The Interactive Domain Model of Best Practices in Health Promotion: Developing and Implementing a Best Practices Approach to Health Promotion

Barbara Kahan, MHSc
Michael Goodstadt, PhD

This paper discusses issues associated with taking a best practices approach to health promotion including determining factors, implementation, and implications for practitioners and policy makers. We suggest that health promotion effectiveness will be increased through adoption of a systematic and critically reflective approach to practice—one which considers all major factors affecting practice and is consciously guided by health promotion values and goals, theories and beliefs, evidence, and understanding of the environment. To help practitioners develop and implement best practices, we outline our Interactive Domain Model of Best Practices in Health Promotion, the IDM Operational Framework, and a set of best practices criteria. The conceptual model, framework, and criteria are based on three domains (i.e., underpinnings, understanding of the environment, and practice) and related subdomains, all of which interact with each other within the context of the immediate and broader environments.

> The broadly accepted definition of "practice" is the application of knowledge (theoretical or technical) in the exercise of a profession, and encompasses a range of discipline-related activities and applications of knowledge. . . . Within health promotion, practice is not fixed by any rigorously defined discipline, and is said to be practised by individuals in diverse organizations, trained in a multiplicity of disciplines. Thus, what actually constitutes practice in health promotion will differ according to the practitioner's institutional location and discipline-related training, i.e., his or her "arena" of practice.
>
> —Boutilier, Cleverly, & Labonte (2000, p. 257)

Health promotion, in its current incarnation, is only a quarter of a century old, although its distinguished ancestors include public health in the 1800s, which emphasized environmental factors, and, more recently, health education that places an emphasis on behavior change (G. Macdonald & Bunton, 1992). People from many different fields and backgrounds, with different

Health Promotion Practice / January 2001 / Vol. 2, No. 1, 43-67

ideas and approaches to health and to the determinants of health, are practicing what is broadly called health promotion. As with any new field, there are many issues to be resolved, such as defining its concepts, clarifying its main focus, and determining its most effective strategies.

Although some authors have provided a limited set of principles for the practice of health promotion and/or health education (Freudenberg et al., 1995; Jackson & Parks, 1997),[1] at this point in health promotion's evolution, there is little consensus regarding what constitutes best practices. However, recent discussions have begun to suggest what a best practices approach to health promotion might look like (e.g., Cameron, Walker, & Jolin, 1998; Heale, 1996; Kahan & Goodstadt, 1998; Kahan, Goodstadt, & Rajkumar, 1999; Nutbeam, 1996). In addition, progress in the development of a best practices approach to health promotion is occurring as a result of recent contributions related to evaluation, theory, evidence, values, and quality in the practice of health promotion (e.g., Caplan, 1993; Davies & G. MacDonald, 1998; Evans, Head, & Speller, 1994; Goodstadt, 1995; L. W. Green & Lewis, 1986; Israel et al., 1995; Kahan & Goodstadt, 1999; Lincoln, 1992; G. Macdonald, 1997; Naidoo & Wills, 1998; Nutbeam & Harris, 1998; Ovretveit, 1996; Perkins, Simnett, & Wright, 1999; Poland, 1992; Rootman, Goodstadt, Potvin, & Springett, in press; Seedhouse, 1997; Thompson, 1992).

An important ingredient in the development of a best practices approach to health promotion is the experience of individual practitioners and organizations who have, in one way or another, been using a best practices approach in their own work. A number of organizations are building on this groundwork in an attempt to define and implement a best practices approach that takes into account all the factors necessary for effective health promotion practice.[2] Synthesizing the experiences and lessons from these attempts to develop a systematic approach to best practices will greatly benefit the field of health promotion.

As an example of the groundwork that is being laid, the following section describes the best practices approach employed by a community-based health promotion agency.

Authors' Note: *We gratefully acknowledge the following for their contributions to and support of the extensive work that has been so critical to the development of the ideas expressed in this article: the Centre for Health Promotion, University of Toronto; the Centre's Best Practices Work Group; Health Canada, Ontario Region; and the participants of the best practices scan and the best practices field testing. Thanks go also to Robin Stadnyk for many best practices discussions and for her review of this article.*

What Does Implementing a Best Practices Approach Look Like?

Career Headways, a 4-year-old nonprofit community agency dedicated to improving the quality of life for people with acquired brain injury, is located in the medium-sized city of Regina, Canada. A summary of a series of interviews conducted in the spring of 1998 with its executive director, Lisa Brownstone, follows. Although Brownstone did not use the term *best practices* in the initial stages of setting up Career Headways, the approach used was clearly similar to the approach discussed in this article, and, in retrospect, Brownstone identifies it as such. The motivation for the choices made was "to build a workplace that was a satisfying one for the people who worked there and delivered the needed services for the people who were coming through the door . . . something that would evolve out of the needs of people with acquired brain injury."

In Brownstone's view, a number of elements exist in the Career Headways program that meet what she would define as best practices criteria:

- It has measurable goals and objectives. "The whole organization is now set up on a goals and objectives basis. And it's all measurable."
- It is participant driven. "The program is the participants' program . . . they're in the driver's seat, we're the driving instructor. They're the ones who are driving it." This occurs through ongoing consultation with participants concerning what's working and what's not and an "open-door" policy to allow for informal feedback. In addition, participants set their own program goals.
- It is evolutionary. "It evolves with the knowledge base. The dream that we started with is very different from what's in place here . . . it's constantly evolving and changing and getting better . . . 'best practices' equals constant improvement, or constant questioning, and always knowing that there's more to learn, and there's always a better way. And that's really critical here. There's a constant making sure that we're delivering the right program to the right people, and that they're getting the most out of it that they possibly can." For example, "with the actual programming, we started with staff developing a plan of action about how they were going to work treatment, and they spent a month and a half before participants arrived, developing that and setting it up—and threw it out the first week the participants were on board. It didn't work. And slowly we've been evolving it ever since. So it's been a year

> and a half of evolution. And it evolves based on staff perceptions and participant feedback."

Based on information provided through the interviews, the Career Headways program meets the best practices criteria that we have defined in another section of this article in a number of ways. These are described below.

Its processes and strategies reflect health promotion values and goals. For example, implicit in the program's overall goal is the desire to increase participants' opportunities to have as high a quality of life as other people; in other words, a desire for equity.

Another program value and goal relates to empowerment; for example, in terms of aiming to have participants "living independently" and increasing their control: "They're taking control back, they're people whose lives had become totally enmeshed in the medical system, and totally enmeshed and dependent on others."

Empowerment is strongly connected to the goal and value of power sharing and participation by all key stakeholders. Thus, at the participant level,

> I meet with the participants quarterly as a group and I have a series of questions that I ask them that allows us to explore the degree to which they find the program acceptable. . . . I then take [participants' feedback] to the staff, and we adapt the program according to the feedback.

Brownstone gives an example of this:

> Everybody who comes onto the program hates testing. They've gone through a phenomenal amount of testing before they've seen us, and they come here and here's yet another set of tests. So we thought that we would make it easier by basically doing testing a little bit here and there over a period of a full month. And they hated that. They wanted to get it over with. We had to throw out the first plan . . . now, the bulk of the testing is done in a two week period. That was participant feedback that drove that change.

Participants are also directly involved in directing day to day activities: Participants "set their goals, their tasks for the week, and then they bring us those tasks, and Monday afternoon the staff meet and actually set up the week's schedule based on the participants' tasks."

At the staff level, staff are involved in decision making concerning programming, ranging from mission and values to deadlines and content: "Staff . . . are always in on the ground floor of whatever's evolving." For example, "one of the areas we needed to do some real work on was what happens around behavioral incidents. And so I developed a policy and procedure based on the feedback from staff."

As a direct result of participant feedback, "Over time we're gradually involving family members more and more as well."

At the board level, members include a combination of professionals and people in the community with stakes in the situation, ranging from frontline vocational counselors to a graduate of the program.

In addition to community representation on the board, "We're now working on a survey to go to people who have left the program, and the next on the list will be developing a survey for payers and community agencies."

Its processes and strategies reflect health promotion theories and beliefs. For example, a holistic approach to health is taken. "We work with not just the physical being but . . . the emotional being, to some degree the spiritual being. It's the whole person we're working with, not just one category, one area."

Its processes and strategies reflect health promotion relevant evidence. Evidence on which to base decisions and plan programming has been drawn from a wide range of sources: published literature, unpublished material, staff and board members' experiences and understanding, feedback from participants, information from other agencies and individuals inside and outside the field, the internet, funders, participants' community workers, and results from regular evaluations of all program components. Both objective and subjective evidence are considered; for example, assessments of participants' progress through standardized tools and through direct input from participants themselves. Both quantitative and qualitative evidence are considered:

> The concrete results that we're seeing already are that the outcome measures that we use to look at power, the degree to which a person feels that they have control over their lives, are showing very, very favorable changes. That's a very numerical result. The feedback that we get from participants [a qualitative result] is that it is very difficult, taking responsibility for your own life is very difficult, and there are moments in which they would prefer that we take responsibility for their lives, but in the end, as they progress through the

> program, they really appreciate it and realize how important that is for them.

