir los enfoques sostenibles mejor adaptados a las necesidades regionales, al tiempo que mantiene la alta calidad por la que se reconoce el trabajo original europeo que dio origen a este programa. La totalidad de las aportaciones regionales sirven para desempeñar un papel decisivo en la ampliación del volumen de conocimiento que el GPHPE tiene previsto crear (IUHPE, 2004). El proceso interactivo entre investigación y práctica, que es fundamental para la labor del proyecto "Poniendo la Evidencia en Práctica" (GEP), es un valioso ejemplo de cómo captar la relación dinámica entre investigación y práctica, que con frecuencia se ignora o se descarta. El GPHPE brinda oportunidades para una mayor difusión del protocolo de revisión consensuado y la herramienta de calidad del proyecto europeo. De esta manera, incrementa el potencial de disponer de un mayor número de vías que explorar y comunicar más allá de las fronteras europeas, que podrían informar sobre los programas de trabajo GEP y mejorarlos ahora y en la segunda fase. Es intención del GPHPE sacar a la luz respuestas y encontrar soluciones basadas en las mejores prácticas, a fin de poder ofrecer asesoramiento sobre el mejor modo de llevar a cabo las intervenciones basándose en evidencia. La aportación de directrices y herramientas del proyecto GEP, que sirven de complemento a las ya existentes, ha sido diseñada para contribuir a la puesta en práctica de la evidencia de la efectividad de la promoción de la salud.

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Cuestiones técnicas

A. A. Aro, S. Van den Broucke y S. Räty, p. 10

Hacia herramientas de consenso europeo que permitan revisar la evidencia y mejorar la calidad de la práctica de la promoción de la salud

Las nociones de evidencia y calidad están adquiriendo importancia en la promoción de la salud. Si bien se espera cada vez más que los especialistas en promoción de la salud demuestren y mejoren la calidad de sus acciones, no debieran limitarse a adoptar los conceptos y herramientas existentes de la medicina basada en la evidencia (MBE) y la garantía de calidad, tal como se aplican en la práctica médica, debido a la naturaleza compleja, dinámica y multisectorial de la promoción de la salud. A fin de demostrar si la promoción de la salud es efectiva y qué intervenciones funcionan mejor y en qué condiciones se podrían poner en marcha, es necesario ampliar los marcos existentes de evidencia y calidad. Es necesario desarrollar y convenir criterios de efectividad que respeten la índole contextual, multidimensional, emancipatoria y ética de la promoción de la salud. Es más, sigue existiendo una brecha significativa entre investigación y práctica, en el sentido de que los practicantes de la promoción de la salud no tienen un buen conocimiento del volumen de conocimiento que existe en materia de métodos de promoción de la salud en diferentes temas y escenarios, y no siempre lo aplican. Para abordar las cuestiones anteriores, los investigadores y practicantes de la promoción de la salud pueden utilizar protocolos y directrices que les permitan revisar la evidencia y mejorar la calidad de las intervenciones. A este respecto, existen cierto número de protocolos que ayudan a revisar la información sobre una promoción de la salud efectiva. Algunos de ellos son aplicables a múltiples temas y en varios escenarios, mientras que otros son más específicos a un tema y contexto. De manera similar, se han proporcionado algunas directrices destinadas a mejorar la calidad de las intervenciones de promoción de la salud, habiendo sido desarrolladas herramientas de evaluación de su calidad. El proyecto europeo "Poniendo la evidencia en práctica" *(Getting Evidence into practice)*, GEP, consolida las directrices y herramientas existentes con vistas a llevar las cuestiones de la evidencia y la calidad un paso más allá. Además de presentar un estado de los conocimientos de la promoción de la salud basado en la evidencia y de facilitar su acceso a los practicantes de la

promoción de la salud, tiene por objeto desarrollar entre los especialistas europeos en promoción de la salud un consenso acerca del contenido y el formato de directrices y herramientas que permitan revisar literatura, documentos y prácticas de promoción de la salud pertinentes, y poner la evidencia en práctica. Este proyecto aprovecha la experiencia existente en más de 25 países en relación con la "puesta en práctica de la evidencia", en términos de fortalecimiento del uso de una amplia base de evidencia que sirva para revisar, establecer directrices para una promoción de la salud eficaz y basada en evidencia, y apoyar su aplicación por los practicantes de promoción de la salud. Para aunar esta experiencia, el proyecto depende de la colaboración entre un consorcio de organismos e instituciones promotores de la salud de casi todos los Estados miembros de la UE.

V. Speller, E. Wimbush y A. Morgan, p. 15

Práctica de la promoción de la salud basada en la evidencia: cómo conseguir que funcione

Esta recapitulación de la teoría que apuntala la puesta en práctica de la evidencia se ilustra con algunos ejemplos de trabajo exploratorio de los organismos nacionales: la Health Development Agency (HDA), en Inglaterra, el Health Scotland, en Escocia, y The Netherlands Institute of Health Promotion and Disease Prevention (NIGZ), en Holanda. Indica dónde debiera desplegarse el esfuerzo futuro destinado a aplicar el creciente volumen de evidencia en materia de promoción de la salud. Advierte que para desarrollar una práctica de promoción de la salud basada en la evidencia, es necesario prestar la misma atención a cuatro líneas de actividad paralelas:

- Revisión sistemática de la investigación y cotejo de la evidencia
- Desarrollo y difusión de orientación basada en la evidencia
- Desarrollo de la capacidad necesaria para que la práctica basada en la evidencia sea efectiva
- Aprendizaje a partir de la práctica efectiva

Basándose en sus experiencias, y partiendo de evidencia acerca de cómo modificar la práctica, este documento advierte sobre la necesidad de hacer un mayor hincapié en la creación de capacidad y en el aprendizaje a partir de la práctica, con el fin de redirigir el enfoque dominante en el cotejo de la evidencia de la investigación. Analiza la necesidad de una mejor comprensión de las diferentes disciplinas, visiones del mundo y enfoques, acuñando para ello la frase "poniendo la evidencia en práctica", al igual que la necesidad de apoyo para resolver las tensiones inherentes a la integración de estas perspectivas en conflicto.

El efecto del contexto en la conducta, y la necesidad de influir en los sistemas y en las estructuras, al igual que en los individuos, a fin de apoyar el cambio, es importante. La teoría de la difusión de las innovaciones es reconsiderada en el contexto de la utilización de la investigación para comprender qué lecciones podría ofrecer la práctica basada en la evidencia. Los modelos de los procesos de difusión pusieron de relieve inicialmente el "empuje" de la innovación *(innovation push)*, que depende de la difusión del conocimiento para llegar a la trasferencia tecnológica – es aquí donde ha estado concentrada hasta la fecha buena parte de la práctica basada en la evidencia, en la comunicación de guias/orientaciones. Los últimos modelos hacen hincapié en los roles del "tirón de la demanda" *(demand pull)*, que se centran en la comunicación investigador / usuario, las barreras organizativas y los facilitadores, y en la necesidad de una interacción continuada entre las ideas y los roles de los líderes de opinión y los agentes del cambio. Los enfoques de empuje del conocimiento tienen por objeto incrementar el flujo de información por medio de su captación, codificación y trasmisión, mientras que los enfoques de tirón del conocimiento tratan de que los practicantes de la promoción de la salud se dediquen a buscar y a compartir la información. Sostenemos que es necesario que una mayor cantidad del esfuerzo que se dedica a la puesta en práctica de la evidencia se dirija a tirar (*pull*) del conocimiento, en lugar de optar por los enfoques que abogan por empujar el conocimiento *(push)*.

Los ejemplos descritos demuestran de qué manera organismos con mandatos nacionales similares han tratado de aprovechar esta comprensión emergente y probar diferentes enfoques. La HDA creó un "ciclo de puesta en práctica de la evidencia" mediante un intento por integrar cada uno de los dispares procesos de generación de evidencia, el desarrollo de guias/orientaciones y el cambio de la práctica, a fin de clarificar sus supuestos subyacentes y aportarles la mayor transparencia posible. Health Scotland muestra que el enfoque basado en la evidencia hace necesario cultivar nuevos roles profesionales y desarrollar mecanismos de colaboración que trasciendan las fronteras de investigación – política – práctica. En Holanda, el trabajo destinado a ir más allá del RCT ha puesto de relieve la necesidad de un cambio desde el paradigma I+D a la gestión activa del conocimiento, que permita garantizar que el conocimiento de use y se comparta con mayor rapidez. Cada una de estas cuatro líneas de puesta en práctica de la evidencia se pueden ver bajo prismas diferentes en estos ejemplos; debemos aprender de sus experiencias acerca de cómo crear capacidad destinada a una promoción de la salud basada en la evidencia.

E. Jané-Llopis, p. 21

De la evidencia a la práctica: efectividad de la promoción de la salud mental

Una salud mental positiva es un bien público global, es esencial para el individuo y para la sociedad, y es un derecho humano fundamental. Sin embargo, la falta de una salud mental positiva y la presencia de desórdenes mentales son comunes en todas las épocas, países y sociedades. A fin de apoyar un enfoque integral de la aplicación de la acción de promoción de la salud mental, a instancias del Plan de Acción Europeo de Salud Mental de la OMS, es posible destacar cuatro dimensiones de puesta en práctica de la evidencia. Estas cuatro dimensiones incluyen seguir:
1) cotejando, revisando y resumiendo la evidencia de la efectividad de la promoción de la salud mental,
2) difundiendo eficientemente la evidencia entre las partes interesadas principales,
3) evaluando la capacidad de aplicación y
4) aprendiendo continuamente a partir de la práctica eficaz, a fin de apoyar una mayor creación de capacidad y mejorar la base de evidencia. Este documento tiene por objeto ilustrar con algunos ejemplos de qué manera la acción en estas cuatro dimensiones puede prestar apoyo en el campo de la promoción de la salud mental. En primer lugar, la evidencia demuestra que la promoción de la salud mental puede ser efectiva y aportar salud y desarrollo económico y social a la sociedad. En segundo lugar, la publicación en Internet de un registro de prácticas de promoción de la salud mental puede apoyar la difusión de la evidencia acerca de aquello que funciona a través de los países y las regiones, proporcionando diferentes herramientas de aplicación. En tercer lugar, la capacidad de aplicación de la promoción de la salud mental se puede evaluar a escala nacional, identificando aquellas áreas clave donde sea posible desplegar una acción, junto con las barreras que haya que salvar a fin de seguir mejorando la aplicación. En cuarto lugar, también es posible apoyar la aplicación mediante el desarrollo continuo de capacidad gracias a iniciativas de formación destinadas, por ejemplo, a desarrollar una plantilla de promoción de la salud mental. La acción en estas cuatro dimensiones es decisiva para facilitar la traducción de la evidencia en práctica, al tiempo que mejora la calidad de la práctica de aplicación, que puede entonces traducirse en nueva evidencia. A esto se añade que la fuerte relación entre salud mental y física y los puntos en común de sus estrategias brindan una oportunidad de incrementar la eficiencia de las intervenciones. Estas líneas de acción, que apoyan la puesta en práctica de la evidencia, ofrecen herramientas que permiten mejorar la eficiencia de la promoción de la salud mental y apoyar la política a favor del desarrollo de una estrategia integral de mejora de la salud mental de la población.

