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Health Promotion Switzerland: Swiss Model for Outcome Classification in Health Promotion and Prevention (SMOC)

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Guidelines for the classification of outcomes in Health Promotion and Prevention

Berne, July 2004

Second revised version

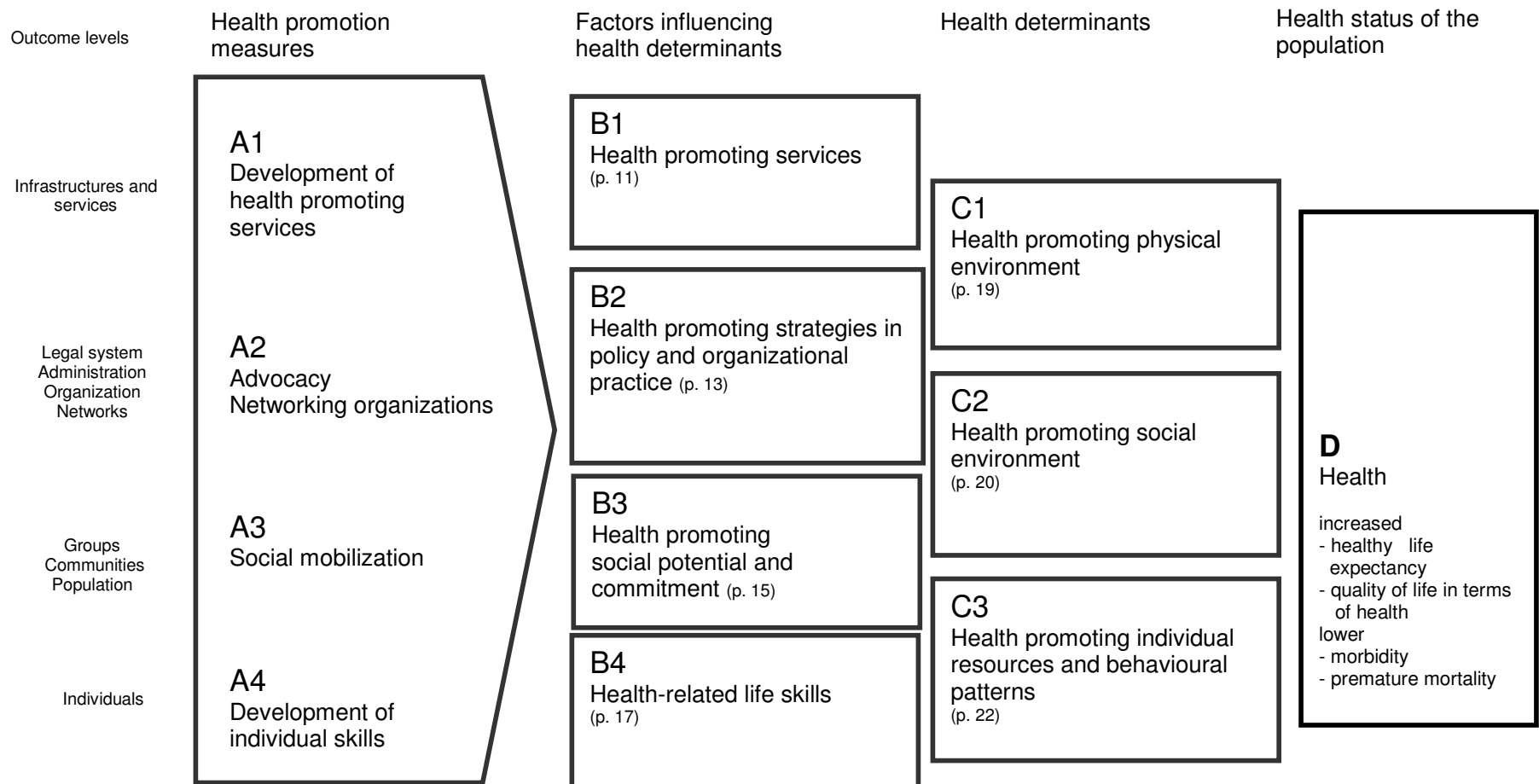
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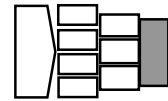
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2.0 Overview of the Swiss Model for Outcome Classification in Health Promotion and Prevention (SMOC)



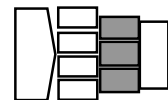
3.0 The four columns of the Swiss Model for Outcome Classification

Since health promotion always aims at the improvement of health, we begin by explaining the right side of the outcome model, i.e. by focussing on the improvement of health (Column D).



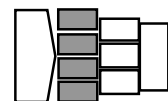
Improvement in the health of a population (Column D)

In terms of a bio psychosocial understanding of health, this is the place for recording the actually intended, ultimate goal of health promotion. Outcomes such as an increased healthy life expectancy for the population or a lower rate of preventable (or premature) morbidity depend on many factors (behaviour and circumstances), which interact in a complex manner. On this level, comprehensive outcomes can only be achieved over an extended period of time and can be verified by epidemiological evidence.



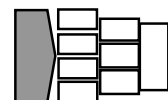
Changes in health determinants (Column C)

An outcome on this level C is a verifiable positive change in an acknowledged health determinant in a setting and/or in a population group. A health determinant is acknowledged if it is based on empirical and /or theoretical work, i.e. on well-conducted studies, evaluations or scientific models which are relevant to target groups and circumstances in Switzerland.



Change in factors influencing health determinants (Column B)

This is the field into which direct outcomes of health promotion strategies are entered. The categories and sub-categories offer room for indicators that have the potential to exert a positive impact on the health determinants.

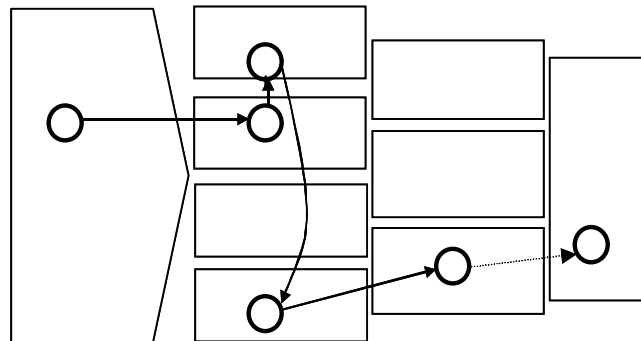


Measures for health promotion (Column A)

Measures constitute actions that are directed towards reaching the objectives of the project, which thus render the project possible, and enable it to progress. It is not absolutely necessary to consider this column when documenting the objectives and outcomes.