Its processes and strategies reflect a health promotion understanding of the environment. Brownstone talks about the critical importance of "climate," or, in health promotion terms, the necessity for a supportive environment:

> I think the climate is really critical. The setting up of an atmosphere that says to the participants, "This is your place, and this is your program, and this is your life, and you need to take control and make use of the opportunities you have in being here, and through that opportunity build more opportunities for yourself and your whole life." And I think that's a critical piece of the puzzle, here, in terms of best practices. And whenever I have a chance, I say, and I think that the staff say, "The door is open, you have concerns about your program, concerns about anything that's going on here, you let us know."
>
> For the staff, the climate is a very supportive board, knowing that that's there, that there isn't a fight. In a lot of agencies, there's this kind of pressure between board and staff, and that isn't there. So that's part of the climate as well, climate of support.
>
> The actual physical plant is also important. So often people with disabilities, because of funding of programs, end up in industrial areas. It's very important to me that we have a very nice central location that is as bright as possible in terms of lighting and those kinds of things, so that the feel of the agency when you walk through the doors is welcoming and light and open.

Another factor important to climate is

> hiring people who are very good at what they're doing, aren't territorial, and aren't afraid to try out new things—[who] aren't afraid to say, "that one didn't work, let's see what I can try next. How can I do this differently so it will work better?"

There are also attempts to address specific challenges in the working environment. Lack of time is one major issue, making it, for example, "very, very hard to consistently carve out time to assess the outcomes, and change the practice depending on those." The agency response to the time issue is that "We're constantly trying to figure out ways that we can deliver quality but not burn ourselves out as staff. So we're spending some of this week looking at that."

Another challenge concerns the need for funding, which in some cases can constrain actions and undermine values. Career Headways has made the following attempt to reduce dependence on government funding:

> For those [participants] who have access to third party funders, we charge those third party funders, so that we're less reliant on government funding. And in the end that means that we're better off than other agencies who are more dependent on government funding. If, for instance, the majority of our funding came from the areas of government that fund employment, we would have to prove that most of our participants left here being employed—(a) that's not necessarily the goal of our participants, and (b) many people with a significant brain injury have difficulty becoming employed. So, chances of the majority of our folks being employed is pretty slight. If our funding is not tied to our participants becoming employed, we can focus on what's important to them.

Also with respect to funding, Brownstone commented, "I think it's very important to stick to your values and not allow funders to undermine that, or the potential for making money in other ways, to undermine that." As a result of this position, although doing evaluations for medical and/or legal purposes can be quite lucrative, the agency has decided to focus on participants' strengths instead: "And that means, instead of spending time in courts, staff is spending time with participants. But, easily, we could have been wooed by money."

A third major challenge concerns the scarcity of relevant measures resulting in the agency's response of creating them.

> While there are many semi or standardized measures that are being used with people with acquired brain injury, almost none of them have proved their worth with the population. So that's a challenge right on its own. The nice thing about that is that you feel like it gives you the opportunity to try out some measures that haven't been tried out and see if they hold some of the keys to the picture. It's very difficult to find a measure that can really satisfactorily show the kinds of changes that people with acquired brain injury go through. There can be some quite fine detail that can make the difference between somebody who's employable, for instance, and not employable. And many measures just look at, "are you able to work," they don't look at the gradation of skills, and the changes in skills.

In addition to attempting to address challenges, the agency recognizes potential facilitating factors and works with them. For example,

> the Career Headways board is made up of people from many different walks of life, mostly within health care. But all of them very strongly believe in the whole idea of the program, and so work together in an incredibly dynamic, supportive, exciting way. There are no hidden agendas.

Brownstone's conclusion concerning using a best practices approach is that

> I wouldn't consider anything else. If we're asking participants to be the best that they can be, then as a whole agency we have to require that of ourselves. We're an agency that's about change and if we're demanding participants to go through extraordinary changes in their lives then we certainly have to ourselves be willing to go through changes as an agency.

Chief among the compelling reasons for adopting a best practices approach to health promotion is the increased likelihood that health promotion goals will be achieved, such as optimal health for all, social justice, and empowerment. A best practices approach is similar to the "quality" movement (from which it draws some of its motivation and processes) in promising benefits that result from an increase in accountability to stakeholders, attention to evidence in support of practice, awareness of the internal environment, involvement of staff at all levels in an organization, and continuous improvement.

However, there are potential risks associated with the quality movement, with its trend toward developing guidelines, standards, and best practice norms; these risks will vary in nature and degree, depending on the approach chosen and the best practices criteria employed.

Thus, best practices in health promotion might be a response (whether implicit or explicit) to a sociopolitical climate that includes cost cutting by funders and an emphasis on financial rather than people-oriented values. In this context, funders might use a best practices approach to control health promotion program content and processes. However, more significantly, there is a risk that taking such an approach might not result in best practices in health promotion. The benefits to health promotion practice will depend on the philosophy and processes employed in identifying and developing best practices: Will it be a grassroots or a bureaucratic venture? Will it be voluntary or enforced?

This article outlines our conceptualization and operationalization of a best practices approach to health promotion. This is based on our own years of health promotion practice, our intimate awareness of ongoing developments in health promotion (including best practices in health promotion), and 3 years of intensive ongoing work that has focused specifically on identifying and implementing a best practices approach to health promotion (with invaluable support from the Best Practices Work Group of the Centre for Health Promotion, University of Toronto). As a result of this work, we define best practices in the following way:

> Best practices in health promotion are those sets of processes and actions that are consistent with health promotion values, theories, evidence, and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation.

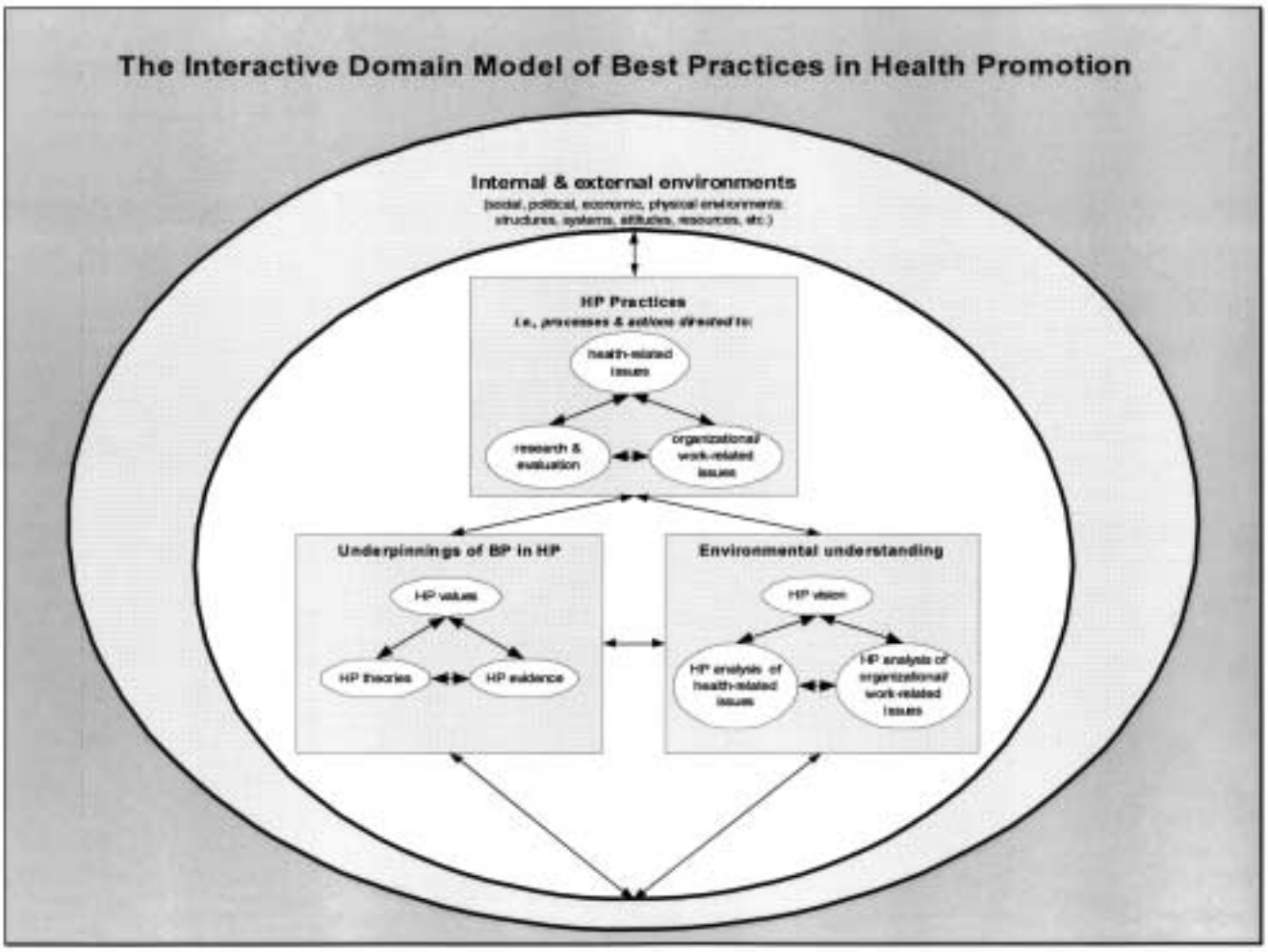
In this article, we do not attempt to prescribe specific best practices; rather, we present for consideration a best practices approach that will lead to the achievement of health promotion goals in any given situation. To encourage a broad-based dialogue and critical examination of issues related to best practices in health promotion, this article addresses three questions:

1. What factors shape health promotion best practices?
2. How can a best practices approach to health promotion be implemented?
3. What are the implications, for both practitioners and policy makers, of taking a best practices approach to health promotion?