K. Slama, p. 28

De la evidencia a la práctica: efectividad del control del tabaco

La promoción de la salud que es persistente, global y duradera modifica los riesgos para la salud, como muestra el efectivo control del tabaco. La interacción de factores individuales, sociales, económicos y políticos crea y mantiene la epidemia del tabaco; la determinación de las buenas prácticas en promoción de la salud requiere tener todos estos factores en cuenta. Si bien es posible someter a prueba los elementos de los programas en ensayos controlados, otros aspectos del control del tabaco, incluido el cambio organizativo y social, la abogacía efectiva y las nuevas definiciones culturales emergentes del consumo del tabaco y de la ilegitimidad de las estrategias de marketing de la industria del tabaco, requieren diferentes medidas de las buenas prácticas. En la política, las mejores prácticas están actualmente resumidas en el Convenio Marco para el Control del Tabaco, que proporciona normas mínimas destinadas al control del tabaco a escala nacional e internacional y a restringir los comportamientos de la industria del tabaco. La evidencia de las prácticas proviene de las estrategias que modifican el valor social del consumo de tabaco. Esto puede incluir políticas que van más allá de estas prácticas hasta la propia definición del tabaquismo como conducta que ha dejado de ser normal y razonable; la educación para la salud y la abogacía por la salud contribuyen decisivamente a dicho cambio, que, a su vez, influye en las elecciones de las políticas. La mejor evidencia en materia de programas se puede evaluar en ensayos aleatorios controlados, a pesar de que la influencia del contexto dificulta la medición del cambio a una escala distinta a la individual. Los estudios indican que los programas escolares u otros programas dirigidos exclusivamente a la juventud son inadecuados, debiendo implicar a la comunidad en su conjunto. La terapia y las medicaciones para dejar de fumar pueden ayudar a nivel individual; la prevalencia en la población es influida por aquellos programas con amplia base poblacional: educación para la salud generalizada en los medios de comunicación, consejo minimo antitabaco en los servicios sanitarios, revelación de documentos internos de la industria del tabaco. En general, el control del tabaco funciona mejor cuando las políticas, las prácticas y los programas funcionan al unísono.

M. B. Mittelmark et al., p. 33

Exploración de la capacidad europea para comprometerse con la promoción de la salud a escala nacional: HP-Source.net

Aún no existe un sistema de información que abarque a toda Europa y que agrupe de manera eficaz y precisa la experiencia y el conocimiento acerca de aquellos enfoques de mejora de la salud que funcionan mejor en diversas partes del continente. Pocos países de la región tienen establecida una política coherente, bien articulada y enérgica que pongan enfasis en la promoción de la salud a modo de suplemento vital de los servicios de asistencia sanitaria. No existen aún vínculos suficientemente buenos entre las ONG que se dedican a la salud y los profesionales sanitarios de la región. Las sinergias que podrían emerger de un sistema mejor conectado de servicios, formación y contacto están lejos de ser una realidad. Los sistemas de información básica, que son esenciales para identificar las prioridades en materia de promoción de la salud y reflejar el progreso, son inconexos. En muchos lugares, es posible encontrar ejemplos de excelencia, aunque la fragmentación y las complejidades culturales, económicas y políticas de Europa dificultan la tarea de esclarecerlos, aprender de ellos y unir las piezas en un sistema sólido de apoyo para la práctica de la promoción de la salud. De esta manera, existe la necesidad de información recogida sistemáticamente acerca del estado de la infraestructura, las políticas y los programas europeos de promoción de la salud. Los legisladores, aquellos que abogan por la promoción de la salud, las ONG, los investigadores, las instituciones educativas y de formación y las comunidades debieran poder acceder fácilmente a esta información.

En Europa, HP-Source.net tiene como finalidad satisfacer parte de la necesidad de un sistema de recogida y difusión de datos que aborde las cuestiones arriba planteadas. Partiendo de una red financiada originalmente por la Comisión Europea, con investigadores de 24 países europeos, HP-Source.net ha evolucionado hasta convertirse en una colaboración internacional voluntaria de investigadores, practicantes de la promoción de la salud y legisladores, que se han fijado como objetivo común maximizar la eficiencia y la efectividad de la política, las infraestructuras y las prácticas de promoción de la salud mediante:
(1) el desarrollo de un sistema uniforme de recogida de información en materia de políticas, infraestructuras y prácticas de promoción de la salud;
(2) la creación de bases de datos y de una estrategia de acceso, de manera que los legisladores, las organizaciones internacionales de salud pública y los investigadores puedan acceder a la información a escala de los países, entre los países y dentro de los países;
(3) el análisis de las bases de datos con el fin de apoyar la generación de modelos que posibiliten una efectividad y eficiencia óptimas de la política, las infraestructuras y la práctica de promoción de la salud;
(4) la trasmisión activa de esta información y conocimiento, y la abogacía activa para la adopción de modelos de efectividad y eficiencia comprobadas, por medio de publicaciones, seminarios, conferencias y sesiones de orientación, entre otros medios. HP-Source.net recoge datos cuantitativos y cualitativos en nueve campos de actividad: política, políticas y prioridades; evaluación; supervisión y/o vigilancia; desarrollo del conocimiento; aplicación; difusión de la información destinada a los profesionales de atención sanitaria; programas y estrategias; mano de obra profesional y financiación. Se recogen datos con referencia a la capacidad nacional de promoción de la salud en general, aunque también respecto a áreas relativas a temas específicos, como la capacidad de promoción de la salud mental y la política en materia de alcohol.

HP-Source.net demuestra la viabilidad de sistemas paneuropeos coordinados de exploración de la promoción de la salud. Otra labor de exploración de la capacidad europea, especialmente aquella de la OMS-EURO, demuestra que en Europa se pueden utilizar diversos planteamientos de exploración de la capacidad, en un enfoque triangular, con vistas a proporcionar los datos que se necesitan para avanzar de la evidencia de la efectividad de la promoción de la salud hacia una política, una infraestructura y una práctica mejoradas.

Catherine Jones y Angela Scriven

¿Hacía dónde nos dirigimos? La siguiente frontera de la evidencia de la efectividad en la región europea

Esta edición especial de *Promotion & Education* examina los debates y acciones contemporáneos acerca de cómo poner la evidencia en práctica en la promoción de la salud, concentrándose principalmente en el Proyecto "Poniendo la Evidencia en Práctica" (*Getting Evidence into Practice Project* - GEP). Los colaboradores no se han limitado a analizar la posición actual. Buena parte de la publicación se refiere a aquello que debe venir a continuación. El objeto de este documento final consiste en sintetizar algunos de los argumentos e ideas presentados por los autores. Se identifican cuestiones clave en términos de la situación actual, seguidas de una evaluación de los esfuerzos que se van a necesitar en el futuro para seguir desarrollando los mecanismos de puesta en práctica de una evidencia adecuada en la promoción de la salud (y de obtención de una evidencia adecuada a partir de la promoción de la salud).

Posición actual

Cinco cuestiones clave dominan esta edición e indican la posición actual de este movimiento de práctica de la promoción de la salud basada en evidencia: la naturaleza de la evidencia; la necesidad de un marco común que permita poner la evidencia en práctica; la capacidad y competencia de la fuerza laboral; la vinculación entre investigación, política y práctica, y la acción en colaboración aunada a la necesidad de una terminología unificada.

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Un debate en marcha fundamentalmente importante se refiere a aquello que constituye una evidencia adecuada de la efectividad en la promoción de la salud. Algunos autores han prestado una atención especial al valor del RCT (ensayos aleatorios controlados), adoptando la visión general de que la complejidad de las intervenciones en el campo de la promoción de la salud requiere diferentes tipos de evidencia. La naturaleza de los resultados y procesos de la promoción de la salud se considera decisiva en el modo como la evidencia se localiza, define y resume (véase, por ejemplo, en el articulo de Aro *et al.* como el concepto de promoción de la salud guía este proceso de evidencia). Slama ofrece asimismo ejemplos prácticos de la lucha contra el tabaco, que ilustran la necesidad de normas flexibles y exhaustivas de evaluación de las mejores prácticas que apoyen la visión general de que la evidencia de la efectividad de la promoción de la salud tiene que ser recabada a partir de una gama diversa de fuentes. Es más, existe un consenso en el sentido de que generar evidencia acerca de aquello que funciona en la promoción de la salud no es suficiente por sí solo. La evidencia debe apuntar también hacia cómo funciona, en qué condiciones y en qué contexto.

Existe un compromiso firme con el marco común de enfoque sistemático de la puesta en práctica de la evidencia de la efectividad de la promoción de la salud, centrado en cuatro componentes igualmente importantes:

- Cotejar, revisar y resumir la evidencia de la efectividad de la promoción de la salud;
- Difundir de manera apropiada la evidencia entre los responsables de formular las políticas y aquellos que practican la promoción de la salud;
- Evaluar la capacidad para aplicar una política, programas y prácticas basados en evidencia;
- Aprender de la práctica eficaz, con vistas a apoyar una mayor creación de capacidad y mejorar la base de evidencia

La exploración y desarrollo de la capacidad de la fuerza laboral con vistas a la aplicación eficaz del creciente volumen de evidencia a la promoción de la salud se considera un elemento importante (y complejo) de este marco, por el que los autores han abogado.