When assigning a place for the recording of planned, and actually obtained outcomes of health promotion projects (as well as for unintentional outcomes) both column B and C are important. Each one of these columns is further divided into categories and sub-categories. Demonstrable improvements in the population's health are to be recorded in column D.

Simple associations of outcomes, for example A2 to B2 to C2 to D, may be the exceptions; more complicated associations are to be expected. For example, advocacy measures (A2) can lead directly to a binding engagement on the part of decision makers (B2), which may be followed by the creation of structures and services (B1). These, in turn, can strengthen the individual health-related life skills (B4), which, over time, can lead to enhanced individual health resources (C3). These enhanced health resources, in turn, demonstrably contribute to the improvement of health (D):



The model provides a system for the recording of health related problems, *planned* outcomes (objectives) and actually *achieved* outcomes. It thus provides a basis for further reflection. It may point to concentrations or gaps, facilitates the estimation of effects and their association with each other, and is also an aid for the correct recording of relevant theoretical and empirical findings.

The model can be used on different levels: on the project or programme level, on the institutional level or even for the planning and evaluation of strategies on the cantonal or federal level. On each of these levels, the SMOC may be used to analyse a given situation, for planning, steering, evaluating or to provide evidence of achieved outcomes. In the latter case, the model is useful to justify the employed means to the public. A further benefit for individual projects, programmes and institutions consists in the fact that the model allows the positioning of the activities in a wider framework and thus facilitates a comparison with other projects, programmes or institutions.

4.0 What are outcomes and objectives?

An **outcome** is a clearly detectable change of a determinant or a characteristic following a measure applied within a project. In the case of positive outcomes, it means the following:

- The presence of a desired characteristic which did not exist before
- The change of an existing characteristic in the desired manner
- The diminution or disappearance of a pre-existing unwanted characteristic

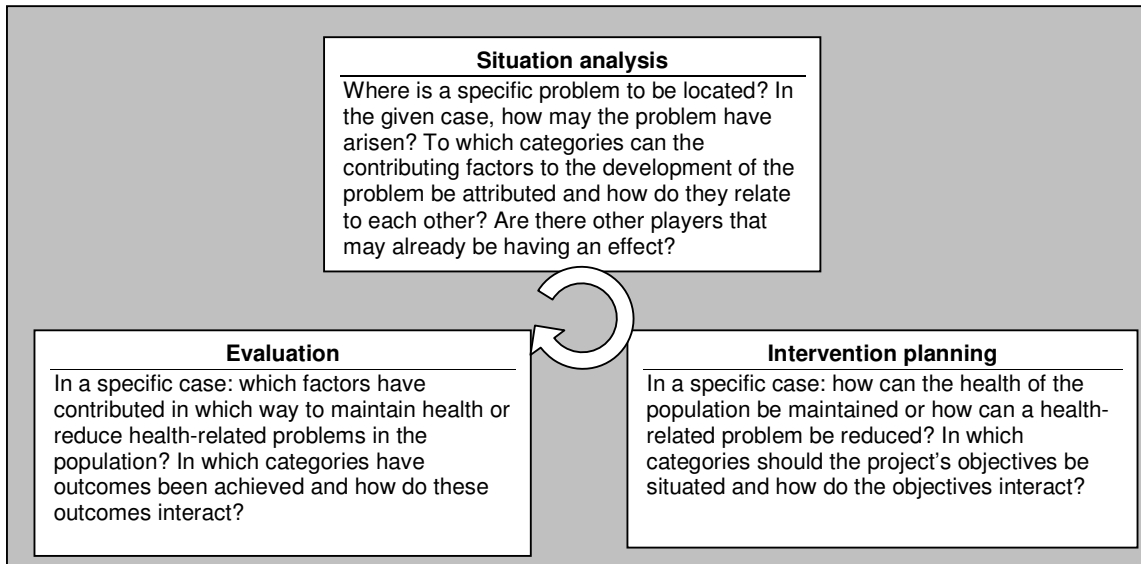
This may be with regard to determinants and characteristics relevant to the health of individuals, population groups or organizations; legal regulations, public opinions, physical or social, natural or man-made environments can be equally affected. As a rule, outcomes refer to the project's intended objectives. Yet, outcomes, whether of positive or negative nature, can be unintended as well. The question of reaching the target group is of particular importance for the discussion of the outcomes: it is important that the effects appear within the targeted groups or structures, and not at random (e.g. in persons who are easy to reach but for whom a change is not urgent). It is important to distinguish between outcomes and measures. In this sense, we are not concerned with the intended or accomplished measures (interventions and activities), but with the intention (objectives) and the achievement (outcome).

An **objective** is a desired outcome, i.e. the description of a desired and expected condition to be achieved by the end of a project.

5.0 Application of the model

The Swiss Model for Outcome Classification is an instrument for analysis and serves to develop quality. In order to exploit its full potential, it should not be used by the project manager or evaluator alone, but should be used collectively e.g. in a meeting of the entire project team, or between the evaluators and key project members, etc.

Generally speaking, the SMOC can be used to analyze a situation, to plan an intervention and to evaluate a measure.



Situation analysis: to demonstrate certain problems and health conditions in a specific case

The SMOC focuses on the analysis of planned and achieved outcomes. However, as a global classification system, it is equally useful in the early stages of a project, i.e. when examining the development of health problems/health conditions in a specific case.

When analyzing a particular situation, the relevant health condition would be noted in column D, while other columns and boxes would be used to record the factors that significantly determine the described condition (column C for health determinants and column B for substantial factors influencing the health determinants). Additionally, the question of effects resulting from the activities of other players in the field can be addressed for each category (context analysis).