FACTORS THAT SHAPE BEST PRACTICES

To address our first question, the present section discusses three domains of factors that shape best practices in health promotion, as shown in our Interactive Domain Model (IDM) of best practices in health promotion (see Figure 1). These domains relate to (a) the "underpinnings" or "foundations" of health promotion—that is, health promotion values and goals, theories and beliefs, and evidence; (b) a health promotion understanding of the internal and external environments; and (c) the processes and actions that constitute health promotion practice. As shown in Figure 1, each of the three domains includes a number of subdomains. Further-

FIGURE 1
The Interactive Domain Model of Best Practices in Health Promotion



more, the relationships among the domains are reciprocal: Each of the constituent parts affects, and is affected by, each of the others. Finally, all domains operate within the context of the immediate and broader environmental conditions.

Underpinnings

Values and Goals

Values are one component of the best practices underpinnings shown in Figure 1. In their practical manifestation, values are expressed in the form of goals. How people interpret and rank their values and goals affects their actions and their support for programs and policies initiated by others. For example, people who rank economic efficiency as more important than meeting human needs, in cases of conflict, may support cuts to social programs such as low-income housing. Clearly, values and goals constitute an important subdomain of influences that determine health promotion practice (Canadian Public Health Association, 1996; Coveney, 1998; Downie, Fyfe, & Tannahill, 1990; Last, 1992; Liss & Nikku, 1994; T. H. MacDonald, 1998; McCormick, 1994; Morgan, 1992; Pellegrino, 1984; Seedhouse, 1997; Vagero, 1995; Wallerstein & Freudenberg, 1998; Whitelaw & Whitelaw, 1996; Wikler, 1978). However, although there may be a general agreement regarding some of health promotion's fundamental values and goals (e.g., equity, empowerment, optimal health), health promotion practitioners and organizations have, generally, not defined the values and/or goals underlying their practice; explicitly identifying and defining these funda-

mental values and/or goals are major challenges to be faced, individually and collectively, in the practice of health promotion.

Theories and Beliefs

At their simplest level, theories are attempts to describe, explain, and predict events or phenomena in the most efficient manner (van Ryn & Heaney, 1992). Theories are not the exclusive domain of scientists (Buchanan, 1994); individuals base their beliefs and actions on their own understandings of the world (that is, they have personal or "lay" theories) (Milburn, 1996; Smith, Sullivan, Bauman, Powell-Davies, & Mitchell, 1999; Watson, Cunningham-Burley, Watson, & Milburn, 1996). Well-developed theories include a set of interrelated concepts that, in turn, are explicit statements or descriptions of ideas. Most lay and professional behavior/practice is guided by relatively simple concepts and theories rather than by fully elaborated theories. Health promotion conceptualization has not achieved a level of sophistication that allows us to refer to a single, coherent theory of health promotion; nevertheless, concepts, although not always acknowledged, are (and should be) a major influence in the practice of health promotion (Dahl & Birkelund, 1997; Dean, 1996; Dean & McQueen, 1996; Francisco, Paine, & Fawcett, 1993; Freudenberg et al., 1995; L. W. Green & Ottoson, 1994; Hafstad, Aaro, & Langmark, 1996; Howze, 1992; Jackson & Parks, 1997; McQueen, 1996).

The construction of theories and concepts is often related to more fundamental beliefs and assumptions about a range of issues, such as the nature of humankind, the nature of society, and the nature of knowledge. For example, the roles we assign to empowerment and community participation in health promotion practice depend, in part, on a number of beliefs and assumptions, such as "people are essentially selfish/generous"; "the root cause of society's ills is capitalism/too much government"; "individuals determine their own fates/our fates are determined by societal structures"; "reality can be known objectively/subjectively"; "there is a single reality/there are multiple realities."

Not surprisingly, differences in underlying beliefs and assumptions have led to confusion regarding the meaning and practice of health promotion; failure to articulate differences in beliefs and assumptions, as well as the logical implications of theories and concepts, exacerbates the problems associated with this confusion. It is, therefore, important to articulate and clarify understandings of theories and concepts of health promotion, including their relation to more fundamental beliefs and assumptions, and to take the steps necessary for reconceptualization and clarification. Health promotion practice, to be "best," must be based on clearly constructed, articulated, and understood theories, concepts, beliefs, and assumptions.

Evidence

As in many other fields (e.g., medicine, education, social services), health promotion is being pressured to base its practice on evidence. This raises many profound issues for the practice of health promotion: How is evidence defined? What evidence is acceptable? What are the sources from which evidence is drawn? How is evidence used? (Davies & G. MacDonald, 1998; Nutbeam, 1999; Perkins et al., 1999; Speller, Lear- mouth, & Harrison, 1997; Ziglio, 1997). Evidence can be qualitative or quantitative, subjective or objective, or a combination of these. Evidence can be a relatively static product or part of an ongoing evolutionary process. It can be derived from formal research and evaluation, from informal reflection on experience, or from practitioners' documentation of their practices and results. All forms of evidence are, in turn, influenced by other factors, including values and goals and assumptions about how knowledge is acquired and used.

There is a danger that, in striving for evidence-based practice, health promotion might be forced into taking an overly restricted view of evidence, especially through the adoption of randomized control trials as the "gold standard" evidence of effectiveness (as is the case with clinical studies; Tones, 1997; Van de Ven & Aggleton, 1999; World Health Organization European Working Group on Health Promotion Evaluation, 1998). If decision makers (e.g., funders and managers) limit their definition of best practices to those based on such narrowly defined evidence, they are unlikely to support many potentially valuable health promotion programs. In this context, the following admonition is worth noting:

> The current policy and political environment is one in which the debate on evidence-based health promotion may steer the search for evidence in a direction and with methods that do not fit health promotion . . . health promotion should maintain control over how "evi-

> dence" is defined. If we are passive, the danger is that particular approaches to evidence-based health promotion, and the utilization of specific methods to assess it, will be forced on us. (Ziglio, 1997, p. 5)

Choices about practice are always affected by evidence of one sort or another, ranging from one's gut feeling to what the scientific literature says, whether one is conscious of this or not. When defined appropriately for the health promotion context, evidence about the effectiveness of past actions points to health promotion practices that will help in achieving goals, and new evidence about the effectiveness of current actions (i.e., from evaluation) will suggest how to improve in the future. Of the highest priority is the further clarification of the meaning of evidence so that it is relevant within the health promotion context and consistent with health promotion values. Without health promotion–relevant evidence, best practices will remain elusive.

Understanding of the Environment

Understanding internal and external environments falls into three subdomains: (a) environmental vision; (b) analysis of the health-related issues, situations, and conditions within the environment; and (c) analysis of organizational- and work-related issues.

Environmental Vision

An adequate understanding of the environment requires a vision of a truly supportive (i.e., ideal) environment. Such a vision serves two important purposes: (a) it provides a picture of how surrounding conditions would be if they were consistent with underpinnings (i.e., consistent with values, theories, and evidence), and (b) it provides direction for work by highlighting differences between an ideal environment and concrete reality.

Analysis of Health-Related Issues

An appropriate environmental understanding includes identifying priorities among health-related issues, clarifying the etiologies of priority health-related issues, and identifying strategies to address the selected issues. Such an analysis should take account of the full range of environmental conditions that, on one hand, have an etiological influence on the health issue and, on the other hand, will facilitate or hinder effectiveness in addressing selected issues. This range of environmental conditions includes local and broad-based social, political, and economic systems and structures, as well as psychological and physical conditions. Using the health-related issue of nutrition as an illustration, an analysis would extend beyond the level of individual nutritional knowledge to include the influence of factors such as income level, geographical location, cultural background, and the wide range of governmental and corporate decision-making processes and policies related to food production, distribution, and cost.

Analysis of Organizational- and Work-Related Issues

Success in addressing selected health-related issues is greatly influenced by environmental factors that affect organizations (i.e., the influence of the external environment) and how organizations, in turn, affect work (i.e., the influence of the immediate environment). As with an analysis of health-related issues, an adequate environmental analysis of organizational- and work-related issues would take into account a broad array of organizational- and work-related factors, ranging from the state of staff morale to the availability of resources; it would also identify priorities, etiologies, and appropriate strategies related to increasing the supportiveness of the organization's and the practitioner's environments.

A Prerequisite for Meaningful Change

A health promotion understanding of the environment provides the basis for developing a response that will (a) address environmental factors that have an influence on the origins and continued existence of the selected health-related issues, (b) employ strategies that capitalize on environmental factors that will contribute to bringing about positive change with respect to the selected issue, and (c) render internal and external environments supportive of actions.

In other words, understanding the environment will help answer a number of questions that are critical to health promotion practice: What, in the environment, should be changed to achieve optimal health? What should be done to bring about significant change? What capacities or resources are needed (or already exist) to help bring about these changes? How can daily work lives be improved, thereby facilitating the effectiveness of the processes and actions that form the basis of health promotion practice?