Se presenta de forma convincente la importancia de un vínculo eficaz entre investigación, política y práctica. La noción de empuje (*push)* y tirón *(pull)* del conocimiento proporciona una potente representación visual de las fuerzas dinámicas en juego entre investigación y práctica, al igual que de la necesidad de equilibrio en este tira y afloja de la evidencia (se puede encontrar una descripción detallada de estos procedimientos en Speller *et al.*)

Finalmente, a pesar de que todos los colaboradores están de acuerdo con que es esencial trabajar en colaboración para que el movimiento basado en la evidencia progrese dentro de Europa y globalmente, existe una divergencia de terminología. Esta edición especial utiliza un amplio abanico de términos, que van desde política y práctica basadas en la evidencia, hasta política y práctica informadas por la evidencia, desde gestión del conocimiento hasta creación de capacidad, desde mejor práctica hasta mejor evidencia y evidencia de la eficacia, y desde desarrollo de la práctica hasta puesta en práctica de la evidencia. La variedad de términos y la necesidad de incorporar con rapidez sobre el terreno los procesos de la evidencia requieren un lenguaje inequívoco común, con el que los profesionales de la promoción de la salud se puedan comunicar eficazmente a través de sus redes de colaboración.

Algunas de las cinco cuestiones anteriores no están resueltas todavía, estando previsto que continúen

Palabras clave

- marco
- evidencia
- capacidad de aplicación

dominando las agendas futuras de aquellos que trabajan en el campo de la puesta en práctica de la evidencia.

Acción futura

La labor del Programa Global de Efectividad de la Promoción de la Salud (*Global Programme on Health Promotion Effectiveness* - GPHPE) está en el núcleo de esta cuestión. No solamente su misión única consiste en examinar y en profundizar en las diferencias entre regiones en materia de enfoques de la efectividad de la promoción de la salud, sino que su visión global guarda relación con la capacidad del programa para reconocer los puntos de confluencia, distinguir las diferencias de contexto y apoyar el fortalecimiento de las vinculaciones y la puesta en común interactiva de este creciente volumen de conocimiento (según lo descrito por Jones y McQueen cuando examina la contribución de la Región Europea).

El proyecto GEP avanza hacia una segunda fase, estando los miembros y asociados del proyecto decididos a ampliar y a extender su alcance y difusión a una audiencia más amplia. Es de vital importancia consolidar las bases de una aplicación sostenible y garantizar la capacidad necesaria para la fase siguiente, que incluye asimismo programas de formación y oportunidades de soporte técnico (véase una descripción en Molleman y Bouwens).

Las actividades de la fase dos supondrán un ejercicio de exploración que permita evaluar la capacidad de las organizaciones de los Estados miembros para utilizar el protocolo de revisión europeo y apoyar y mejorar la calidad de las intervenciones basadas en la evidencia. Sin embargo, tal como aducen Mittelmark *et al.*, es necesario realizar una exploración de la capacidad de la promoción de la salud que vaya más allá de estos parámetros, al tiempo que se garantiza que la información del ejercicio de exploración sea un valioso activo y un mecanismo para aquellos que abogan por la promoción de la salud en toda Europa. La exploración de la capacidad no solamente es un elemento clave de cara a las estrategias de aplicación, sino que también tiene una variedad de usos en las comunicaciones, el desarrollo del conocimiento y la educación, el desarrollo de la fuerza laboral, la abogacía y el desarrollo de la política. El siguiente desafío sigue residiendo en incrementar la capacidad para utilizar la evidencia en la práctica, y para producirla a partir de la práctica (véase en Speller, *et al.* una explicación más detallada y el estudio de casos).

Todos los autores que colaboran en esta edición especial formulan recomendaciones claras y coherentes acerca de la dirección futura de los enfoques de la promoción de la salud basados en la evidencia que los programas GEP y GPHPE pueden llevar a delante.

Es decisivo fortalecer las redes dentro y entre los países, con vistas a poner en común el aprendizaje y fomentar las comunidades mixtas de investigación, política y práctica. Junto con esto, se sugiere la necesidad de establecer nuevos roles profesionales que tengan como mandato estratégico trabajar a través de la interfaz y entablar vínculos eficaces entre investigación, política y práctica. Podría ser útil establecer otros puestos clave que trabajasen dentro de comunidades de desarrollo de investigación y práctica, actuando en calidad de agentes del cambio y líderes de opinión en el campo basado en la evidencia. Estos puestos tendrían la responsabilidad de crear volúmenes de conocimiento acerca de la disponibilidad de información y cómo utilizarla en la práctica, junto con su posterior comunicación a aquellos que practican la promoción de la salud

Es necesario proseguir con los esfuerzos de colaboración destinados a evaluar tanto la capacidad actual (en su sentido más amplio), como las iniciativas de formación con vistas a incrementar la capacidad (véase el análisis de Jané-Llopis acerca de la creación de capacidad por medio de la formación). Es crucial para el futuro que establezcamos sólidos mecanismos de vinculación e intercambio que sirvan para que los investigadores, aquellos que financian la investigación y los responsables de formular las políticas se embarquen en intercambios productivos sobre cuestiones de interés común. Existen, no obstante, barreras que obstaculizan el desarrollo de una interacción más fluida entre las partes clave interesadas en este movimiento basado en la evidencia. El reto más importante de cara al futuro, tanto para el GEP como para el GPHPE, reside pues en cómo salvar las barreras de infraestructura, organizativas y políticas que entorpecen el progreso. La promoción de la salud, con sus perspectivas disciplinarias inclusivas e integradoras, debe tomar la iniciativa para encontrar modos de desarrollar capacidad, de manera que el conocimiento de la evidencia y de cómo medir la evidencia vengan acompañados de los recursos estructurales, humanos y materiales necesarios para utilizar y consolidar la evidencia.

Hans Saan

Evidenz im Gesundheitswesen: der europäische Weg

Evidenz ohne Kapazität ist eine leere Hülle.

Mohan Singh

Diese Sonderausgabe von *Promotion & Education* präsentiert einen wichtigen Schritt für die Gesundheitsförderung in Europa. Sie zeigt, wie Europa ein Forum für eine einheitlichere evidenz-gestützte Praxis entwickelt. Die Themen Effektivität und Evidenz sind langsam zu einer allgemeinen Herausforderung und Aufgabe geworden. Die pan-europäische Zusammenarbeit begann 1989 in Rotterdam mit einer Sonderkonferenz der Internationalen Union für Gesundheitsförderung und Gesundheitserziehung (IUHPE - International Union in Health Promotion Education) zum Thema Effektivität und der Erarbeitung einer ganzen Anzahl von Broschüren mit finanzieller Unterstützung der Europäischen Kommission. Die IUHPE setzte die Arbeit im Rahmen von Sonderkonferenzen in Griechenland, Israel, Finnland, Estland, London und im Jahre 2005 in Schweden fort. Die in den ersten Broschüren präsentierten Themen zur Effektivität wurden in der Publikation *The evidence of health promotion effectiveness* (IUHPE, 2000) erneut aufgegriffen, damals dank der Europäischen Kommission und Unterstützung des amerikanischen Bundesamtes für Gesundheit, CDC.
Mit der Zeit verschob sich der Fokus der Debatten von der wissenschaftlichen zur politischen Ebene. Dies widerspiegelt die Verpflichtung der Fachleute aus dem Umfeld der Gesundheitsförderung, sich für gleiche Gesundheitsbedingungen einzusetzen, indem Prioritäten und Entscheidungen in vielen politischen Bereichen hinterfragt werden. Regierungen verlangen ebenfalls Kosteneffizienz und ihre Position ist heute generell: »Wenn Sie das nicht beweisen können, werden wir nicht investieren“. Begriffe und verwandte Prozesse wie *Evidenz* und *Best Practice* mussten in den Fachwortschatz der Gesundheitsförderer mit aufgenommen werden.
Zwischenzeitlich wurde in anderen Bereichen des Gesundheitswesens die Strategie entwickelt, durch Überprüfungen (*reviews*) die beste Evidenz aus zahlreichen Veröffentlichungen zu Forschungsarbeiten zu filtern, einige sprechen wie Speller *et al* in dieser Ausgabe von einer 'Evidenz-Industrie'. Die Gesundheitsförderung liess sich aus vielerlei Gründen nicht so leicht in diesen Geschäftsbereich einpassen. Ihr 'teilnehmendes' und politisches Wesen beinhaltet Prozesse, die sich nicht so einfach mit den kontrollierten Bedingungen vereinbaren liessen, die für das experimentelle Design der Forschung, das von einigen als goldener Standard angesehen wird, erforderlich sind.

Wie immer entsteht durch Reibung Energie. Viele europäische Einrichtungen zur Gesundheitsförderung waren sich darüber im Klaren, dass sie alle mit der Verflechtung von Wissenschaft, Politik und Praxis zu kämpfen hatten. Sie entschieden sich für die Zusammenarbeit mit der IUHPE und EuroHealthNet (siehe Molleman und Bouwens zur Diskussion von EuroHealthNet) - mit erneuter Unterstützung der Europäischen Kommission - in Form des europäischen Projekts zur Umsetzung von Evidenz in die Praxis - '*Getting evidence into Practice' (GEP)*. Sie orientierten sich dabei an drei Punkten. Erstens: zur Sicherung einer gemeinsamen 'Evidenz-Basis' wurde ein Prüfprotokoll (*review protocol*) geschaffen, das Erfahrungen und Diskussionspunkte der verschiedenen Länder berücksichtigte. Zweitens: die effizientesten Programme können als Lehrstücke für kritische Punkte verwendet werden. Viele Länder verfügen über Prüflisten für diese kritischen Punkte, um Qualität und eine optimale professionelle Planung zu sichern. Diese Prüflisten wurden nun zu einem gemeinsamen Standard vereint. Um zu zeigen, dass diese Daten kontinuierlich auf den neuesten Stand gebracht werden müssen, wurden zwei Themen der IUHPE auf Grund der in Entwicklung befindlichen Protokolle und Qualitätsstandards erneut aktualisiert (siehe Slama's Artikel zur Tabakkontrolle in Abschnitt 5 dieser Sonderausgabe sowie Jané-Llopis Bericht zur geistigen Gesundheit im gleichen Abschnitt).