Intervention planning: to demonstrate anticipated outcomes and chains of outcomes

In the planning phase of a project, the SMOC will be used to record the intended outcomes and to demonstrate the links between them.

There are two distinct levels:

1. Intended long-term outcomes (induced in part by the project, but with a view that goes beyond the duration of the project).
2. Health-relevant objectives (planned, health-relevant outcomes in the target-groups by the end of the project).

Whenever the SMOC is used, these two levels must be strictly differentiated. For a better visual differentiation, the two levels may be coloured differently. Crucially important are the question about the ultimate state of health to be achieved (D) and the health determinants (C) to be influenced by the project, as are the intermediate and more tangible goals deemed to contribute to this end. These questions ought to show up the underlying chains of outcome in a project:

In the planning phase, the following steps are needed:

- Long-term outcomes: demonstrate, how the project will positively influence the health of the population or a population-group. To which long-term outcomes is the project likely to

contribute? By classifying these intended long-term outcomes, the context in which the project aims to be active will be outlined.

- Objectives (made more tangible by mentioning the indicators, if necessary): list and attribute the health-relevant objectives to the categories and sub-categories of the model. Each objective and/or indicator must be attributed to its accurate sub-category. If this seems impossible, the objective may need to be checked and possibly re-formulated (see 'SMART-criteria'²). The descriptions of categories and sub-categories and the examples will help to correctly attribute the objectives. If needed, measures can be attributed to the measure categories (level A) at this point.
- Associations of outcomes: show the known or presumed associations between the individual objectives of the project and between the objectives and the intended long-term outcomes (visualization with arrows). Ideally, these associations of outcomes should be based on empirical data. If no evidence is available (and no theoretical base either), the presumed outcomes must be plausibly explained.

When planning an intervention, there is not only a need to justify the chosen interventions, but explanations should also be offered if objectives are missing from some of the categories.

Evaluation: assesses the outcomes and the associations of outcomes (i.e. the proposed outcome model)

For the evaluation of a project, the actually achieved outcomes will be listed and attributed to the relevant categories and sub-categories. Based on this, the following reflections are possible:

- Is there an concentration of outcomes in particular categories and sub-categories?
- How do the achieved outcomes correspond to the formulated project objectives?
- How have the presumed associations of outcomes been confirmed or remained elusive in the project?
- Have new associations of outcomes been discovered indicating a need to modify the model?
- Have there been positive or negative unplanned outcomes?

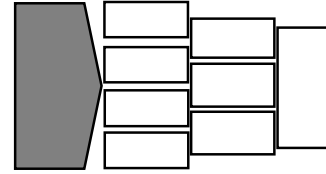
In view of continuing or improving a project, some of the following questions may also be helpful:

- In the light of experiences made during the project, should the presumed associations of outcomes be re-thought or revised?
- Are there any reasons why the objectives should be weighted differently in order to achieve the intended long-term effects?

Important : The SMOC may be used for intermediate evaluations or at any point of taking stock during a project and not only for evaluations at the end. If used during the project, the insights gained from the exercise can be used for further project steering.

² See www.quint-essenz.ch, quality criterion 'Definition of objectives'

6.0 The measure categories



This is the level where the measures implemented by a project can be recorded. The distinction between measures and objectives/outcomes is pivotal. In this sense, the 'training course of vocational skills teachers' is a measure, whereas an outcome could be formulated like this: '90% of the teachers participating in a training course have integrated the contents of the course into their lessons'.

This model focuses on the outcome dimension. The option to differentiate or sub-divide the measure categories was therefore not taken. Users may find it helpful to assign the measures to the measure categories, but it is not absolutely necessary. The model, as it is used by Health Promotion Switzerland, allows for the systematic listing of project outcomes but has dispensed with the listing of measures.

A1 Development of health-promoting services

→ The planning and implementation of infrastructure services and provision for health promotion and prevention belong to this category. These may be aimed at the population and/or professionals.

Examples

- Development of a range of counselling and advice services
- Implementation of programmes which promote physical activity
- Training of disseminators
- Creation of a user-friendly and publicly accessible data bank about health-related subjects, health-promotion projects and players

A2 Advocacy, cooperation of organizations

→ This deals with measures aimed at spreading and sustaining health promotion concerns in politics, administration and organizations.
→ Measures may include advocacy and lobbying, coordination and cooperation.

Examples

- Development of institutional/organizational networks
- 'Lobbying' and 'Advocacy'
- Creation of national/regional coordination centres or platforms

A3 Social mobilization

→ In contrast to A2, these measures do not address formal organizational units, but aim at the ultimate beneficiaries of health promotion, i.e. the public, or certain population groups.

Examples

- Initiation of self-help groups
- Community work/work within a neighbourhood
- Participation procedures in communities
- The 'Slow-up Movement' is promoted to further nationwide coverage

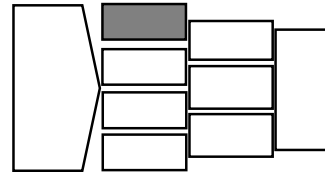
A4 Development of individual skills

→ These measures address individuals directly. They include health-related information, education, advice, promotion and training, and they are aimed at the development of health-related personal life skills.

Examples

- Organizing programs which promote physical activity compatible with daily life
- Stress management programs
- Nutrition and exercise advice
- Public information event relating to 'Agenda 21'
- Information campaigns dealing with social influences on health

7.0 Outcome categories and sub-categories



7.1 Health-promoting services - B1

We understand the term 'provision' to mean the provision of services or products, which are developed, operated and/or distributed by health promotion and prevention practitioners.

- 'Provision of services' could mean: Information and advice centres, counselling services, platforms for exchange between professionals
- 'Products' could mean: leaflets, brochures and other printed material, internet platforms, video games, articles warning against harmful influences, tools for exercising health-favourable behaviour etc.

Projects often begin with the development of such provisions. Thus, the first outcome is often the creation of services and products. The SMOC, however, only accounts for outcomes and not to the mere availability of services and products (outputs).

Provisions can be directed at target groups in the population or at persons whose interventions – through their position - have a multiplying effect, i.e. non-professionals who undergo specific training in order to promote health-related provisions to certain population groups (e.g. teachers, youth group leaders, ...).