Practice

The major subdomain of practice consists of the processes and actions required to address selected health-

related issues; this is supported by two other subdomains: (a) addressing organizational- and work-related factors that enhance or detract from an effective response to health issues (see Understanding of the Environment above), and (b) carrying out research and evaluation to gain further knowledge and understanding regarding the nature of the selected health issue and how to respond to it in the most effective manner (see Evidence above).

Because of the interrelationships among these three aspects of health promotion practice, each subdomain supports, and has implications for, each of the other subdomains. For example, research and evaluation contribute not only to the effectiveness of processes and actions directed at selected health issues, they also contribute to the ability to address relevant organizational and work factors. Similarly, it is crucial to recognize that the domain of practice has reciprocal effects on the domains related to the underpinnings of health promotion and understanding of relevant environments. Practice is, in a sense, the testing ground for what is thought to be known and understood about health-related issues and how to most effectively respond to these issues.

Environmental Conditions

Each of the domains of factors shown in the IDM (see Figure 1) affects, and is affected by, the environmental conditions within which people live and work. These are the conditions practitioners are addressing in relation to understanding and responding to health-, organizational-, and work-related issues (see Understanding of the Environment above). Environmental factors influence what people observe and experience, how they interpret their observations and experiences, and how their actions are supported or impeded.

IMPLEMENTING A BEST PRACTICES APPROACH TO HEALTH PROMOTION

Two steps are required to answer our second question, "How can a best practices approach to health promotion be implemented?" First, practitioners must identify the practices that are appropriate to a given situation; that is, that take into account the many aspects of best practices identified in the domains discussed in previous sections. Second, the identified best practices must be implemented. We have developed (and pilot tested) an Operational Framework that provides practitioners with a process for accomplishing these two steps, that is, identifying and implementing practices based on the IDM of best practices in health promotion.

Identifying Best Practices

At its most basic level, identification of best practices occurs when a practitioner notes (often informally) that one activity works better than another, or when groups of practitioners share information about what works best. However, a strong argument can be made for developing a more systematic method for identifying best practices, one that encourages the continuous development and evolution of guidelines and criteria based on feedback from practitioners' experiences.

Guidelines for Identifying Best Practices in Health Promotion

Guidelines for health promotion practice, whether specific or general, exist in a variety of forms: as an outline of health promotion principles, a list of characteristics to include in health promotion projects, a series of steps to follow for different health promotion activities, a set of questions to ask during planning and evaluation, a checklist of points to consider, or health promotion logic models for planning, implementing, and evaluating health promotion programs.

Freudenberg et al. (1995), for example, provided guidelines for effective health education that might be applicable to taking a best practices approach to health promotion. According to Freudenberg et al., health education interventions (or, for our purposes, health promotion interventions[1]) should

1. be tailored to a specific population within a specific setting;
2. involve participants in planning, implementation, and evaluation;
3. integrate efforts aimed at changing individuals, social and physical environments, communities, and policies;
4. link participants' concerns about health to broader life concerns and to a vision of a better society;
5. use resources within the environment;
6. build on the strengths found among participants and their communities;
7. advocate for the resources and policy changes needed to achieve the desired health objectives;
8. prepare participants to become leaders;
9. support the diffusion of innovation to a wider population; and
10. seek to institutionalize successful components and to replicate them in other settings.

A sample of other health promotion guidelines (with only two points provided from each example's longer list) includes the following:

- Characteristics of good practice in health promotion (Evans et al., 1994, pp. 10-11):
  1. "An agreed philosophy" (including guiding principles, values, and ethics), and
  2. "Consumer involvement."
- A checklist of key points for moving toward a health-promoting organization (Simnett, 1995, p. 13)
  1. "is based on a concept of health which includes the interaction of physical, mental and social aspects," and
  2. "views the development of a positive self-image and individuals taking increasing control of their lives as central to the promotion of good health."
- Strategic principles that guide health promotion (Canadian Public Health Association, 1996, p.2):
  1. "Health promotion addresses health issues in context. It recognizes that many individual, social and environmental factors interact to influence health. It searches for ways to explain how these factors interact to plan and act for the greatest health gain."
  2. "Health promotion draws on knowledge from a variety of sources. It depends on formal knowledge from the social, economic, political, medical and environmental sciences. It also depends on the experiential knowledge of people."
- Principles underlying best practices in health promotion by the Best Practices Work Group, Centre for Health Promotion, University of Toronto (included in Kahan & Goodstadt, 1998, p. 11):
  1. "*Theoretical understanding of health and its determinants*: Best Practices in health promotion both reflect and contribute to a theoretical understanding of health."
  2. "*Available resources*: Best Practices in health promotion make effective use of available resources in achieving the goals of health promotion."
- Guidelines for designing and evaluating health promotion programs on the basis of ecological principles (Stokols, 1996, p. 288) follow
  1. the ecological principle "Personal characteristics and environmental conditions often have interactive as well as direct effects on well-being" and
  2. its corresponding procedural guideline, "Examine the joint influence of behavioral, dispositional, developmental, demographic factors on people's exposure and responses to environmental hazards and demands."

Suggested Criteria for Best Practices in Health Promotion

In Table 1, we provide examples of criteria and guiding principles that might be employed with respect to each domain of the IDM (see Figure 1). We derived these criteria from several sources, including

- our understanding of factors that help shape best practices, as discussed in previous sections;
- the work of our Centre for Health Promotion's Best Practices Work Group;
- other guidelines (see examples, above); and
- other sources (e.g., Canadian Public Health Association, 1997; Denzin & Lincoln, 1994; Determinants of Health Working Group, 1997; Federal Provincial and Territorial Advisory Committee on Population Health, 1994; Frank, 1995; Goodstadt, 1996; Hamilton & Bhatti, 1996; Labonte, 1997; McKnight, 1985; McLaughlin & Kaluzny, 1994; Naidoo & Wills, 1995; National Forum on Health, 1996; Shadish, 1995; Stone, 1988; Wallerstein, 1992; World Health Organization, 1986).

The IDM Operational Framework for Identifying and Implementing Best Practices in Health Promotion

A recent study of health promotion professionals and practitioners identified a need for help in identifying, developing, and implementing best practices in health promotion (Kahan et al., 1999). The IDM Operational Framework (see Table 2) is our response to this need. This framework incorporates two features: (a) On its horizontal dimension, it employs a familiar sequence of seven steps required to plan, implement, and evaluate initiatives; and (b) on its vertical dimension, it uses the IDM (see Figure 1) as a filter that accompanies each of the seven steps. Table 3 provides "trigger" questions to guide practitioners in their use of the IDM Operational Framework.

In essence, the IDM Operational Framework (which we are currently field testing) involves a step-by-step process that progresses through four stages (i.e., diagnosis, planning, implementation, and evaluation) with respect to each of the three domains of the IDM. This framework can help practitioners in two ways: It provides a way for them (a) to develop their own criteria (i.e., health promotion–based ideal) by which they can identify and assess alternative actions, and (b) to develop action plans that are consistent with health promotion underpinnings and a health promotion understanding of the environment.

TABLE 1
Suggested Health Promotion Best Practices Criteria and Guiding Principles

Best practices in health promotion occur when the processes and actions relating to health-related issues, organizational- and work-related issues, and research and evaluation reflect criteria related to each of the following domains: (a) health promotion values/principles/goals/ethics, (b) health promotion theories/concepts/underlying beliefs and assumptions, (c) health promotion relevant evidence, (d) a health promotion understanding of internal and external environments, and (e) health promotion processes and actions. Examples of criteria and guiding principles within each of these domains are given below.

Underpinnings

Values	Health • Optimal health for all Social justice • Equity (the fair distribution of resources) • Respect for diversity Power sharing • Reduction of power differentials • Individual and community empowerment • Participation by relevant stakeholders in decision making, partnerships, etc. • Individual and community capacity development The environment • Ecological respect and sensitivity Enrichment of individual and community life • Authenticity • Creativity • Critical reflection • Joy • Meaningfulness • Social connectivity
Theories and beliefs	Underlying beliefs • Health is positive, holistic, multilevel, and strongly influenced by the determinants of health. • Change will occur only through an intersectoral effort. • Collectively, people have the innate capacity to identify and resolve the issues facing them. Theories should • be drawn from a wide variety of disciplines; • be appropriate to the level of analysis and intervention, that is, individual, immediate environments, and social structures; • be used in an integrated way; • be used at each stage of the practice, that is, in planning, implementation, and evaluation; • contribute to understanding the nature and origins of issues/problems; and • contribute to understanding how to make a difference, change, or influence.
Evidence	Evidence should • be used at each stage of practice; • include results/outcomes related to past and current practice (both internal and external to the particular initiative); • include the relationship between these results/outcomes and processes; • be both qualitative and quantitative, and subjective and objective—such evidence should be used in a complementary fashion; • use a variety of methods and sources; • derive from ongoing research and evaluation that draws on a wide variety of sources, including all key stakeholders and relevant key informants; • contribute to continuous learning and knowledge building; • be reliable, trustworthy, and credible;

(continued)

TABLE 1 Continued

Underpinnings	
	• be appropriate to the issue, setting, etc.; • include information supporting new or nonmainstream ideas as well as information contradicting generally accepted ideas (i.e., not be restricted to information supporting conventional wisdom) and be reviewed and updated regularly.
Environmental understanding	
Vision	The vision of the internal and external environments should be consistent with and reflect health promotion goals and values, theories and beliefs, and evidence

Analysis of health-related issues	Environmental analysis of health-related issues should
	• identify priority health-related issues;
	• identify which priority health-related issue to address currently;
	• describe the selected health-related issue and how it is related to health;
	• describe the environment within which the selected issue exists with respect to social, political, and economic systems and structures; psychological conditions; and physical conditions;
	• identify the etiology of the selected health-related issue;
	• identify how to positively influence the issue;
	• identify existing/potential capacities and challenges that exist in the internal and external environments related to positively influencing the issue;
	  • identify how to best make use of/enhance current/potential capacities; and
	  • identify how best to deal with/minimize current/potential challenges.
	Selection of the issue should
	• be based on appropriate participation by relevant stakeholders;
	• reflect the influence of the broader determinants of health (including their structural origins); and
	• give attention to power-related issues and the potential role of empowering strategies.
	The selected issue should
	• be winnable,
	• be specific,
	• unite members of the group,
	• involve them in a meaningful way in achieving problem solution, and
	• be part of a larger plan or strategy.