In einem nationalen holländischen Programm des Gesundheitsamtes der Stadt Rotterdam und des niederländischen Instituts für Gesundheitsförderung und Krankheitsprävention (Netherlands Institute of Health Promotion and Disease Prevention – NIGZ) wurden diese Themen im Bereich Evidenz ebenfalls abgedeckt. Der Antrieb für die niederländischen Programme kam a) aus den Verteilungskriterien für Forschungsgelder durch den nationalen Rat für Gesundheitsforschung und Entwicklung (National Health Research and Development Council) und b) aus einem gross angelegten Really-Consoliated-Truth (RCT) Projekt, das aufgrund einer Unstimmigkeit zwischen Design und politischer Dynamik gestoppt worden war. Mit der Hilfe des internationalen Kollegiums wurde in den Niederlanden in vier Konferenzen eine Debatte für Entscheidungsträger, Praktiker und Forscher durchgeführt; als Inspirationsquelle diente die *Evaluation in Health Promotion* (Rootman *et al*, 2001). Aus diesem Programm wurden vier Lehren gezogen:

1. Ein gemeinsamer Referenzrahmen stellt die wichtige Schnittstelle

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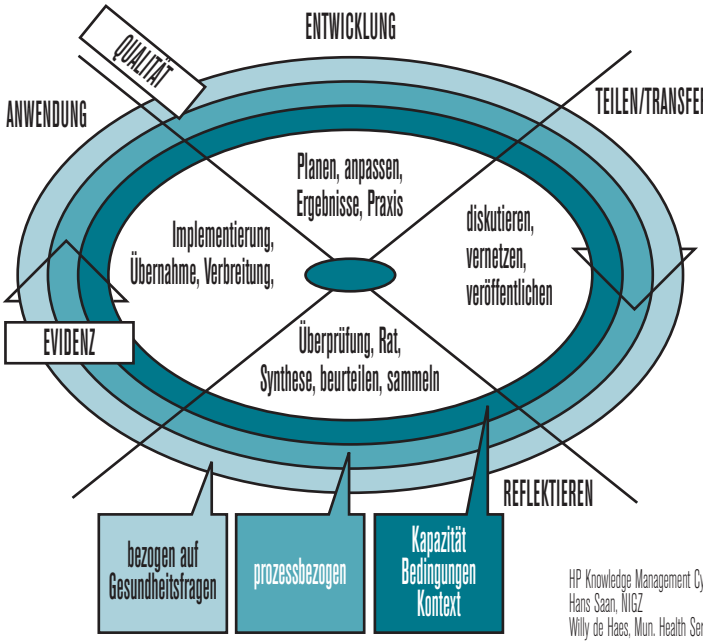
Schlüsselbegriffe

- Kapazitätsaufbau
- Effektivität
- Evidenz
- Partnerschaft



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Hans Saan, NIGZ
Willy de Haes, Mun. Health Service Rotterdam eo

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Saan, H. & Haes, W.de (2005) ***Gezond Effect Bevorderen,*** The Netherlands Institute of Health Promotion and Disease Prevention.

zwischen der Vielzahl von Aktivitäten zur Gesundheitsförderung, der Terminologie und der Prinzipien dar.

2. Soll Evidenz hilfreich sein, dann muss sie nicht nur aufzeigen,
   a) was funktioniert sondern auch
   b) wie etwas funktioniert und
   c) unter welchen Bedingungen.
   Evidenz aus Forschung sollte daher Ergebnisse, Prozesse und Kapazität darstellen. Da die gegenwärtig verfügbare Evidenz diese Dreiteilung nicht bietet, ist eine andere Forschung erforderlich.
3. Angemessene Forschung zur Gesundheitsförderung sollte die primären Eigenschaften des Feldes berücksichtigen: Menschen als Partner, Respekt für dynamische Abläufe und Komplexität der Gesundheitsförderung sowie ein gutes Verständnis für die für Veränderungen erforderliche Zeit. So wird eine grössere Vielfalt von Forschungsbemühungen benötigt, die sowohl auf die Prozesse als auch auf die Logistik fokussieren. Kapazität ist hier als wichtige Bedingung einzustufen.
4. Evidenz wird wie alles Wissen nicht spontan geteilt, der Wissenstransfer muss wie in anderen Bereichen auch koordiniert werden. Das hier dargestellte Modell zeigt 4 Phasen: *Wissensentwicklung, Informationstransfer, Überprüfung, Anwendung*. Das *Wissensstadium* muss Ergebnisse, Prozesse und Kapazitäten beinhalten, da das *Anwendungsstadium* nicht nur vom Wissen abhängt, wie etwas funktioniert, sondern auch davon, wie und warum.

Diese Sonderausgabe präsentiert das Projekt 'Getting Evidence into Practice' (GEP – Projekt zur Umsetzung von Evidenz in die Praxis). Es gibt Beiträge zur Kapazität (siehe Mittelmark *et al*); über das britische System für Wissensmanagement, das für die angemessenen Gegebenheiten sorgt, um Evidenz in die Praxis umzusetzen (siehe Speller *et al*); über die Beiträge, die Europa zum globalen Programm für die Effektivität von Gesundheitsprojekten (Global Programme on Health Promotion Effectiveness – GPHPE) leisten kann (McQueen und Jones) und eine Untersuchung der Zukunftsaussichten für das GEP-Projekt und evidenz-basierte Praxis in der Gesundheitsförderung (Jones und Scriven). Diese Beiträge zeigen, dass wir uns von einer disziplinären Dominanz der Gesundheit und den Verhaltenswissenschaften weg hin zu anderen Wissenschaften bewegen, einschliesslich Politik, Wirtschaft und Management. Eine Schlüsselbotschaft ist, dass Forscher die Verantwortung dafür tragen müssen, nicht nur eine andere Art 'Really Consolidated Truth' (RCT) zu fokussieren, sondern vielmehr über ihre Publikationen hinaus auf den Nutzen ihrer Studien für politische Fragen, Praxis und Öffentlichkeit zu achten.
In vielen Ländern wird darüber nachgedacht, wie Systeme zur Vernetzung und zum Austausch von Forschung, Politik und Praxis überarbeitet werden müssen, um Synergien nutzen zu können. Dies geschieht nicht nur in den Niederlanden, in Europa, sondern weltweit. Die von der IUHPE koordinierten globalen Programme zur Effektivität von Gesundheitsförderung bieten eine hervorragende Gelegenheit, um unsere europäischen Erfahrungen zu teilen und weltweit Rückmeldungen dazu zu erhalten.
Herzlich willkommen zur vorliegenden Sonderausgabe zur Arbeit des GEP-Projektes. Die Konferenz in Stockholm wird sicher Gelegenheit zum Ausbau unserer fachlichen Gemeinschaft bieten, die uns als evidenz-basierte Praktiker, Politiker, Forscher und Interessevertreter für Gesundheitsfragen weiter 'empowert', d.h. uns im wahren Sinne des Wortes 'Kräfte entwickeln' lässt.

Gerard R. M. Molleman und Jan G. M. Bouwens

Die Evidenzbasis aufbauen: von der Instrumentenentwicklung zum Agenda-Setting und zur Definition eines gemeinsamen Programms für Gesundheitsförderung in Europa

Jedes Land, welches Gesundheitsförderungsprogramme entwickelt, muss sich mit Fragen nach verfügbarer Information, nach evidenz-gestützten Interventionen und nach den besten Umsetzungsformen beschäftigen. Politische Entscheidungsträger und Management verlangen ebenfalls nach Transparenz, Verantwortlichkeit und Kosteneffizienz, was qualitativ hoch stehende Nachweise für die Wirksamkeit der Gesundheitsförderung dringlich macht.

Viele GF-Organisationen und -Institutionen beschäftigen sich damit, wie Evidenzen 'in die Praxis' zu bringen seien oder 'aus der Praxis heraus' kommen können (siehe Speller *et al* in dieser Spezialausgabe für Beispiele aus England, Schottland und Holland). Auf internationaler Ebene wird heute eine immer engere Zusammenarbeit gesucht, damit Doppelspurigkeiten vermieden und Ideen und Arbeitsmethoden ausgetauscht werden (siehe Mittelmark *et al* im Teil 5 dieser Ausgabe, für konkrete Beispiele bereits bestehender Kollaborationen). Kooperative und partnerschaftliche Tätigkeiten sind gerade auch deshalb nützlich, weil sich das Sammeln und Definieren von Wissenserkenntnissen und Evidenznachweisen so komplex gestaltet.

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Das europäische Projekt 'Getting Evidence into Practice' (GEP)

Seit Februar 2004 wird das Projekt 'Getting Evidence into Practice' (GEP) von der Europäischen Kommission finanziert. Das Projekt steht für Zusammenarbeit unter den wichtigsten nationalen Interessevertretern und internationalen Netzwerken in Form des Europäischen Evidenz Konsortiums. Bis heute sind über 20 europäische Länder vertreten. Das Projekt konzentriert sich auf Gesundheitsförderung, Public Health und Präventionsmassnahmen. Während der ersten Phase sind zwei Hauptresultate erzielt worden: Erstens und wie in dieser Ausgabe von *Promotion & Education* beschrieben, wurden im Projekt die Evidenz für zwei ausgewählte Themen und die aktuelle Evidenzbasis zu wirkungsvoller Gesundheitsförderung aktualisiert. Zweitens wurde auch ein breit anerkanntes Prüfprotokoll (*Consensus Review Protocol*) zur Evidenzfindung, -sammlung, -definierung und -beschreibung ausgearbeitet. Ebenso wurde ein europäisches Instrument für Qualitätssicherung entwickelt, das es erlauben wird, Gesundheitsförderung zu beurteilen und zu verbessern.