B1-1 Awareness of the service

- Awareness of the service and its characteristics by all relevant target groups
- To distinguish: the characteristics of the service will be recorded in this category, as compared with the characteristics of the person in B 4-1,.

Examples

- The potential users know the name and the appearance of the service
- They remember the type of service being provided
- They know when and how they can make use of the service
- Mediators (such as specialized centres, the mass media) know the service, and draw the attention of potential users to it
- Key players know about the service (e.g. local authorities or the media)

B1-2 Accessibility of the service and reaching of target groups

- Temporal accessibility (opening times)
- Local accessibility (distance from the service)
- Attractiveness (appearance and image which is adapted to the target group psychologically, socially and culturally)
- Affordability
- Congruence between intended and actually reached target group

Examples

- The target group is able to handle the internet game without problems
- The opening times of the advice centre are convenient for the target group
- The internet platform appeals to the members of the network
- The campaign reached 85% of the intended target groups
- The users of the information system are part of the defined target group

B1-3 Use of the service and satisfaction with it

- Number and profile of the service users
- Frequency, length of time, and type of use of services
- Satisfaction of the users refers here to a subjective, “intuitive” evaluation (as opposed to B1-1 and B1-2, which is more concerned with “objective facts”
- This refers to both the global satisfaction with the service and specific elements
- This, too, refers to the satisfaction with outcomes of provided services, and not to the satisfaction with process indicators

Examples

- The persons making use of an information system are part of the defined target group
- The service is used to 85% of its capacity
- 20% increase in telephone information given by the advice and counselling service, as compared with the previous year
- High satisfaction with a course in a continuing education programme
- 95% of the clients are willing to recommend the service

B1-4 Sustainability of the service

- Secure and stable organizational basis
- Networking with potential mediators and other providers in the area of activity
- Take-over or continuation of the service or of its idea by other providers

Examples

- The exercise program is integrated into an existing organisation or institution
- The providers of the continuous education program are networking with others
- The service is designed for long-term use (e.g. financing is assured, local/temporal aspects etc.)
- The public recognizes the range of available services as meaningful and necessary
- Further specialized centres have taken over the concept of the service, and now offer it as well

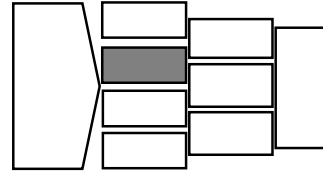
B1-5 Improved professionalism in health promotion

- Non-professional ‘multipliers’ need to improve their expertise in terms of planning, realizing and evaluating health-promoting activities, both generally or for specific target groups or themes.
- To distinguish: Unlike in B4 and C3, the concern here is not with individual health skills, but with the expertise needed or displayed by non-professionals who are planning and realizing health-promoting activities for and with others.

Examples

- Teachers have the required skills to address health-promoting themes in the classroom
- In a municipality, key persons are able to guide participation processes independently
- Youth camp group leaders feel able to plan and conduct health-promoting activities during a holiday camp

7.2 Health-promoting public policy and organizational practice – B2



Policy in the present context includes strategies and efforts

- by the state sector (communities, cantons and federal government).
- by the public and private sector (institutions, organizations, federations and networks)

It intends to direct national or corporate structures. It includes at least targets and objectives, measures, personnel and material resources, as well as regulations for the interaction between all concerned players. The main players of such a policy are not primarily experts in health promotion and prevention. The experts only motivate these main actors to strive for self-organization and activity, with the goal to achieve conditions favourable to health.

B2-1 Binding engagement of decision-makers and/or key persons

- A key person has influence in certain areas and institutions and may act as spokesperson
- Influence, power, and prestige may take effect politically, publicly or through private connections
- Thus, influence can be exerted by public figures (from politics, economy, culture, sports, sciences)
- Binding, i.e. public or written endorsements

Examples

- The management pledges publicly to become involved in the subject of health promotion
- A written consent exists concerning plans to develop a health promotion project for the company
- Parliament (federal, cantonal or communal level) has submitted a postulate to the government, demanding the drafting of a programme for the prevention of violence
- Several well-known personalities from different sectors of public life pledged publicly to support this cause
- Several organisations and institutions decided to create a network towards achieving certain common goals

B2-2 Action-relevant, binding documents

- This refers to the drawing-up of documents such as basic principles, models, plans, concepts, laws, ordinances, regulations and similar proposals
- These products are finalized, negotiated and agreed upon by decision-makers, and are ready to be implemented

Examples

- The management has implemented guidelines for company-specific health promotion
- The local council approved the plan proposing measures for the promotion of quality of life in the community
- The trade association agreed upon basic principles and procedures concerning the promotion of health within the affiliated companies
- The network of health-promoting hospitals opted for the creation of a coordination centre and made a decision as to the method of its funding
- A decision was made by the contracting parties in favour of the cantonal AIDS Prevention Program
- Complaint procedures regarding mobbing in the work-place have been revised

B2-3 Successful organizational changes

- Financial, material and personnel resources are invested in the HP project
- Working conditions, working relationships or work procedures were changed

Examples

- A group concerned with health in the workplace started to operate in a institution or organisation
- The Commission for Health Promotion was granted a yearly credit of SFR 10,000 by the municipal council
- There are new, more flexible working time regulations making it easier to maintain the work-life balance
- There are new regulations facilitating the complaints procedure regarding mobbing in the work-place
- The ban on using building material harmful to health is being enforced
- Threshold values for the use of loud speaker systems are being upheld
- The person in charge of implementing the national HP initiative within the company has the necessary resources at his disposal

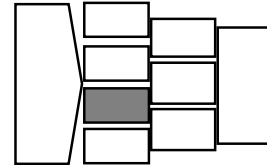
B2-4 Successful exchange and cooperation

- This category refers to the existence of information exchange and cooperation in the context of health promotion concerns
- An important aspect consists in the collaboration between sectors

Examples

- The transport authority now collaborates regularly with the health authority
- The cantonal delegate for health promotion is regularly invited to participate in consultations of other departments
- The inter-sectoral network for health promotion receives efficient support from its coordination centre
- The systematic, trans-sectoral information exchange operates in a satisfactory manner for all concerned

7.3 Health-promoting social potential and commitment – B3



Social potential refers to the ability of small or larger population groups to stand up for their concerns in a competent manner, or more generally, to find solutions for collective problems. These are the main points signalling 'empowerment'. The term 'commitment' refers to the motivational aspect of these abilities, namely the willingness to become active, and the confidence that this commitment to a common cause is worth the effort.