Analysis of organizational- and work-related issues	Environmental analysis of organizational- and work-related issues should
	• describe the organizational- and work-related internal and external environments with respect to social, political, and economic systems and structures; psychological conditions; and physical conditions;
	• identify which environmental elements are supportive or detrimental to health promotion organizations/work;
	• identify priority organizational- and work-related issues (i.e., supportive elements to enhance or detrimental elements to diminish);
	• identify which priority issue to address currently;
	• identify the etiology of the selected organizational- or work-related issue;
	• identify existing/potential capacities and challenges in the internal and external organizational/work environments related to positively influencing the selected organizational- or work-related issue;
	  • identify how to best make use of/enhance current/potential capacities; and
	  • identify how best to deal with/minimize current/potential challenges.

Practice (processes and actions)	Processes and actions relating to selected health-related and organizational- and work-related issues and to research and evaluation should reflect • health promotion values/principles/goals/ethics, • health promotion theories/concepts/underlying beliefs and assumptions, • health promotion–relevant evidence, and • a health promotion understanding of internal and external environments.

TABLE 1 Continued

Environmental understanding	
Processes	Processes should be • empowering, • capacity building, • team/community building, • participatory, • respectful of differences, • supportive, • flexible, and • health enhancing.
Actions	A multistrategy approach should be used that includes a combination of the following strategies: • health education, • health communication, • community organization and development, • organizational development and change, • advocacy, • policy development, • intersectoral collaboration, • self-help, • modeling, and • mediation. Strategies should be designed to respond to • the selected health-related issues, and • the selected organizational- and work-related issues. Strategies should be multilevel (i.e., addressing individuals, immediate environments, and social structures); if this is not possible, they should be implemented with an awareness of the limitations of a single-level approach and with the intent of complementing the other two levels to the extent possible Actions directed to research and evaluation of strategies and processes should be ongoing.

Table 4 provides an example of how the IDM Operational Framework might be applied to the issue of breast cancer by a hypothetical, community-based organization (i.e., Against Breast Cancer) with respect to its underlying values and evidence base.

IMPLICATIONS FOR PRACTITIONERS AND POLICY MAKERS

The third question posed at the beginning of this article was "What are the implications, for both practitioners and policy makers, of taking a best practices approach to health promotion?" It is apparent that two notable characteristics of our IDM Operational Framework have major implications for both practitioners and policy makers: (a) the framework emphasizes the importance of taking a "critically reflective" approach to identifying and applying best practices in health promotion, and (b) the framework provides a means for optimizing benefits and minimizing risks associated with taking such an approach.

Taking a Critically Reflective Approach

There is a major assumption underlying our consideration of the identification and implementation of best practices in health promotion. This assumption is that the quality and value of practice depends on the awareness, articulation, clarity, and reflection associated with each of the domains included in the IDM (Figure 1); in combination, this awareness, articulation, clarity, and reflection constitute a critically reflective approach.

- Awareness: Without awareness, ideas, feelings, actions, and conditions cannot be scrutinized or addressed. Without awareness, they remain unrecognized and unnamed; if they change, it is by accident

(text continues on p. 64)

TABLE 2
The Interactive Domain Model Operational Framework for Identifying and Implementing Best Practices in Health Promotion (HP)

	Diagnosis				*Step 5: Planning (developing an action plan to bring about changes identified in Step 4)*					*Step 6: Implementation of action plan*	*Step 7: Evaluation*
	Step 1: Describe current issue/ situation and current response	*Step 2: Identify HP ideal (i.e., criteria, guidelines, etc.)*	*Step 3: Apply HP ideal to current situation; that is, develop a blueprint of what the current situation/ response would be like if it were consistent with HP ideals identified in Step 2*	*Step 4: Identify changes required in current situation/response (Step 1) to develop or follow blueprint described in Step 3; that is, what should stop, start, stay the same, be done differently*	*What actions are needed to bring about the changes identified in Step 4?*	*What available and additional resources are required to implement identified actions? What actions are required to get the required resources?*	*Who will do what re the identified actions (re changes and resources)?*	*When will the actions be done (timeframes and timelines)?*	*Which measurable objectives re identified actions will be used?*	*Implement action plan developed in Step 5*	*Evaluate action plan implemented in Step 6 and revise plan accordingly*
Underpinnings											
Values and goals											
Theories and beliefs											
Evidence											
Environmental understanding											
Vision of desired environments											
Analysis of health-related issues											
Analysis of organizational- and work-related issues											
Practice (processes and actions)											
Response to health-related issues											
Response to organizational- and work-related issues											
Research and evaluation											

TABLE 3
The Interactive Domain Model Operational Framework: Guiding Questions

	Diagnosis				*Step 5: Planning (developing an action plan to bring about changes identified in Step 4)*					*Step 6: Implementation of action plan*	*Step 7: Evaluation*
	Step 1: Describe current issue/ situation and current response	*Step 2: Identify HP ideal (i.e., criteria, guidelines, etc.)*	*Step 3: Apply HP ideal to current situation; that is, develop a blueprint of what the current situation/ response would be like if it were consistent with HP ideals identified in Step 2*	*Step 4: Identify changes required in current situation/response (Step 1) to develop or follow blueprint described in Step 3; that is, what should stop, start, stay the same, be done differently*	*What actions are needed to bring about the changes identified in Step 4?*	*What available and additional resources are required to implement identified actions? What actions are required to get the required resources?*	*Who will do what re the identified actions (re changes and resources)?*	*When will the actions be done (timeframes and timelines)?*	*Which measurable objectives re identified actions will be used?*	*Implement action plan developed in Step 5*	*Evaluate action plan implemented in Step 6 and revise plan accordingly*
Underpinnings											
Values and goals	What are the organization's or project's goals and values?	What are the goals and values of HP?	What would the organization's or project's goals and values look like if they were consistent with the HP ideal?	To ensure consistency with the organization's or project's goals and values as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re goals and values	. . . re goals and values	. . . re goals and values	. . . re goals and values	. . . re goals and values	. . . re goals and values	. . . re goals and values
Theories and beliefs	What are the organization's or project's theories, concepts, assumptions, and beliefs?	What are the theories, concepts, assumptions, and beliefs underlying the practice of HP?	What would the organization's or project's theories etc., look like if they were consistent with the HP ideal?	To ensure consistency with the organization's or project's theories, etc., as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re theories, etc.	. . . re theories, etc.	. . . re theories, etc.	. . . re theories, etc.	. . . re theories, etc.	. . . re theories, etc.	. . . re theories, etc.
Evidence	What evidence is the organization or project using to make decisions about its work or proposed work? What evidence exists re the effectiveness of the organization's or project's work or proposed work?	What is the role and nature of evidence with respect to the practice of HP?	What kind of evidence (existing or potential) re effectiveness would the organization or project use to be consistent with the HP ideal?	To ensure consistency with the organization's or project's evidence as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re using and obtaining evidence	. . . re using and obtaining evidence	. . . re using and obtaining evidence	. . . re using and obtaining evidence	. . . re using and obtaining evidence	. . . re using and obtaining evidence	. . . re using and obtaining evidence

(continued)