Evidenzbasiertes Arbeiten heisst nicht nur Informationen zu sammeln, sondern diese auch zugänglich und brauchbar zu machen. In der Praxis kann dies durch eine top-down Strategie geschehen, die ihrerseits eine grosse Distanz zwischen Forschern und Praktikern schaffen kann. Dazu kommt, dass die gängige Praxis systematischer Überprüfungen (*reviews*) oft wertvolle Informationen aus dem dynamischen GF-Umfeld und aus Prozessfaktoren vernachlässigt. Es müssen Wege gefunden werden, um Evidenzen aufzuzeigen, die aus dem breiten Spektrum der Gesundheitsförderung stammen und Forschung, Politik und Praxis mit einbeziehen; die Durchführungsweise von systematischen Überprüfungen muss ausgeweitet werden und graue Literatur, Expertenmeinungen und Quellen aus dem nicht-englischsprachigen Raum berücksichtigen.
Der Gebrauch des Qualitätsinstrumentes kann dazu beitragen, Erfolg versprechende Massnahmen aus der Praxis zu identifizieren, diese weiter zu erforschen und so diese Erfahrungen zu 'echten' Wirksamkeitsnachweisen aufzuwerten. Dieser interaktive Prozess zwischen Forschung und Praxis kann zur Entscheidungsfindung in der Gesundheitsförderung beitragen.

Aufbau von Kapazitäten und Infrastruktur

Der Aufbau solider Grundlagen wird in der nächsten Phase des 'Getting Practice into Evidence' Projektes das zentrale Anliegen sein, denn nur so wird die nachhaltige Umsetzung und die Sicherung der nötigen Kapazitäten möglich werden. Dies beinhaltet eine

Schlüsselbegriffe

- Zusammenarbeit
- Evidenz
- Policy
- Forschung
- Systematische Überprüfungen (*systematic reviews*)

Bestandesaufnahme, um die Kapazitäten zum Gebrauch des Prüfprotokolls der einzelnen nationalen und regionalen Institutionen der EU-Länder einzuschätzen; sind sie fähig, die Qualität evidenz-gesicherter Interventionen zu ermessen und zu unterstützen und/oder 'best practice' Beispiele zu liefern. Die Betreuung wird durch Schulungsprogramme und fachliche Unterstützung erfolgen. Das Prüfprotokoll und das Qualitätssicherungsinstrument werden für gemeinsame europäische Gesundheitsthemen wie Übergewicht oder Gesundheitsungleichheit eingesetzt.

Alle diese Aktivitäten sollten im EU-Raum Teil des Kerngeschäfts der Gesundheitsförderung werden und sich auch in den nationalen und lokalen Strukturen widerspiegeln. Da viele europäische Länder mit denselben Gesundheitsproblemen zu kämpfen haben, bedeutet das gemeinsame Angehen dieser Probleme einen offensichtlichen zusätzlichen Gewinn. Durch den Austausch von Erfahrungen, Erkenntnissen und Wissen zum Thema Evidenz, wie auch durch die gemeinsame Suche nach den besten Lösungen, kann viel gewonnen werden.

In der nächsten Phase möchte das 'Getting Evidence into Practice' Projekt noch näher mit dem WHO-Health Evidence Network zusammenarbeiten, weil der Brückenschlag zwischen evidenz-gestütztem Wissen, Entscheidungsprozessen und Politik auf europäischer Ebene noch optimiert werden kann. Auch die Zusammenarbeit mit IUPHE und EuroHealthNet trägt entscheidend zur Verbreitung der Resultate bei.

Die gemeinsame Definition der Standards und die Übertragung dieser Standards in konkrete Programme tragen dazu bei, dass im ganzen europäischen Raum Gesundheitsförderung nach dem Ansatz der evidenz-gestützten Praxis betrieben wird; damit wird auch die Positionierung der Gesundheitsförderung innerhalb des Europäischen Zentrums für die Prävention und die Kontrolle von Krankheiten (ECDC) gestärkt. Diese Entwicklungen werden den Rahmen bilden für ein gemeinsames Programm, welches Gesundheitsförderern aus Forschung, Politik oder Praxis Richtprinzipien anbietet, an welchen sich ihre Projekte und Interventionen orientieren können. Dies bedeutet für jedes Land einen Zusatzwert an sich, respektiert aber auch das jedem Land eigene Kerngeschäft, seine vom Kontext bedingte eigene Gesundheitsförderungs-Dynamik und seine Eigenständigkeit.

Catherine Jones und David McQueen

Der Beitrag der europäischen Region an das weltweite Programm zur Effektivität in der Gesundheitsförderung (GPHPE)

Das weltweite Programm zur Effektivität in der Gesundheitsförderung (GPHPE) wird in Zusammenarbeit mit der Weltgesundheitsorganisation (WHO), den US Centers for Disease Control and Prevention und vielen anderen Partnern durch die IUHPE - International Union for Health Promotion and Education (Internationale Union für Gesundheitsförderung und Gesundheitserziehung) koordiniert. Zu den Partnern gehören unter anderen the African Medical Research Foundation; Health Canada; the Health Development Agency, England; Gesundheitsförderung Schweiz; the Netherlands Institute for Health Promotion and Disease Prevention and the Voluntary Health Association of India. Dieses in seiner Art einzigartige Programm hat sich zum Ziel gesetzt, den Standard für die Politik (*policy-making*) und die Praxis der Gesundheitsförderung weltweit zu heben, indem die Evidenzen zur Effektivität in Bezug auf gesundheitliche, soziale, wirtschaftliche und politische Auswirkungen Überprüfungen unterzogen werden, die Evidenzbasis Politikern und Entscheidungsträgern, Lehrenden, Praktikern und Forschern verständlich gemacht und die Diskussion zur Bedeutung der Wirksamkeitsnachweise angeregt wird.

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Das GPHPE Programm ist ein Dachprogramm und beinhaltet verschiedene Regionalprojekte sowie andere themenverwandte Aktivitäten aus allen Erdteilen. Das Programm gewinnt zusätzlich an Wert, da es mit seiner globalen Sichtweise einerseits in respektvoller Weise die Unterschiedlichkeiten im Umgang mit der Effektivität in der Gesundheitsförderung begutachten und untersuchen kann, andererseits aber auch fähig ist, konkrete Gemeinsamkeiten aufzuzeigen, kontext-/umweltbedingte Unterschiede zu berücksichtigen und Vernetzungsbemühungen sowie gegenseitigen Wissenstransfer zu unterstützen. Ebenfalls wichtig ist, dass sich das GPHPE Programm auch mit der Nutzung der Wissenserkenntnisse beschäftigt.

Das Pogramm umfasst verschiedenste Tätigkeiten, Produkte und Publikationen. Sie alle wurden zum besseren Verständnis der potenziellen Auswirkungen verschiedener Gesundheitsförderungsansätze und –interventionen entwickelt. Um Synergien nutzbar zu machen, werden heute in vielen Ländern die Bemühungen in Bezug auf Vernetzung und Austausch in Forschung, Politik und Praxis überdacht (siehe dazu auch den

Schlüsselbegriffe

- Nachweis von Effektivität
- Policy-making
- Quellen der Evidenz
- Forschung

Leitartikel dieser Ausgabe). Gerade darum hat das europäische Projekt GEP (Getting Evidence into Practice) nun Gelegenheit, seine Erfahrungen mit der restlichen Welt zu teilen und einen Beitrag an die gegenwärtigen Überlegungen zu leisten, wie die aus der Praxis kommende Evidenz aufgedeckt, gemessen und erfasst werden kann.

Das Projekt definiert die Effektivität gleich wie das GPHPE Programm. Anerkannt wird nämlich, dass die Evidenzen für Effektivität aus einer Vielzahl von Quellen stammen können, welche über die herkömmlichen Evaluationsgrenzen hinausgehen. Um die Evidenzbasis zu erweitern, kann nicht nur aus der grauen Literatur, aus Expertenmeinungen und nicht-englischen Quellen geschöpft (siehe Molleman and Bowens, in dieser Ausgabe, zur weiteren Diskussion über Quellen der Evidenz), sondern Evidenz kann auch aus der Praxis 'extrahiert' werden (von Speller *et al.* wird dieser Punkt weiter entwickelt).

Die grösste Herausforderung für das GPHPE Programm ist die Entwicklung nachhaltiger Ansätze, welche den regionalen Bedürfnissen Rechnung tragen, dabei aber die anerkannt hohe Qualität der europäischen Arbeiten, welche das Programm ausgelöst haben, beibehalten. Für den weiteren Ausbau der verfügbaren Wissenserkenntnisse, welchen das GPHPE anstrebt (IUHPE, 2004), wird die Gesamtheit der Beiträge aus den Regionen eine entscheidende Rolle spielen. Der interaktive Prozess zwischen Forschung und Praxis, der für das GEP Projekt so zentral ist, bietet ein gutes Beispiel, wie dieses oft vernachlässigte und herabgesetzte, jedoch sehr dynamische Zusammenspiel erfasst werden kann. Das GPHPE Programm bietet Gelegenheit, das einen weiten Konsensus geniessende Europäische Prüfprotokoll (*review protocol*) und das Qualitätssicherungsinstrument weiter zu verbreiten und so das Potenzial zu schaffen, vielversprechende Forschungswege weiter zu verfolgen und über den europäischen Raum hinaus zu kommunizieren. Diese Vorgehensweise dürfte den GEP Arbeitsprogrammen jetzt und in der zweiten Phase wiederum zugute kommen. Das GPHPE Programm will Antworten und Lösungen finden, die sich auf die 'best practice' abstützen. Damit wird es möglich werden, Ratschläge zu Interventionsverbesserungen abzugeben, welche sich auf Evidenzen stützen. Die vom GEP Projekt ausgearbeiteten Richtlinien und Instrumente werden ebenso dazu beitragen, die Evidenzen für Effektivität in der Gesundheitsförderung in die Praxis umzusetzen.