The development of these abilities through the use of interventions, in particular campaigns with the mass media, can be divided into the following levels: Knowing – Accepting – Supporting – Adopting – Participating. The first phases of this process are also termed "Sensitizing".

This category refers exclusively to population groups, and not to health promotion professionals!

B3-1 Existence of active groups focusing on health-promoting concerns or themes

- This concerns interest groups or bottom-up citizen initiatives These groups are capable of functioning autonomously without external intervention
- They are able to externalise activities

Examples

- A self-help group was set up
- The parent initiative for 'Safe Ways to School' holds its inaugural session
- The initiative decided to adopt an action program for the coming year
- The informal working group of the region's decision-makers meets regularly in order to exchange health-relevant social topics
- The neighbourhood group discusses health concerns repeatedly

B3-2 Enlisting of new players

- This refers to participation in the sense of cooperation, co-development and co-management as well as self-organization of population groups
- As a n outcome of the mobilization efforts, persons who were inactive until now, start to enlist in the project. On the one hand, these should be members of groups who used to be underprivileged/underrepresented in this sector (e.g. women, migrant women, marginalized people). On the other hand, this could be private commitment on behalf of public figures (e.g. a community leader, a well-known female athlete,...)

Examples

- Persons who were inactive until now, became involved in the concern
- The executive board includes two representatives each of three underprivileged groups
- Young people helped to review and redesign the program for an event

B3-3 Awareness of the concern by population groups

- Here the concern includes ideas, statements of needs, propositions, requests, programs
- This is about the external effects of the subject matter, in that as many as possible of those concerned know about it, discuss it and form an opinion about it
- The concern may be propagated by official agencies (e.g. local authorities), private organizations (e.g. health groups) or grass-roots groups
- To distinguish: This is about public awareness of a topic; the awareness of a service (provision of a service, product) is attributed to B1-1

Examples

- The topic of health promotion is repeatedly taken up and debated in the local newspaper and radio
- 45% of the residents know that the subject is presently discussed in public and that it is a very important topic
- During an event focusing on the subject of HP, all essential positions were expressed
- The topic is regularly discussed in the different daily newspapers

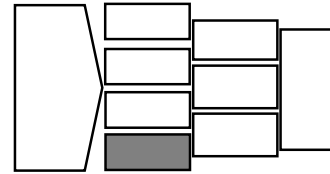
B3-4 Acceptance of a concern by population groups

- This concerns the social norm, i.e. what is generally considered to be right
- A health promotion concern should at least be recognized as being legitimate or as something 'to be taken seriously' by the majority of the population
- Ideally, it should be seen as being a priority by a majority of the population
- To distinguish: The concern is here the characteristic of a population group as compared to the characteristic of an individual as in B4-2.

Examples

- 80% of the residents think the topic is at least quite important
- The essential opinion leaders/the most important peers among the students stress the concern repeatedly and publicly
- The number of active requests from the population for information about the topic (submitted to the initiators or other competent bodies/organizations) has markedly increased

7.4 Individual health-related life skills – B4



By health-related life skills we understand knowledge, attitudes, beliefs or values, as well as skills that are significant for one's own health. Included are skills dealing with oneself as a bio- psychosocial being, and skills dealing with one's social and physical environment. That means that an individual would act in a health promoting way if he/she had the motivation and the ability to do so.

B4-1 Factual health-relevant knowledge and capacity to act on knowledge

- On the one hand, this refers to concrete knowledge of facts, topics and contents that improve the individual's capacity to act
- On the other hand, it is also about knowledge of procedures, methods and strategies
- To distinguish: Here it is the characteristic of the person as compared to the characteristic of the service in B1-1

Examples

- Students know where to get specialized advice and counselling
- Employees know the nutrition slogan of "5 a day"
- City residents know which of the social factors in their neighbourhood have an impact on their health
- Parents and teachers know that the "Children's Health" initiative was started in their city

B4-2 Positive attitudes and intentions towards a health-relevant topic

- In order to act on knowledge, the gained information has to be judged positively and appear sufficiently worthwhile and useful
- The same goes for conduct to be avoided; there needs to be a positive attitude towards alternatives
- To distinguish: Here it is the characteristic of the person as compared to the characteristic of a population group in B3-4

Examples

- Young men assess the messages about nutrition aimed at them as being positive
- Women recognize the benefit of regular preventive medical check-ups
- Party-goers accept the fact that saying No to unknown party drugs is beneficial to their health
- Men have a positive attitude towards the use of condoms
- 40% of the adult population feel that the procedures of 'Agenda 21' are important for their health

B4-3 New personal and/or social skills

- Personal skills refer to the performing of actions which one can do by oneself alone and for oneself (e.g. to make a difficult decision or to clarify one's feelings)
- Social skills refer to interactions or communications with other persons, thus they require a counterpart (individual or group)
- See also "life skills"
- To distinguish: collective changes in B2-4

Examples

- The apprentices are able to apply a problem-solving model to a topic relevant to themselves
- The course participants decline invitations to join others in drinking alcohol, when they intend to drive a car
- In conflict situations, the course participants are able to take steps to avoid escalation
- With support, the course participants are able to follow the steps of the stop-smoking program

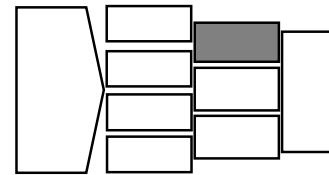
B4-4 Strengthened self-confidence regarding a health-relevant topic or an activity

- This concerns the trust in one's ability to effect change with a positive result, i.e. the trust that a certain action in my specific case will indeed be effective and that I will also be able to accomplish it in my every day life
- In general, it is the feeling of having enough knowledge for informed decision-making, and to be really able to assess the pros and cons for oneself
- To distinguish: In contrast to B3-4, this refers to the self-confidence of the individual

Examples

- Visitors to the open-air swimming pool feel reassured that the skin protection measures taken against sun radiation are effective
- The course participants of the stop-smoking program are convinced that the program is effective, and feel confident that they can carry it through
- Young women trust themselves to be able to decline unprotected sex during a future encounter
- Each target person is convinced that the recommended action will indeed result in the desired positive effect for him/herself

7.5 Health-promoting physical environment and infrastructure - C1



By physical environment and infrastructure we understand

- the natural physical environment as well as
- the man-made and altered environment

Outcomes could refer to the following areas: work, education, school, household, home, leisure, mobility.