TABLE 3 Continued

	Diagnosis				*Step 5: Planning (developing an action plan to bring about changes identified in Step 4)*					*Step 6: Implementation of action plan*	*Step 7: Evaluation*
	Step 1: Describe current issue/ situation and current response	*Step 2: Identify HP ideal (i.e., criteria, guidelines, etc.)*	*Step 3: Apply HP ideal to current situation; that is, develop a blueprint of what the current situation/ response would be like if it were consistent with HP ideals identified in Step 2*	*Step 4: Identify changes required in current situation/response (Step 1) to develop or follow blueprint described in Step 3; that is, what should stop, start, stay the same, be done differently*	*What actions are needed to bring about the changes identified in Step 4?*	*What available and additional resources are required to implement identified actions? What actions are required to get the required resources?*	*Who will do what re the identified actions (re changes and resources)?*	*When will the actions be done (timeframes and timelines)?*	*Which measurable objectives re identified actions will be used?*	*Implement action plan developed in Step 5*	*Evaluate action plan implemented in Step 6 and revise plan accordingly*
Environmental Understanding											
Vision of desired environments	What is the organization's or project's vision of its internal and external environments?	What vision of the environment, consistent with HP goals and values, theories and beliefs, and evidence, guides HP practice?	What would the organization's or project's vision of its internal and external environments look like, if it were consistent with the HP ideal?	To ensure consistency with the organization's or project's vision of its internal and external environments as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re environmental vision	. . . re environmental vision	. . . re environmental vision	. . . re environmental vision	. . . re environmental vision	. . . re environmental vision	. . . re environmental vision
Analysis of health-related issues	How does the organization or project currently define or analyze the health-related issues in its environment? Which health-related issues are priorities? Which of the priority health-related issues should be selected by the organization or project? What is the etiology of the selected issue? What is required to make a difference to the selected issue?	How would HP define or analyze health-related issues in its internal and external environments with respect to priorities, etiology, pathways to positive change, capacities, and challenges, if it is to be consistent with HP goals and values, theories and beliefs, and evidence?	What would the organization's or project's environmental analysis of health-related issues look like, if it were consistent with the HP ideal?	To ensure consistency with the organization's or project's environmental analysis of health-related issues as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re environmental analysis	. . . re environmental analysis	. . . re environmental analysis	. . . re environmental analysis	. . . re environmental analysis	. . . re environmental analysis	. . . re environmental analysis

Analysis of organizational- and work-related issues	How does the organization or project currently define or analyze the organizational- and work-related issues in its environment? Which organizational- and work-related issues are priorities? Which of the priority organizational- and work-related issues should be selected by the organization or project? What is required to make a difference to the selected issue?	How would HP define or analyze organizational- and work-related issues in its internal and external environments with respect to priorities, etiology, pathways to positive change, capacities, and challenges, if it is to be consistent with HP goals and values, theories and beliefs, and evidence?	What would the organization's or project's environmental analysis of organizational- and work-related issues look like, if it were consistent with the HP ideal?	To ensure consistency with the organization's or project's environmental analysis of organizational- and work-related issues as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re environmental analysis	. . . re environmental analysis	. . . re environismental analysis	. . . re environmental analysis	. . . re environmental analysis	. . . re environmental analysis	. . . re environmental analysis
Practice (processes and actions)											
Response to selected health-related issues	What processes and actions does the organization or project use to respond to its selected issue(s)?	What processes and actions, consistent with HP goals and values, theories and beliefs, evidence, and understanding of the environment, form the HP response to selected health-related issues?	What would the organization's or project's processes and actions that form the response to selected health-related issues look like, if they were consistent with the HP ideal?	To ensure consistency with the organization's or project's processes and actions related to its response to selected issues as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re response to selected health-related issues	. . . re response to selected health-related issues	. . . re response to selected health-related issues	. . . re response to selected health-related issues	. . . re response to selected health-related issues	Implement action plan to make processes and actions forming the response to selected health-related issues consistent with HP underpinnings and environmental understanding	. . . re response to selected health-related issues
Response to selected organizational- and work-related issues	What processes and actions form the organization's or project's response to its organizational- and work-related issues?	What processes and actions, consistent with HP values and goals, theories and beliefs, evidence, and understanding of the environment, form the HP response to selected organizational- and work-related issues?	What processes and actions should or could form the organization's or project's response to selected organizational- and work-related issues to be consistent with the HP ideal?	To ensure consistency with the organization's or project's processes and actions related to its response to selected organizational- and work-related issues as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re response to organizational- and work-related issues	. . . re response to organizational- and work-related issues	. . . re response to organizational- and work-related issues	. . . re response to organizational- and work-related issues	. . . re response to organizational- and work-related issues	Implement action plan to make processes and actions forming the response to organizational- and work-related issues consistent with HP underpinnings and environmental understanding	. . . re response to selected organizational- and work-related issues

(continued)

TABLE 3 Continued

	Diagnosis				*Step 5: Planning (developing an action plan to bring about changes identified in Step 4)*					*Step 6: Implementation of action plan*	*Step 7: Evaluation*
	Step 1: Describe current issue/ situation and current response	*Step 2: Identify HP ideal (i.e., criteria, guidelines, etc.)*	*Step 3: Apply HP ideal to current situation; that is, develop a blueprint of what the current situation/ response would be like if it were consistent with HP ideals identified in Step 2*	*Step 4: Identify changes required in current situation/response (Step 1) to develop or follow blueprint described in Step 3; that is, what should stop, start, stay the same, be done differently*	*What actions are needed to bring about the changes identified in Step 4?*	*What available and additional resources are required to implement identified actions? What actions are required to get the required resources?*	*Who will do what re the identified actions (re changes and resources)?*	*When will the actions be done (timeframes and timelines)?*	*Which measurable objectives re identified actions will be used?*	*Implement action plan developed in Step 5*	*Evaluate action plan implemented in Step 6 and revise plan accordingly*
Research and evaluation	What processes and actions does the organization or project use to carry out research and evaluation?	What processes and actions, consistent with HP goals and values, theories and beliefs, evidence, and understanding of the environment, form the basis for HP research and evaluation?	What would the organization's or project's processes and actions that form the basis for research and evaluation look like, if they were consistent with the HP ideal?	To ensure consistency with the organization's or project's research and evaluation processes and actions as outlined in its HP blueprint, what should stop, start, stay the same, be done differently?	. . . re research and evaluation	. . . re research and evaluation	. . . re research and evaluation	. . . re research and evaluation	. . . re research and evaluation	Implement action plan to make processes and actions consistent with HP underpinnings and environmental understanding	. . . re research and evaluation

NOTE: HP = health promotion.

TABLE 4
Hypothetical Application of Interactive Domain Model Operational Framework to the Issue of Breast Cancer

	Diagnosis				*Step 5: Planning (developing an action plan to bring about changes identified in Step 4)*				
	Step 1: Describe current issue/situation and current response	*Step 2: Identify HP ideal (i.e., criteria, guidelines, etc.)*	*Step 3: Apply HP ideal to current situation; that is, develop a blueprint of what the current situation/response would be like if it were consistent with HP ideals identified in Step 2*	*Step 4: Identify changes required in current situation/ response (Step 1) to develop or follow blueprint described in Step 3; that is, what should stop, start, stay the same, be done differently*	*What actions are needed to bring about the changes identified in Step 4?*	*What available and additional resources are required to implement identified actions? What actions are required to get the required resources?*	*Who will do what re the identified actions (re changes and resources)?*	*When will the actions be done (timeframes and timelines)?*	*Which measurable objectives re identified actions will be used?*
Values	Current values listed by members of the ABC executive • Good health • Quality of life • Prevention versus treatment • Empowerment of women with breast cancer • Self-determination • Respect for different opinions • Accessibility of services for all women • Community participation • Ongoing learning • Being supportive of others • Efficiency • Cost effectiveness • Sustainability The only values initially listed by all members were health, accessibility of services, and prevention	"Ideal" values agreed on by the executive group • Health • Social justice • The individual • Community • The environment Guiding principles • The whole organization will participate in identifying and defining values • Values are reviewed on a regular basis	• Health: increase/enhance health of women with breast cancer; prevent breast cancer in other women; support the health of those who live or work with women with breast cancer (e.g., family members, health professionals) • The individual: that women with breast cancer are treated with respect and dignity; that diversity is accepted, appreciated, and accommodated for (in terms of cultural differences, differences in treatment choices, etc.) • Social justice: ensure that all women with breast cancer have equitable access to services by addressing barriers that might affect some women more than others, that gender inequities within the health care system affecting women with breast cancer adversely are redressed, that women with breast cancer are full participants in making decisions concerning themselves and have as much control over their lives as possible (as long as others are not negatively affected), and that all women with breast cancer are able to enjoy the highest possible quality of life • Community: that positive interactions and links among women with breast cancer, their friends and families, and others will be fostered so that social and practical support is available when necessary • The environment: ensure that all environments surrounding women with breast cancer will be as supportive as possible, and that the environment and its associated resources will be respected as much as possible when addressing breast cancer issues so that resources will not be wasted or damaged	• Bring this values piece forward to the membership for discussion. • Decide whether to aim for consensus and how to handle disagreements constructively. • Make sure that there is a process in place to ensure that the actions we choose reflect our values. • Put in place a process so that values will be reviewed regularly.	• Distribute to membership the values drafted by executive. • Ask for written or oral feedback. • Call a meeting to discuss ABC's values: set a time, book space, send out notices, find someone who is skilled at consensus building and dealing with disagreements constructively to facilitate the meeting. • Set up a values committee that will be responsible for organizing processes to ensure that ABC's actions reflect values and that values are reviewed regularly.	• Time (available in small amounts; works best for group if spread out over a longer period) • Meeting space (available room in local church) • Expertise: one member knows a consultant in organizational development who might be a good facilitator or might be able to recommend one • Volunteers: to be on values committee • Desire and commitment to follow through (enthusiastically available); for example, designing, producing and distributing notice; collecting feedback from members	• A plan was drawn up detailing who is to do what with respect to specific actions and obtaining required resources, when each action will be completed by, and measurable objectives. • It was agreed that the results will be used to revisit Step 3; that is, possibly to revise values so that they are acceptable to the group as a whole, and to have specific processes in place for regularly reviewing values and their role in ABC.		