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Technische Belange

A. A. Aro, S. Van den Broucke und S. Räty, S. 10

Unterwegs zu europäischen Konsensinstrumenten zur Evidenzüberprüfung und Qualitätsentwicklung der Praxis in der Gesundheitsförderung

Die Begriffe 'Evidenz' und 'Qualität' werden in der Gesundheitsförderung immer wichtiger. Von Gesundheitsförderern wird heute immer mehr verlangt, die Qualität ihrer Aktivitäten zu belegen und zu verbessern. Weil Gesundheitsförderung inhärent komplex, dynamisch und multi-sektoriell ist, kann sie sich nicht darauf beschränken, Konzepte und Instrumente zur Evidenzstützung oder Qualitätssicherung aus der medizinischen Praxis zu übernehmen. Um die Wirksamkeit von GF-Massnahmen aufzuzeigen und zu belegen, welche Interventionen sich unter welchen Bedingungen eignen, muss das Evidenz- und Qualitätsverständnis für die GF erweitert werden. Wirkungskriterien, welche den umweltbedingten, multidimensionalen, emanzipatorischen und ethischen Aspekten der Gesundheitsförderung Rechnung tragen, müssen entwickelt und anerkannt werden. Problematisch ist auch die grosse Distanz zwischen Forschern und Praktikern; diese führt dazu, dass die Praktiker die verfügbaren Erkenntnisse über wirkungsvolle Methoden der Gesundheitsförderung in verschiedenen Bereichen und Settings zu wenig kennen und in der Umsetzung zu wenig berücksichtigen.

Um diese Probleme anzugehen, die Evidenzen zu überprüfen und die Qualität der Massnahmen zu verbessern, können Forscher und Praktiker sich an Protokolle und Richtlinien halten. Verfügbar sind verschiedene Protokolle, welche die Überprüfung der vorhandenen Informationen zu effektiver Gesundheitsförderung erleichtern. Einige davon sind für verschiedenste Bereiche und Settings geeignet, während andere eher themen- oder kontext-spezifisch sind. In ähnlicher Weise existieren auch eine Anzahl von Richtlinien, welche zur Qualitätsverbesserung der Gesundheitsförderungsmassnahmen beitragen, gleichzeitig gibt es nun Instrumente zur Qualitätsmessung.

Das europäische Projekt GEP 'Getting Evidence into Practice' stützt sich auf bestehende Richtlinien und Instrumente, um den Fragenkomplex der Evidenzen und Qualität einen Schritt weiter zu bringen. Es zeigt nicht nur den gegenwärtigen Stand der Evidenzbasis in der Gesundheitsförderung auf und macht diese für Praktiker zugänglicher, sondern hat auch zum Ziel, unter europäischen Fachleuten einen Konsens zu erwirken. Dieser betrifft inhaltliche und formelle Aspekte von Richtlinien und Instrumenten, von Reviews, Dokumenten und der GF- Praxis; und nicht zuletzt sollen die Evidenzen in der Praxis eine Umsetzung finden. Das Projekt kann sich dabei auf die in diesem Bereich gesammelte Erfahrung von über 25 Ländern abstützen, insbesondere in Bezug auf den Gebrauch der grossen Evidenzbasis bei Reviews, die Festlegung von Richtlinien für wirkungsvolle und evidenz-gestützte GF und die Unterstützung von Fachleuten bei der Umsetzung. Um diesen Erfahrungsschatz auszuschöpfen, verlässt sich das Projekt auf die Zusammenarbeit mit einer grossen Anzahl von GF-Einrichtungen aus beinahe allen EU-Ländern.

V. Speller, E. Wimbush und A. Morgan, S. 15

Evidenz-gestützte Praxis der Gesundheitsförderung: wie es funktionieren kann

Dieser Überblick über die Theorie zur Umsetzung von Evidenz in die Praxis stellt Beispiele von Forschung nationaler Agenturen vor: die Agentur zur Gesundheitsentwicklung (Health Development Agency – HDA) in England; Health Scotland und das niederländische Institut für Gesundheitsförderung und Krankheitsprävention (Netherlands Institute of Health Promotion and Disease Prevention - NIGZ). Er zeigt, wo zukünftig Anstrengungen unternommen werden sollten, um die immer stärker werdende Rolle der Evidenz in der Gesundheitsförderung zu verankern. Für die Entwicklung einer evidenz-basierten Gesundheitsförderung müssen vier Schienen gleichermassen berücksichtigt werden:

- Systematische Überprüfung der Forschung und Kollation der Evidenz
- Entwicklung und Verbreitung evidenz-gestützter Führung
- Entwicklung von Kapazitäten für eine effektive evidenz-gestützte Praxis
- Lernen aus der effektiven Praxis

Die aus den o.g. Beispielen gewonnenen Erfahrungen und die Evidenz, wie die Praxis verändert werden kann, führen zur Empfehlung, dass weiterer Nachdruck auf den Kapazitätsaufbau und das Lernen aus der Praxis gelegt werden sollte, um das Hauptaugenmerk wieder auf die Kollation von Evidenz und Forschung zu lenken. Es muss ein besseres Verständnis für die verschiedenen Disziplinen, Weltansichten und Ansätze geschaffen werden, die das Motto 'von der Evidenz zur Praxis' in sich birgt. Dieser Artikel möchte dazu beitragen, die Spannungen zu lösen, die der Integration solch unterschiedlicher Perspektiven innewohnen.

Um Änderungen herbeizuführen, sind die Auswirkung der Umwelt auf das Verhalten sowie die Notwendigkeit der Beeinflussung von Systemen, Strukturen und Individuen, wichtig. Die Theorie von der Verbreitung von Innovationen wird in einem neuen Kontext betrachtet. Nämlich soll verstanden werden, welche Lehren aus der Forschung für die evidenz-gestützte Praxis gezogen werden können. Modelle von Verbreitungsprozessen fokussierten zunächst stark auf die 'schubweise' Innovation, die auf der Verbreitung von Wissen zum Erreichen eines Technologietransfers beruht – darauf konzentriert sich bis heute ein Grossteil der evidenz-gestützten Praxis – auf der Kommunikation von Führungsempfehlungen. Spätere Modelle betonen die Rollen der 'Nachfrageinflation'; sie richten ihren Fokus auf die Kommunikation Forscher/Benutzer, organisatorische Barrieren und Erleichterungen, das Bedürfnis für kontinuierlichen Ideenaustausch, und die Rollen von Meinungsmachern und Initiatoren bzw. Umsetzern von Veränderugen (engl. *change agents*). Der 'Wissensschub' verfolgt das Ziel, den Informationsfluss durch Sammeln, Klassifizieren und Weiterleiten zu verstärken, während der 'Wissenssog' dafür sorgt, dass Praktiker Informationen suchen und teilen. Aus unserer Sicht sollte bei der Umsetzung von Evidenz in die Praxis der Fokus stärker auf dem Wissenssog denn auf dem Wissensschub liegen.

Die beschriebenen Beispiele zeigen, wie Agenturen mit ähnlichen nationalen Bedingungen versucht haben, dieses sich entwickelnde Verständnis zu nutzen und unterschiedliche Ansätze auszuprobieren.

Die HDA schuf einen Zyklus 'Von der Evidenz zur Praxis', in welchem man versuchte, jeden der unterschiedlichen Prozesse zur Generierung von Evidenz zu integrieren, eine Richtung zu weisen und die Praxis zu ändern, die ihr zugrunde liegenden Annahmen zu klären und so transparent wie möglich zu machen. Health Scotland zeigt, dass ein evidenz-gestützter Ansatz die Kultivierung eines neuen Fachverständnisses und die Entwicklung kollaborativer Mechanismen erfordert, die über die Grenzen von Forschung, Politik und Praxis hinaus funktionieren. In den Niederlanden hat die Arbeit ausserhalb der RCT unterstrichen, dass ein Paradigmawechsel von Forschung und Entwicklung hin zu aktivem Wissensmanagement notwendig ist, um eine schnellere Verbreitung und Verwendung von Wissen zu gewährleisten. Die vorliegenden Beispiele zeigen, wie die vier Schienen zur Umsetzung von Evidenz in die Praxis unterschiedlich genutzt werden können. Wir sollten aus diesen Erfahrungen lernen, wie Kapazitäten für evidenz-basierte Gesundheitsförderung entwickelt werden können.

E. Jané-Llopis, S. 21

Von der Evidenz zur Praxis: Effektivität in der Förderung von psychischer Gesundheit

Positive geistige Gesundheit ist ein gesellschaftliches Gut, das sowohl für den Einzelnen wie auch für die Gesellschaft essenziell ist; zudem ist geistige Gesundheit ein grundsätzliches Menschenrecht. Mangelnde geistige Gesundheit und psychische Störungen sind allerdings in allen Altersgruppen, Ländern und Gesellschaften verbreitet. Der Europäische Aktionsplan für Geistige Gesundheit der (WHO) fordert einen umfassenden Umsetzungsansatz für die Förderung der geistigen Gesundheit. Um dieser Forderung gerecht zu werden und um vorhandene Evidenzen für die Praxis zu nutzen, müssen vier Dimensionen besonders berücksichtigt werden. Diese beinhalten die folgenden Aspekte:
1) Zusammenstellung, Überprüfung und Zusammenfassung der Effektivitäts-Evidenzen für die Förderung geistiger Gesundheit;
2) effiziente Verbreitung der Erkenntnisse an die wichtigsten Interessenvertreter;
3) Einschätzung der Umsetzungsmöglichkeiten; und
4) ständiges Lernen aus wirksamer Praxis, um den Weiterausbau der Kapazitäten zu unterstützen und die Evidenzbasis zu vergrössern.