C1-1 Reduction of pollution caused by physical-chemical influences

- The production or the discharge is reduced at source or the target group will collectively benefit from effective protective measures
- The issues here are actual radiation such as electromagnetic waves, sound and noise but also other harmful substances such as ozone and fine dust particles in the air, nitrate in the water, additives or residues in foodstuffs
- To distinguish: individual protective behaviour (e.g. the use of sun cream) does not belong to this category, but to C3-1

Examples

- People living on a main thoroughfare are less exposed to noise due to speed limits, noise-proof windows, protective walls and a tunnel
- Noise exposure inflicted on club-goers was reduced
- The threshold values for mobile phone antennae were not exceeded

C1-2 Conservation and improvement of natural resources

- Here natural resources refer to basic life sustaining resources such as water, air, forest, sufficient living space, recreational areas close to residential areas
- To distinguish: This refers to outcomes in the holistic ecological sense, in contrast to C1-1, where the central factor is the reduction of the individual exposure

Examples

- The grassland area within the urban agglomeration was preserved and did not fall victim to a planned building project
- The water quality of a lake used by swimmers has improved
- A forest close to the city was officially declared a recreational area and was cleaned up by the local school children, thus becoming a place for rest and recreation

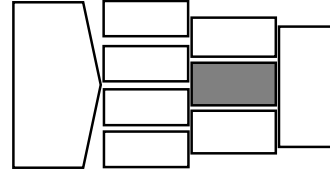
C1-3 Health-promoting installations and products

- This refers to services, installations and products which sustain health and well-being
- They go beyond purely preventive effects and offer health-favourable possibilities for recreation, relaxation, life-balance, activities or challenge
- It is established that they promote more health-favourable choices
- Generally, the service and product providers are not experts in the field of health promotion and prevention (in contrast to B1)
- To distinguish: This refers to man-made material resources in contrast to C1-2, which deals with 'naturally present' resources (nature).

Examples

- An interconnected network of safe bike paths prompting bike traffic away from the road
- Playgrounds and sports fields in a neighbourhood are aimed at different target groups, which results in additional use
- Sports- and exercise-friendly measures and installations in a company (e.g. showers for joggers or bicycle riders) are taken up

7.6 Health-promoting social/societal environment – C2



By the term social/societal environment, we understand widely available social support services, and the climate in which social interactions take place (social climate). In other words, the whole social structure (community, company) is involved and not just some selected and isolated features. Outcomes could refer to the following areas: work, education, school, household, home, leisure, mobility.

C2-1 Social support, social networks, social integration

- Improvement of social support in the target groups
- Events, services and installations are available throughout the social structure. They
 - promote contact, encounters and exchange with other people, and encourage mutual help,
 - facilitate the utilization of professional support and assistance and/or
 - promote the integration of marginalized population groups
- In contrast to B1, these services are offered by non-professional health promoters

Examples

In a housing estate, a system of neighbourly support for the elderly has been established

- Community centres in neighbourhoods are being used by different population groups
- 8 out of 10 interviewed inhabitants of a neighbourhood declare to have at least two neighbourly contacts to rely upon in case of need
- In canton X, families with a health burden are effectively assisted

C2-2 Social climate

- The social climate is the expression of the dominant mood in a social structure (a company or a community,...)
- Health-promoting norms and values, social cohesion in society
- Changes in the social climate of a company or community can manifest themselves in several ways: the nature of the interaction between partners at different levels in a hierarchy (supervisors - co-workers, politicians – citizens), in the degree of trust, and the identification with the community or company (feeling of togetherness, see also "Social Capital")
- To distinguish: This refers to collective changes of a social structure. Similar changes in knowledge, attitude and conduct of individual persons or small groups are assigned to B4

Examples

- A positive psychosocial culture is increasingly prevalent in Swiss companies. This promotes well-being in the work place and lowers the stress level
- The residents of the city feel generally safe
- There are visible and real manifestations of solidarity
- Community life is marked by mutual esteem and acceptance
- The general attitude in a school is conducive to physical activity; initiatives for more physical activities are generally well regarded and are welcomed

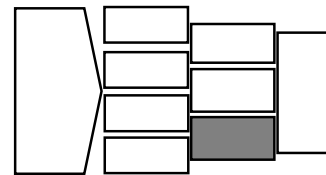
C2-3 Equal access to general social resources

- This category deals with equal access to health-promoting resources by *all* groups of society (particularly in terms of work, education, income, affordable housing, health services, etc.); it also means equality of chances in health on a social level (determinants of health on the macro level)
- In contrast to C1 (physical environment and infrastructure) this category is concerned with equal opportunity in terms of cultural and socio-economic factors (such as socio-economic discrimination, relative poverty, ...)
- To distinguish: Categories C2-1 and C2-2 are concerned with factors of the near social environment (micro/meso)

Examples

- Migrants' access to health provision is beginning to match the Swiss population's access to the same services
- Youth unemployment is declining
- Differences in income and education are less marked
- Migrants' access to educational provisions is improved
- Social and economic policy take account of the needs of single parent families
- There is sufficient subsidized or affordable housing

7.7 Health-promoting individual resources and behavioural patterns – C3



Individual resources include mental and physical resources and individual social skills and competences. The term 'behavioural pattern' refers to overall established behaviour and suggests that particular modes of behaviour are interconnected and must always be considered in context. Outcomes could refer to the following areas: work, education, school, household, home, leisure, mobility.