(continued)

TABLE 4 Continued

	Diagnosis				*Step 5: Planning (developing an action plan to bring about changes identified in Step 4)*				
	Step 1: Describe current issue/situation and current response	*Step 2: Identify HP ideal (i.e., criteria, guidelines, etc.)*	*Step 3: Apply HP ideal to current situation; that is, develop a blueprint of what the current situation/response would be like if it were consistent with HP ideals identified in Step 2*	*Step 4: Identify changes required in current situation/ response (Step 1) to develop or follow blueprint described in Step 3; that is, what should stop, start, stay the same, be done differently*	*What actions are needed to bring about the changes identified in Step 4?*	*What available and additional resources are required to implement identified actions? What actions are required to get the required resources?*	*Who will do what re the identified actions (re changes and resources)?*	*When will the actions be done (timeframes and timelines)?*	*Which measurable objectives re identified actions will be used?*
			• The whole membership of ABC will have an opportunity to identify and define ABC's values. • These values will be reviewed regularly to make sure we still agree with them and to make sure we are actively integrating them into ABC's work.						
Evidence	• Experiences of some group members were shared at the initial meeting and recorded; the membership at large has been requested to supply written summaries of their experiences and observations (whether in a personal or professional capacity). • One member has done a literature search on MEDLINE concerning screening issues (e.g., age and frequency for mammograms, breast self-exams). • Another member has started collecting material on pros and cons of using tamoxifen as a preventive. • Possible sources for demographic information (e.g., mortality and morbidity rates) were identified. • It was agreed there are many unknowns with respect to breast cancer and in some cases conflicting evidence. The group feels there is a need for more evidence concerning screening issues; the roles of diet, alcohol,	Evidence should • Include results/ outcomes of past and current practice (from both the specific project itself and other projects) and the relationship between these results/outcomes and processes • In content be qualitative and quantitative, and subjective and objective • Derive from ongoing research and evaluation, including individual and group critical reflection • Derive from a variety of methods and sources including key informants and key stakeholders • Contribute to continuous learning and knowledge building • Be reliable, trustworthy, and credible • Be appropriate to the issue, setting, etc. • Include information supporting new or nonmainstream ideas as well as evidence	• We will have a comprehensive set of information including the following: • Results of activities by groups similar to ABC (locally, nationally, internationally) and what contributed to these results (including processes) • Basic demographics of people with breast cancer in our area • Morbidity and mortality statistics according to subpopulations for our area • The range of opinions and data concerning breast cancer prevention (including traditional medical approaches and nontraditional complementary or alternative approaches) • The feelings, observations, and experiences of people directly affected by breast cancer in our area • The information we gather will be from • Women with breast cancer • Their families and friends • Professionals involved in breast cancer (e.g., health promotion practitioners, nurses, physicians, radiologists, counselors, etc.) • Researchers • Community breast cancer groups • Others with an interest in breast cancer (e.g., government bureaucrats, politicians, hospital administrators, etc.) • We will draw on written and oral sources. • Before acting on any of the information we collect, we will make sure it is	• Conduct comprehensive literature search and review on relevant breast cancer topics • Compile required statistics • Survey key informants and key stakeholders • Identify procedures for figuring out which information is appropriate to our area and which information is reliable • Produce bimonthly newsletter that will include column on evidence • Design evaluation processes	• Identify relevant journals, databases, organizations, key informants, and key stakeholders • Identify how to contact them (e.g., phone numbers, web site addresses, etc.) • Design collection tools such as interview/survey questions • Review what others have done in terms of criteria for judging which information is appropriate and reliable • Collect, synthesize, and analyze data • Organize the newsletter (solicit/write material, input it, lay it out, print it, distribute it, etc.) • Identify and review evaluation options • Set up committees to be responsible for tasks in their areas; for example, collecting evidence, producing newsletter, evaluating	• Volunteers to be on committees • Skills: library/ internet searches, research and evaluation, group, publications • Equipment: computer with internet access, printer, photocopier • Resource centers such as libraries • People who are willing to take on tasks • Time • Money for printing newsletter, long distance phone costs, postage, transportation, copying/obtaining material • Cooperation of key informants, key stakeholders, etc.	• A plan was drawn up detailing specifically who is to do what with respect to specific actions and obtaining required resources, when each action will be completed by, and measurable objectives • The results will be used to revisit Step 3; that is, to specify more concretely the blueprint for ongoing reference with respect to evidence

organochlorine compounds, hormone replacement therapy, radiation, lack of exercise, and electromagnetic fields in contributing to breast cancer; use of tamoxifen.	that contradicts generally accepted ideas (i.e., not be restricted to that supporting conventional wisdom) • Be reviewed and updated regularly	appropriate for our area's particular circumstances. • We will also scrutinize it critically to make sure it is reliable (e.g., believable sources, proper methodology, etc.). • We will make this information readily available to our members and to others who are interested through bimonthly bulletins. • We will review and update information regularly through an ABC evidence committee. • We will evaluate and review our own processes and activities on an ongoing basis, and synthesizing, making available, and acting on the results from these evaluations and reviews.

NOTE: Hypothetical scenario: Against Breast Cancer (ABC) was formed a couple of months ago, when over 50 people—women with breast cancer, family members, health professionals, and other concerned citizens—met to address the issue of breast cancer in their community. It was decided that the main goals would be prevention of breast cancer and improving quality of life for breast cancer survivors. ABC currently receives no funding from government, corporations, or other organizations; it is dependent on memberships, donations, and volunteer time. There is an elected executive but no paid staff. At the last meeting of the executive, the executive decided to use the Interactive Domain Model Operational Framework as a planning tool in the identification and implementation of a best practices approach to health promotion in addressing the issue of breast cancer. They set aside one day last month to begin applying the framework to their initiative. The table displays what they accomplished at that time concerning the application of the framework to values and evidence.

rather than design. Practitioners are often unaware of the beliefs and assumptions underlying health promotion practice, even though practice is extremely sensitive to these issues. Best practices in health promotion are only attainable if practitioners are conscious and aware of their own (and their society's) values, ideas, beliefs, and understandings.

- Articulation: Articulation is an essential precondition for dialogue about ideas and feelings related to health promotion practice; this dialogue, with its interchange of thoughts and feelings, increases synergy among health promotion practitioners and helps to define areas of convergence and divergence. Inadequate articulation of health promotion domains (and subdomains) has its origins in a number of factors, including lack of awareness (see above), failure to recognize the importance of the health promotion domains, and fear of conflict.
- Clarity: Without clarity, confusion reigns, resulting in a shallow understanding of the domains (and subdomains), their interrelationships, their relative importance, and their long- and short-term implications and consequences for practice. In addition, lack of clarity impedes discussions because in the absence of clearly articulated assumptions, it is difficult to determine where genuine agreement or disagreement lies. Although health promotion practitioners may employ a common language (i.e., use similar words), the meanings they attach to words such as *equity* and *empowerment* vary widely; this can result in the selection and implementation of inappropriate practice responses, thereby reducing health promotion's potential impact (Israel, Checkoway, Schultz, & Zimmerman, 1994; Rissel, 1994; Stevenson & Burke, 1992).
- Reflection: Without reflection, there can be little awareness or clarity. Reflection is the mirror that reveals things otherwise left hidden; it is the means by which concepts can be critically examined and revised, and by which internal contradictions can be recognized and eliminated. Reflection allows people to make judgments about what works and what is consistent with their values, and to apply what they have learned to current and future practice (Eakin & Maclean, 1992). Concerning reflection, Evans et al. (1994) wrote, "Rather than close our eyes to perceived failure, we should embrace experience as an effective form of learning and be willing to adapt future practice accordingly. Equally we should reflect on our successes to transfer the lessons to other situations which arise in the continuing development of health promotion services (p.12)."

Using violence against women as a concrete example, effective policies and actions are dependent on (a) being aware of the nature of violence against women and the extent to which it exists, so that appropriate action can be taken (in contrast to keeping the issue of violence against women hidden, and therefore ignored, as in the past); (b) articulating the issue in a way that brings it into the public realm, where it can be fully discussed (resulting in increased awareness of the issue and reduced inhibitions against speaking about violence against women); (c) achieving clarity, thereby enhancing our understanding and articulation of the issue, its impact, and how to address it—for example, women will no longer be blamed for the violence they suffer; and (d) reflecting on the nature and impact of our thoughts, words, and actions concerning violence against women in an effort to improve services, programs, and policies. In our example, this critically reflective approach (which does not necessarily occur in the linear fashion presented here) would be explicitly applied to each element of the IDM, that is, with respect to the values underlying the identification of violence against women as an issue worthy of attention, the theories and beliefs associated with the issue (e.g., "the cycle of violence"), the evidence supporting specific strategies to decrease the incidence of violence against women, an understanding of the environment with respect to this issue, and practice choices.

In conclusion, making a habit of fostering awareness, articulation, clarity, and reflection with respect to the various domains outlined in the IDM approach to best practices provides a solid basis for effective health promotion practice.

Optimizing Benefits, Minimizing Risks

In the opening section of this article, we mentioned benefits that can arise from taking a best practices approach to health promotion. A more complete list of desirable benefits includes the achievement of health promotion goals, increased accountability of health promotion practice to the general community, increased credibility of health promotion practice, and capacity building among everyone involved in health promotion initiatives. Examples of possible risks to minimize include erosion of health promotion values and goals, development of negative power relationships, loss of flexibility and creativity, restricted range of approved initiatives, and neglect of process issues.