Die folgenden Ausführungen werden anhand einiger Beispiele aufzeigen, wie Arbeit in diesen vier Dimensionen die Förderung der geistigen Gesundheit unterstützen kann. Erstens zeigt die Evidenz, dass die Förderung geistiger Gesundheit wirkungsvoll sein kann und in einer Gesellschaft sowohl Gesundheit, sowie soziale und wirtschaftliche Entwicklung bewirken kann. Zweitens kann ein im Internet abrufbares Register zur Praxis der Förderung der geistigen Gesundheit die regionen- und länderübergreifende Verbreitung derjenigen Methoden unterstützen, die erwiesenermassen Erfolg haben und so auch verschiedene Umsetzungsinstrumente anbieten. Drittens können für jedes Land die Umsetzungskapazitäten für die Förderung der geistigen Gesundheit geprüft, die bestehenden Massnahmen in den wichtigsten Bereichen identifiziert und die Hindernisse, die weiteren Aktivitäten im Wege stehen, angegangen werden. Viertens kann die Umsetzung durch ständige Kapazitätsentwicklung in Form von Ausbildungsangeboten unterstützt werden, beispielsweise durch die Schulung ausgebildeter Arbeitskräfte für die Förderung der geistigen Gesundheit. Um die Evidenzbasis für die Praxis zu nutzen, werden diese vier Dimensionen unabdinglich sein. Sie werden die Qualität der Umsetzungspraktiken verbessern, die ihrerseits wieder dazu beitragen, neue Evidenzen zu schaffen. Die Effizienz der Interventionen hat zudem noch Steigerungspotenzial, da die Strategien für die so eng verbundenen Bereiche der psychischen und körperlichen Gesundheit sehr ähnlich sind. Diese Aktionsachsen unterstützen die Nutzung vorhandener Evidenzen in der Praxis, vermitteln Instrumente zur Effizienzsteigerung bei der Förderung der geistigen Gesundheit und unterstützen eine Politik, welche die Entwicklung umfassender Strategien zur Verbesserung der geistigen Gesundheit der Bevölkerung anstrebt.

K. Slama, S. 28

Von der Evidenz zur Praxis: die Wirksamkeit der Tabakkontrolle

Gesundheitsrisiken werden durch beständige, umfassende und langfristige Gesundheitsförderung verändert, wie die wirkungsvolle Tabakkontrolle gezeigt hat. Die Tabakepidemie wird durch wechselwirkende individuelle, soziale, ökonomische und politische Faktoren gestaltet und beeinflusst; um die *best practice* für die Gesundheitsförderung festzulegen, müssen alle diese Faktoren mit einbezogen werden. In kontrollierten Versuchen können verschiedene Elemente eines Programms getestet werden; andere Aspekte der Tabakkontrolle – organisationelle und soziale Veränderungen, wirkungsvolle Interessevertretung, neu auftauchende kulturelle Definitionen des Tabakgebrauchs und nicht-legitime Marketingstrategien der Tabakindustrie - brauchen aber andere *best practice* Massstäbe.
Die *best practice* für die Politikgestaltung ist gegenwärtig in der Rahmenkonvention für Tabakkontrolle *(Framework Convention for Tobacco Control)* enthalten, welche Minimalstandards zur nationalen und internationalen Tabakkontrolle und zur Einschränkung der Methoden der Tabakindustrie vorgibt. Die Evidenz für *Practice*-Ansätze stammt von denjenigen Strategien, welche die soziale Werthaltung des Tabakkonsums verändern. Politikgestaltung (*policy*) kann dazu gehören, es geht aber soweit, dass Rauchen nicht länger als normales und vernünftiges Handeln definiert wird; Gesundheitserziehung und Interessevertretung sind bei solchen Veränderungen instrumentell und beeinflussen ihrerseits politisch-strategische Entscheidungen. Die beste Evidenz für Programme kann durch randomisierte Kontrollstudien belegt werden, wobei es die umwelt- und kontextbedingten Einflüsse sehr schwierig machen, Veränderungen auf anderen als der individuellen Ebene aufzuzeigen. Studien zeigen auch, dass Programme für das Setting Schule oder die Zielgruppe der Jugendlichen unzulänglich sind und dass die Allgemeinheit mit einbezogen werden muss. Rauchstopp-Therapien und Medikamente können Einzelnen helfen; die Prävalenz in der Bevölkerung wird aber durch diejenigen Programme beeinflusst, welche die breiteste Bevölkerung erreichen: Umfassende und weit gestreute Gesundheitsinformationen in den Massenmedien, Kurzberatungen bei Kontakten mit dem Gesundheitsdienst, Enthüllung von vertraulichen Dokumenten der Tabakindustrie. Insgesamt funktioniert Tabakkontrolle am besten, wenn Politik, Praktiken und Programme koordiniert arbeiten.

M. B. Mittelmark et al., S. 33

Erfassung der europäischen Kapazität für Gesundheitsförderung auf nationaler Ebene: HP-Source.net

Es gibt zur Zeit noch kein gesamteuropäisches Informationssammelsystem, das auf effektive und akkurate Weise die Erfahrungen und das Wissen zu den in den verschiedenen Teilen Europas wirkungsvollsten GF-Ansätzen vereinigt. Wenige europäische Länder betreiben eine kohärente, klare und überzeugende Politik, welche die Gesundheitsförderung als unabdingbaren Teil der Gesundheitsdienstleistungen positioniert. Nicht-Regierungs-Organisationen (im weiteren Text NGO's – Non Governmental Organisations) im Gesundheitsbereich und Gesundheitsfachleute sind in Europa noch nicht gut genug miteinander verbunden. Die Synergien, die durch eine bessere Verknüpfung von Dienstleistungen, Schulung und *outreach* entstehen können, sind noch weitgehend ungenutzt. Die grundlegenden Informationssysteme, die für die Priorisierung in der Gesundheitsförderung und zur Aufzeichnung von Entwicklungsfortschritten essenziell sind, sind nicht miteinander vernetzt. Hervorragende Beispiele für gelungene Projekte lassen sich an vielen Orten finden. Die Fragmentierung und kulturelle, wirtschaftliche sowie politische Komplexität Europas machen jedoch die Auswahl dieser Vorbilder nicht leicht, sie erschweren es, Lehren aus ihnen zu ziehen und die Einzelteile zu einem starken System zur Unterstützung von Gesundheitsförderung in der Praxis zu verbinden. Daher besteht ein grosses Bedürfnis nach einem System, das Informationen zum Stand der Infrastruktur, der Politik und den Programmen zur Gesundheitsförderung in Europa sammelt. Diese Informationen sollten für Politiker, GF-Interessevertreter, NGO's, Forscher sowie für Ausbildungs- und Schulungseinrichtungen und Gemeinschaften leicht zugänglich sein.

In Europa soll *HP-Source.net* dieses Bedürfnis nach einem Informationssammelsystem teilweise befriedigen – als System für die Verknüpfung und Verbreitung von Informationen zu den genannten Problemen und Themen. Ursprünglich ausgehend von einem Netzwerk mit Forschern aus 24 europäischen Ländern und finanziell unterstützt durch die Europäische Kommission hat sich *HP-Source.net* mittlerweile zu einem freiwilligen, internationalen Kooperationszusammenschluss von Forschern, Praktikern und Politikentscheidungsträgern entwickelt. Gemeinsames Ziel ist die Stärkung der Effizienz und Effektivität von Politik, Infrastruktur und Praxis der Gesundheitsförderung durch:
(1) die Entwicklung eines einheitlichen Systems zur Informationsbeschaffung für die Politik, Infrastruktur und Praxis der Gesundheitsförderung;
(2) die Entwicklung von Datenbanken und Zugangsstrategien, um diese Informationen zwischen den Ländern und innerhalb derselben für politische Entscheidungsträger, internationale Public Health Organisationen und Forscher zugänglich zu machen;
(3) die Analyse der Datenbanken, um die Entwicklung von Modellen zur maximalen Effizienz und Effektivität für die Politik, Infrastruktur und Praxis in der Gesundheitsförderung zu unterstützen;
(4) die aktive Verbreitung von Informationen und Wissen sowie die aktive Förderung der Übernahme von Modellen mit nachgewiesener Effizienz und Effektivität - unter anderem durch Publikationen, Seminare, Konferenzen und Briefings. *HP-Source.net* sammelt quantitative und qualitative Daten aus 9 Bereichen: Politik, Strategien und Prioritäten; Evaluierung; Monitoring und/oder Überwachung; Weiterentwicklung von Wissen; Implementierung; Informationen für Fachleute im Gesundheitswesen; Programme und Strategien; professionelle Arbeitsgruppen; Beschaffung finanzieller Mittel. Die Daten werden allgemein im Bezug zur nationalen Kapazität für Gesundheitsförderung gesammelt, aber auch im Hinblick auf spezifische Bereiche wie die Kapazität zur Förderung von geistiger Gesundheit und Alkoholpolitik.

HP-Source.net zeigt, dass ein koordiniertes, pan-europäisches System zur Erfassung der GF-Kapazität möglich ist. Weitere europäische Ansätze zur Kapazitätserfassung, insbesondere derjenige von WHO-EURO, verdeutlichen, dass in Europa unterschiedliche Ansätze zur Kapazitätserfassung verwendet werden können; durch eine Triangulierung werden die nötigen Daten verfügbar gemacht, die es wiederum erlauben, den Schritt von Effektivitätsnachweisen der Gesundheitsförderung hin zu einer verbesserten Politik, Infrastruktur und Praxis zu machen.

Catherine Jones und Angela Scriven

Wohin gehen wir? Aufbruch zur nächsten Grenze für Effektivitäts-Nachweise in der europäischen Region

Diese Spezialausgabe von *Promotion & Education* untersucht die gegenwärtigen Debatten und Tätigkeiten rund um die Frage, wie Evidenzen in die Gesundheitsförderungspraxis zu bringen seien, insbesondere im Hinblick auf das Projekt zur Umsetzung von Evidenz in die Praxis (GEP - Getting Evidence into Practice Project). Die Autoren gehen dabei über eine einfache Diskussion der gegenwärtigen Positionen hinaus. Viele Beiträge weisen darauf hin, was in nächster Zukunft geschehen muss. Dieser abschliessende Artikel soll eine Zusammenfassung der von den Autoren präsentierten Standpunkte und Ideen sein. Identifiziert werden die Hauptprobleme der gegenwärtigen Situation, dann wird bemessen, welche Kräfte für die Weiterentwicklung der Mechanismen nötig sind, damit die einschlägigen Evidenzen in der Gesundheitsförderungspraxis ihren Niederschlag finden oder aus derselben heraus kommen können.