C3-1 Health-promoting individual skills

Health promoting mental and physical resources such as:

- Individual characteristics/attitudes such as positive attitude to life including purpose in life, optimism, zest for life.
- Coping mechanisms; appropriate personal strategies to cope with internal and external demands and stresses.
- Sense of coherence; self efficiency
- Social skills including the ability to initiate, sustain and benefit from social engagements (appropriate judgement of the social environment, appropriate tolerance level for frustration)
- physical fitness, well functioning immune system, healthy bodyweight
- To distinguish: C3-1 refers to basic, comprehensive personality traits, whereas C3-2 means specific and concrete behaviour

Examples

- The residents of a neighbourhood feel able to make use available community centres and other facilities and are more willing to accept offers for help from neighbours
- Young men have developed a greater awareness for healthy eating
- Children have gained greater confidence in the knowledge that at least one non-judgemental adult person in their vicinity would be available for them in a crisis situation
- The percentage of people with a healthy bodyweight has increased and been maintained because the national strategy has been implemented over years
- Parents are physically fit enough to play with their children, take them on bicycle tours, etc
- Elderly people continue to keep themselves fit

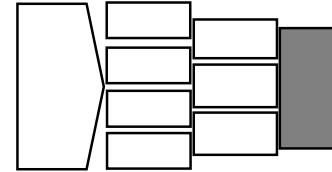
C3-2 Improved health-relevant behaviour and patterns of behaviour

- Strengthening and maintaining health-promoting behaviour such as physical activity, relaxation, diet.
- Personal interest and lobbying for health-promoting living conditions.
- Reducing or stopping health-detrimental behaviour or risky behaviour such as aggressive driving, smoking, persistently ignoring health-promoting advice.
- Increased individual protection against risks
- To distinguish: Collective measures for protection are in C1-1
- To distinguish: Contrary to B3 (where the focus is on health-promoting social engagement for a particular theme) the focus here is on long-lasting changes of individual behaviour patterns (from passive to active)

Example

- Increasingly, students resolve their conflicts in school without resorting to violence
- Young men follow the '5 fruits or vegetables a day' rule
- Older working people in Switzerland have increased physical activity in daily life
- People in the workforce have become more attentive to health-endangering working conditions
- Smoking in Swiss secondary school children is demonstrably on the decrease
- The population protects itself better against direct solar radiation
- Cyclists wear helmets more often than before

8.0 Health



Ultimately, health promotion and prevention always aim at improving the health of the population or individual population groups. According to the definition of health by the WHO, it refers to a sustained improvement of the mental, physical and social well-being. Today's state of knowledge of the health sciences supports such an understanding of health as well.

Here, indicators to be measured are, on the one hand, a higher healthy life expectancy of the population, or a greater number of years without illnesses and disabilities, as well as indicators of the higher health-related quality of life. On the other hand, these are indicators of a decreasing rate of preventable (or premature) morbidity as well as premature mortality.

In this sense, it is rarely possible to directly attribute measurable, lasting changes in the health of the population to individual health-promoting projects. Such changes are rather the result of a great number of health-impacting factors, i.e. factors stemming from both the sector of individual behaviour and the (living, learning and working...) conditions. Thanks to numerous studies, we know today which of these factors are proven to have a negative or positive impact on the health of the population. These are the so-called health determinants. Changes of these determinants as outcomes of health-promoting interventions are recorded in column C. At the same time, it should be noted that positive outcomes reached in the area of one or several health determinants can be 'neutralized' by simultaneous, negative impact of other interventions and sectors on these or other health determinants. An example for this may be found in the workplace, where progress in health-promoting activities may be counteracted by increased stress and uncertain conditions of employment.

Example

- The healthy life expectancy of the Swiss population has risen
- The proportion of 75 year old persons without chronic illness or disability has risen
- Older people show a consistently good level of fitness
- The proportion of 40 to 50 year old people with back problems interfering with their everyday lives, decreased significantly
- The suicide rate of young people is declining
- In a town or community, quality of life in terms of health has been improved

9.0 Empowerment, participation and equality of chances in the Swiss Model for Outcome Classification.

As so far described, the basic principles of empowerment and participation have not appeared in the SMOC. The reason for this is that these terms cannot be assigned unambiguously to one outcome category of the model. This will be explained as follows:

Empowerment

Empowerment designates not only the outcome of an intervention, but, in the first place, an approach to intervention, or even more generally, an attitude present at the time of intervention³. On the one hand, empowerment should be recorded in the same space as the measures, but it will also appear in some of the outcome categories, which refer to the population (in particular in B3 and B4).

Participation

It is very similar in the case of participation. This has become an important element or sign of quality of health promotion measures. Beyond that, it may then also become an outcome in the sense that willingness and ability to participate in social activities and to exert influence becomes manifest or has been reinforced (e.g. B4).

Equality of chances in health

Equality of chances in health are also not attributable to one category alone, but will appear on the level of social potential (B3), individual health-related life skills (B4) and on all levels of the C-category (i.e. physical environment and infrastructure, social/societal support, access to work and education, individual resources,...).

10.0 Literature

Cloetta, Bernhard; Spencer, Brenda; Spörri, Adrian; Ruckstuhl, Brigitte; Broesskamp-Stone, Ursel; Ackermann, Günter: Ein Modell zur systematischen Kategorisierung der Ergebnisse von Gesundheitsförderungsprojekten. In: Prävention. Zeitschrift für Gesundheitsförderung. 27. Jg 3/2004.

Cloetta B, Spencer B, Spörri A, Ruckstuhl B, Broesskamp U, Ackermann G. Un outil pour la catégorisation des résultats de projets de promotion de la santé. Promotion & Education XII:2, in press.

³ See: Stark, W (2003) Empowerment. In Bundeszentrale für gesundheitliche Aufklärung (Hrsg.) Leitbegriffe der Gesundheitsförderung. Schwabenheim a.d.Selz: Fachverlag Peter Sabo, 28-31.