Gegenwärtige Situation

Die fünf Hauptprobleme, denen in dieser Ausgabe so prominent Raum gegeben wird, illustrieren den gegenwärtige Zustand, in welchem sich die Bewegung der evidenz-gestützten Praxis in Gesundheitsförderung befindet. Es sind dies: die Beschaffenheit der Evidenz; die Notwendigkeit eines gemeinsamen Rahmens zur Umsetzung von Evidenz in die Praxis; die Möglichkeiten und Fähigkeiten der Fachkräfte; Vernetzung zwischen Forschung, Politik und Praxis; Zusammenarbeit und die Notwendigkeit einer einheitlichen Terminologie.

Immer wieder wird die grundlegend wichtige Frage diskutiert, was eigentlich ein angemessener Wirksamkeitsnachweis in Gesundheitsförderung sei. Verschiedene Autoren setzen sich besonders aufmerksam mit dem Wert von RCT *(Really Consolidated Truth)* auseinander und kommen generell zum Schluss, dass für Gesundheitsförderungsmassnahmen andere Arten von Evidenzen angebracht seien. Wie Evidenzen verortet, definiert und zusammengefasst werden, ist den Autoren gemäss von den Charakteristika der GF- Ergebnisse und –Prozesse abhängig (siehe beispielsweise den Abschnitt bei Arja *et al* für den Mechanismus, wie das Konzept der Gesundheitsförderung den Evidenzfindungsprozess leitet). Slama zeigt Beispiele aus der Praxis der Tabakkontrolle, welche ebenfalls die Notwendigkeit für flexible und weit gespannte Bewertungsmassstäbe für *best practice* illustrieren; er unterstützt die generelle Ansicht, dass die Evidenzen für Wirksamkeit in der Gesundheitsförderung aus verschiedensten Quellen gewonnen werden müssen. Zudem ist man sich auch einig, dass die Erbringung von Evidenzen zu 'funktionierender' Gesundheitsförderung allein nicht genügt. Evidenzen müssen auch aufzeigen können, wie und unter welchen Bedingungen und in welchem Kontext etwas funktioniert.

Ein grosses Engagement besteht für den gemeinsamen Rahmen eines systematischen Ansatzes zur Umsetzung von Evidenz in die Praxis, beruhend auf vier gleichwertig wichtigen Teilen:

- Vergleichende Zusammenstellung, Überprüfung und Zusammenfassung der Effektivitäts-Nachweise für Gesundheitsförderung;
- Geeignete Verbreitung der Nachweise an politische Entscheidungsträger und Praktiker;
- Einschätzung der Kapazität, evidenzgestützte Politik, Programme und Praxis zu implementieren;
- Lernen aus wirksamer Praxis, zum weiteren Ausbau der Kapazität und zur Verstärkung der Evidenzbasis.

Weiter wird von allen Autoren befürwortet, dass in diesem Rahmen die Bestandesaufnahme der Kapazität und die Kapazitätsentwicklung der fachlichen Arbeitskräfte zwei wichtige (und komplexe) Elemente zur wirksamen Umsetzung der immer zahlreicher werdenden Evidenznachweise in Gesundheitsförderung sind.

Mit grosser Schlagkraft wird die Wichtigkeit der Vernetzung zwischen Forschung, Politik und Praxis aufgezeigt. Die Begriffe 'Wissenssog' und ,'Wissensschub' illustrieren die Dynamik der Kräfte, die zwischen Forschung und Praxis im Spiel sind; ein Gleichgewicht in diesem Tauziehen um Evidenzen ist nötig (Speller *et al.* beschreiben diese Prozesse im Detail).

Schlussendlich ist zu bemerken, dass sich die Autoren zwar einig sind, dass gemeinschaftliches Vorgehen essenziell ist, um die Evidenzbasis-Bewegung in Europa und weltweit vorwärts zu bringen, dass aber die Terminologie noch sehr uneinheitlich ist. Auch in dieser Spezialausgabe werden viele Ausdrücke gebraucht: von evidenz-gestützter Politik zu evidenz-informierter Politik und Praxis, von Wissensmanagement zum Aufbau von Kapazitäten, von best practice zu bester Evidenz und weiter zu Effektivitäts- oder Wirksamkeitsnachweis oder von Praxisentwicklung zur

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Schlüsselbegriffe

- Rahmenplanung
- Evidenz
- Kapazität zur Umsetzung

Umsetzung von Evidenz in die Praxis. Diese Vielzahl von Ausdrücken und auch die nötige schnelle Einführung von Evidenzprozessen in die Basis machen einen eindeutigen Sprachgebrauch unabdinglich, denn nur so können Fachleute des Bereichs Gesundheitsförderung effizient untereinander und innerhalb ihrer Netzwerke kommunizieren.

Einige der fünf hier erwähnten Punkte warten weiterhin auf eine Lösung und werden auch zukünftig vorherrschend auf dem Programm aller stehen, die sich mit der Umsetzung von Evidenz in die Praxis beschäftigen.

Zukünftiges Handeln

Für die Zukunft zentral ist die Arbeit des weltweiten Programms zur Effektivität in der Gesundheitsförderung (GPHPE - Global Programme on Health Promotion Effectiveness). Zur einzigartigen Mission dieses Programms gehört nicht nur die Prüfung und Untersuchung der unterschiedlichen Ansätze in Bezug auf Effektivität in Gesundheitsförderung in den verschiedenen Regionen. Seine globale Sicht erlaubt dem Programm auch, Gemeinsamkeiten zu erkennen, Unterschiede in ihrem Kontext zu sehen und die Verstärkung der Vernetzung und den interaktiven Wissenstransfer zu fördern (beschrieben von Jones and McQueen in ihrer Untersuchung des Beitrags der Region Europa).

Das europäische Projekt zur Umsetzung von Evidenz in die Praxis (GEP) kommt nun in seine zweite Phase und die am Projekt Beteiligten sind entschlossen, seine Reichweite zu vergrössern und zu erweitern und an ein grösseres Publikum zu gelangen. In der nächsten Phase wird auf den nun geschaffenen Grundlagen für eine nachhaltige Umsetzung aufgebaut werden, ebenso müssen die nötigen Kapazitäten gesichert werden; diese beinhalten Schulungsprogramme und Möglichkeiten für fachtechnische Unterstützung (siehe Mollemans und Bouwens für einen Umriss).

Weiter wird Phase zwei eine Bestandesaufnahme beinhalten, welche die Kapazitäten zum Gebrauch des Prüfprotokolls in den verschiedenen Einrichtungen der EU-Länder einschätzt und die Qualität evidenz-gestützter Interventionen fördert und verbessert. Allerdings weisen Mittelmark *et al.* darauf hin, dass die Kapazität für Gesundheitsförderung über diese Parameter hinaus bemessen werden muss; ebenfalls ist zu sichern, dass die in der Bestandesaufnahme enthaltenen Informationen für die Verfechter der Gesundheitsförderung in ganz Europa eine Gewinn bringende Hilfe darstellen. Eine Bestandesaufnahme der Kapazitäten ist nicht nur ein Schlüsselelement für Umsetzungsstrategien, sondern kann auch in der Kommunikation, der Wissenserweiterung und Ausbildung, der fachlichen Schulung, der Interessevertretung und Politikentwicklung auf verschiedene Art und Weise eingesetzt werden. Die nächste Herausforderung wird sein, die Kapazität für die Anwendung der Evidenzen in der Praxis zu erhöhen und Evidenzen aus der Praxis zu erzeugen (siehe Speller *et al* für weiterführende Überlegungen und Fallbeispiele).

Alle Autoren dieser Sonderausgabe machen klare und übereinstimmende Empfehlungen für die zukünftige Richtung evidenz-gestützter Ansätze in Gesundheitsförderung; GEP und GPHPE können diese voran bringen.

Als entscheidend werden die Stärkung der Netzwerke innerhalb und unter den verschiedenen Ländern beurteilt, denn so kann Wissen ausgetauscht werden und gemischte Forschungs-, Politik- und Praktikergemeinschaften werden gefördert. Zusätzlich wird vorgeschlagen, dass eine neue Position entwickelt wird für Fachleute, welche an strategischen Schnittstellen eingesetzt würden, um Forschung, Politik und Praxis wirkungsvoll zu verbinden. Nützlich könnte auch die Schaffung anderer Schlüsselpositionen innerhalb der Forscher- und Praktikergemeinschaften sein; sie würden als Meinungsmacher oder Vermittler von Veränderungen in der Arena der Evidenzbasis dienen. Die Inhaber dieser Stellen wären verantwortlich für die Zusammenstellung der gesamten Wissenserkenntnisse, der Kommunikation der vorhandenen Informationen an die Praktiker und der Anwendung des Wissens in der Praxis.

Um die gegenwärtig bestehenden Kapazitäten (im weitesten Sinn) und Trainingsangebote zur Kapazitätserhöhung zu ermitteln, müssen die kollaborativen Bemühungen weiter geführt werden (siehe Jané-Llopis zum Aufbau der Kapazitäten durch Trainingsangebote). Solide Vernetzungs- und Austauschmechanismen zwischen Forschern, Leistungsträgern, politischen Entscheidungsträgern und Praktikern, welche einen produktiven Austausch über gemeinsame Probleme ermöglichen, werden für die Zukunft entscheidend sein. Allerdings bestehen Hindernisse, welche der Entwicklung eines flüssigen Zusammenspiels zwischen den wichtigsten Interessengruppen der 'Evidenz-Bewegung' im Wege stehen. Aus diesem Grund ist für GEP und GPHPE die allergrösste Herausforderung für die Zukunft, die strukturellen, organisationellen und politischen Hindernisse abzubauen, die dem Fortschritt im Wege stehen. Gesundheitsförderung ist eine einbindende und integrierende Disziplin und muss auf der Suche nach Wegen zur Kapazitätsentwicklung die Führung übernehmen. So werden die Evidenzerkenntnisse und das Wissen zur Evidenzmessung - ergänzt durch strukturelle, personelle und materielle Ressourcen - zur Anwendung kommen und zum Grundstein werden, auf dem aufgebaut wird.

International Union for Health Promotion and Education

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This structure is currently being developed

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