11.0 Annex I: Example of application

Sample project: 'Fit and healthy at school'	
Problem	Increasing overweight in children
Setting	Schools
Target group	Teachers, parents and primary school children in canton x
Vision/ long-term effects:	More school children with a healthy bodyweight Schoolchildren eat a healthier diet and have more physical activity
Objectives:	<ul style="list-style-type: none"> All primary schools in county x participate in the project 'Fit and healthy at school' The principle of 'healthy school snacks' is introduced successfully and children only bring healthy snacks to school 90% of all teachers are aware of the association between physical activity, diet and health and are able to implement this awareness in their classroom teaching and by organizing health-related school projects The parents of at least 60% of the schoolchildren have been reached through 'Fit and healthy at school' workshops Based on the 'fit and healthy at school' workshops, municipalities have decided to continue activities promoting 'healthy' schools and have started to put them into action Parent participants of the workshops and their children have started to integrate more physical activities and a healthier diet into their daily lives 90% of all teachers have participated in a regional training session in preparation for the 'Fit and healthy at school' workshops

1) Thus, when planning an intervention with the help of the SMOC, the **vision/long-term effects** will be attributed first to the appropriate categories:

Vision 1	More school children have a healthy bodyweight	C3-1
Vision 2	School children eat healthier food	C3-2
Vision 3	School children have more physical activity	C3-2

2) In a second step, the health-relevant objectives of the project are entered into the SMOC. Each objective will be attributed to its accurate sub-category. If this seems impossible, the objective needs to be checked and possibly re-formulated (see 'SMART- criteria'). To facilitate correct entries and attributions, descriptions and examples are provided for each of the categories and sub-categories. If needed, measures can similarly be attributed to the measure categories (level A).

Objectives		
Objective 1	All primary schools in county x participate in the project 'Fit and healthy at school'	B2-2
Objective 2	The principle of 'healthy school snacks' is introduced successfully and children only bring healthy snacks to school	C3-2
Objective 3	90% of all teachers are aware of the association between physical activity, diet and health and are able to implement this awareness in their classroom teaching and by organizing health-related school projects	B1-5
Objective 4	The parents of at least 60% of the schoolchildren have been reached through 'Fit and healthy at school' workshops	B3-2
Objective 5	Based on the workshops, municipalities have decided to continue activities promoting 'healthy' schools and have started to put them into action	B2-2
Objective 6	Parent participants of the workshops and their children have started to integrate more physical activities and a healthier diet into their daily lives	B4-2
Objective 7	90% of all teachers have participated in a regional training session in preparation for the 'Fit and healthy' workshops	B1-3
Measures		
Measure 1	Talks with the departement of education and with school principals	A2
Measure 2	At least 6 regional training sessions for teachers	A1
Measure 3	At least 2 'Fit and healthy' workshops for children and their parents in each school - in collaboration with the project team and the teachers	A1/A4
Measure 4	Information for parents	A3

3) The most important associations between the project's objectives and the long-term outcomes can now be deliberated and entered into the model (these chains of outcomes should be plausible and comprehensible, at best they should have a theoretical or empirical base). e.g. objective 1 is an important

condition for objective 2 and 7; objective 7 is a condition for objective 3 and objective 3 in turn is a condition for measure 3, etc.

With the SMOC as a background, these three planning steps could be illustrated in the following way (different colour for visions, objectives and measures):

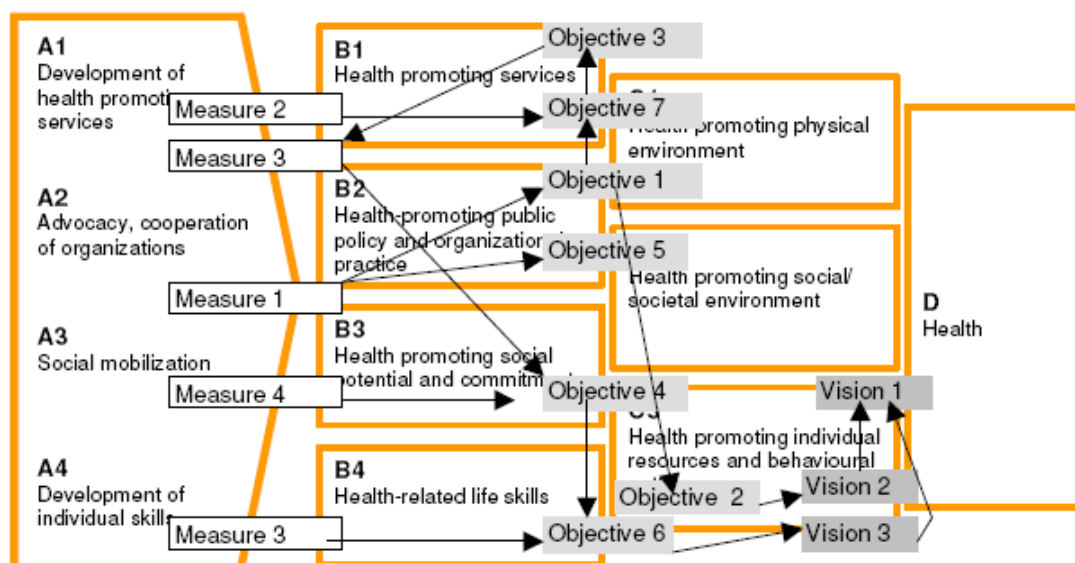


Illustration: Chains of outcomes

Such an illustration will help to decide if a planned intervention is consistent and comprehensible. For example, are there objectives on level C or D which are no longer feasible since the expected chains of effect were not forthcoming? In the given example, this would be the case if we had aimed at a healthier school environment without explicitly showing the way to achieve such an objective, and if we had only planned to offer workshops for parents.

During the **evaluation** phase, the outcomes actually achieved will be noted into the model in a similar way, and the associations of effects made apparent.

- Should the presumed chains of effect be re-thought or revised in the light of experiences made during the project? Was the assumption correct that workshops could realistically contribute to more physical activity in everyday life?
- Are there any reasons why the weight attributed to the different objectives should be changed in order to achieve the intended long-term effects? Would it be more appropriate, for instance, to put more emphasis on the school structures in order to achieve longer lasting effects?
- Have there been any positive or negative unplanned side effects? Have the parents been stimulated to organize activities independently?

12.0 Annex II: Detailed overview of the outcome columns B and C