As previously discussed, we are proposing that the best practices approach most likely to enhance potential benefits and to minimize potential risks is one that

- uses as its guideposts for daily practice health promotion values and goals, health promotion–relevant theories, beliefs, and evidence, and a health promotion understanding of the environment; and
- emphasizes the importance of critical reflection with respect to practice, so that practice is not static but is continually improving.

In addition, we propose that a best practices approach to health promotion enhances benefits and minimizes risks when it

- assumes that a best practices approach to health promotion should identify the multiplicity of best practices that are contingent on specific circumstances rather than identify a singular best practice (which might, in reality, be appropriate for a limited number of people or in only a few circumstances; McKenzie, 1997);
- is multilevel, involving specific roles and responsibilities for (a) community groups and other stakeholders; (b) health promotion organizations (acting in cooperation with community stakeholders, in broad-based partnerships with other health promotion organizations, or acting independently); and (c) practitioners, acting either individually or collectively;
- is based on general guidelines that (a) provide a framework that is flexible enough to be adapted to specific circumstances; (b) support the development of more specific guidelines to be applied to different aspects of health promotion practice and in different situations; (c) include clearly defined criteria against which to assess practice (whether these criteria are those suggested in Table 1, or derived from other sources); and (d) are developed by people with a thorough understanding of health promotion;
- encourages meaningful and respectful dialogue (together with creativity and experimentation) among stakeholders that is centered on a process of thinking through and articulating points of agreement and disagreement rather than promoting complete consensus as an ideal;
- is voluntary, self-monitored, and documents practice by observing and recording outcomes and impacts;
- emphasizes the relationship between the processes and outcomes involved in health promotion rather than favoring one at the expense of the other; and
- works to provide the resources required to implement the best possible best practices (e.g., time, funding, expertise, and tools).

From the perspective of policy makers, best practices in health promotion will be both appropriate and effective when policy makers

- use a best practices approach in their own work—one that follows the guidelines listed above to maximize benefits and minimize risks;
- develop and implement policies that reflect a best practices approach; and
- develop and implement policies that are supportive of a best practices approach.

EPILOGUE

Although there are many challenges to developing and implementing best practices in health promotion, a spirit of adventure will carry us far in overcoming them. Adopting a systematic and critically reflective approach that considers all the major factors that shape health promotion practice, as exemplified in the IDM and its corresponding Operational Framework, will increase the effectiveness of health promotion practice.

NOTES

1. Although it is important to distinguish health promotion from health education, recent developments in the conceptual, theoretical, and practice base of health education suggest that (a) there is considerable overlap between the two fields, and (b) this correspondence is likely to increase in the near future. For this reason, we will on occasion draw from theory and practice found in the (nominal) health education literature that "crosses over" and contributes to the field of health promotion (see, e.g., Capwell, 1997; L. W. Green, 1999; R. S. Green & Newman, 1999; and McKenzie, 1997).

2. For example, the Best Practices Work Group at the Centre for Health Promotion, University of Toronto and the Association of Ontario Health Centres Best Practices Committee.

REFERENCES

Boutilier, M., Cleverly, S., & Labonte, R. (2000). Community as a setting for health promotion. In B. Poland, L. Green, & I. Rootman (Eds.), *Settings for health promotion: Linking theory and practice* (pp. 250-307). Newbury Park, CA: Sage.

Buchanan, D. R. (1994). Reflections on the relationships between theory and practice. *Health Education Research*, *9*(3), 273-283.

Cameron, R., Walker, R., & Jolin, M. A. (1998). *International best practices in heart health*. Toronto, Canada: Heart Health Resource Centre.

Canadian Public Health Association. (1996). *Action statement for health promotion in Canada*. Ottawa: Author.

Canadian Public Health Association. (1997). *Health impacts of social and economic conditions: Implications for public policy*. Ottawa: Author.

Caplan, R. (1993). The importance of social theory for health promotion: from description to reflexivity. *Health Promotion International*, *8*(2), 147-157.

Capwell, E. M. (1997). Health education graduate standards: Expansion of the framework. *Health Education & Behavior*, *24*(2), 137-150.

Coveney, J. (1998). The government and ethics of health promotion: The importance of Michel Foucault. *Health Education Research*, *13*(3), 469-468.

Dahl, E., & Birkelund, G. E. (1997). Health inequalities in later life in a social democratic welfare state. *Social Science and Medicine*, *44*(6), 871-881.

Davies, J. K., & MacDonald, G. (Eds.). (1998). *Quality, evidence and effectiveness in health promotion*. London: Routledge.

Dean, K. (1996). Using theory to guide policy relevant health promotion research. *Health Promotion International*, *11*(1), 19-26.

Dean, K., & McQueen, D. (1996). Perspectives: Theory in health promotion. *Health Promotion International*, *11*(1), 7-10.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Determinants of Health Working Group. (1997). *Determinants of Health Working Group synthesis report*. Ottawa, Canada: National Forum on Health.

Downie, R. S., Fyfe, C., & Tannahill, A. (1990). *Health promotion: Models and values*. Oxford, UK: Oxford University Press.

Eakin, J. M., & Maclean, H. M. (1992). A critical perspective on research and knowledge development in health promotion. *Canadian Journal of Public Health*, *83*(Suppl. 1), S72-S76.

Evans, D., Head, M. J., & Speller, V. (1994). *Assuring quality in health promotion: How to develop standards of good practice*. London: Health Education Authority.

Federal Provincial and Territorial Advisory Committee on Population Health. (1994, September). *Strategies for population health: Investing in the health of Canadians*. Ottawa: Minister of Supply and Services Canada.

Francisco, V. T., Paine, A. L., & Fawcett, S. B. (1993). A methodology for monitoring and evaluating health coalitions. *Health Education Research*, *8*(3), 403-416.

Frank, J. W. (1995). The determinants of health: a new synthesis. *Current Issues in Public Health*, *1*, 233-240.

Freudenberg, N., Eng, E., Flay, B., Parcel, G., Rogers, T., & Wallerstein, N. (1995). Strengthening individual and community capacity to prevent disease and promote health: In search of relevant theories and principles. *Health Education Quarterly*, *22*(3), 290-306.

Goodstadt, M. S. (1995, February). *Health promotion and the bottom line: What works?* Paper presented at the Seventh National Health Promotion Conference, Brisbane, Australia.

Goodstadt, M. S. (1996). *The theory of health promotion*, Health Promotion Strategies Handouts.

Green, L. W. (1999). Health education's contributions to public health in the twentieth century: A glimpse through health promotion's rear-view mirror. *Annual Review of Public Health*, *20*, 67-88.

Green, L. W., & Lewis, F. M. (1986). Formative evaluation and measures of quality. In L. W. Green & F. M. Lewis (Eds.), *Measurement and evaluation in health education and health promotion* (pp. 27-53). Mountain View, CA: Mayfield.

Green, L. W., & Ottoson, J. M. (1994). *Community health* (7th ed.). St. Louis, MO: C. V. Mosby.

Green, R. S., & Newman, F. L. (1999). Total quality management principles promote increased utilization of client outcome data in behavioral health care. *Evaluation and Program Planning*, *22*(2), 179-182.

Hafstad, A., Aaro, L. E., & Langmark, F. (1996). Evaluation of an anti-smoking mass media campaign targeting adolescents: The role of affective responses and interpersonal communication. *Health Education Research*, *11*(1), 29-38.

Hamilton, N., & Bhatti, T. (1996). *Population health promotion: An integrated model of population health and health promotion*. Ottawa, Canada: Health Promotion Development Division.

Heale, J. (1996). *Best practice programs for injury prevention*. Toronto, Canada: Ontario Injury Prevention Resource Centre.

Howze, E. H. (1992). The uses of theory in health advocacy: Policies and programs. *Health Education Quarterly*, *19*(3), 369-383.

Israel, B. A., Checkoway, B., Schultz, A., & Zimmerman, M. (1994). Health education and community empowerment: Conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Education Quarterly*, *21*(2), 149-170.

Israel, B. A., Cummings, K. M., Dignan, M. B., Heaney, C. A., Perales, D. P., Simons-Morton, B. G., & Zimmerman, M. A. (1995). Evaluation of health education programs: Current assessment and future directions. *Health Education Quarterly*, *22*(3), 364-389.

Jackson, E. J., & Parks, C. P. (1997). Recruitment and training issues from selected health advisor programs among African Americans: A 20-year perspective. *Health Education & Behavior*, *24*(4), 418-431.

Kahan, B., & Goodstadt, M. (1998). An exploration of best practices in health promotion. *Health Promotion in Canada*, *34*(4), 9-11.

Kahan, B., & Goodstadt, M. (1999). Continuous quality improvement and health promotion. *Health Promotion International*, *14*(1), 83-91.

Kahan, B., Goodstadt, M., & Rajkumar, E. (1999). *Best practices in health promotion: A scan of needs and capacities in Ontario*. Toronto, Canada: Centre for Health Promotion, University of Toronto.

Labonte, R. (1997). *Power, participation and partnerships for health promotion*. Melbourne, Australia: Victorian Health Promotion Foundation.

Last, J. M. (1992). The ethics of health promotion. *Westminster Affairs*, *5*(3), 1-4.

Lincoln, Y. S. (1992). Fourth generation evaluation: The paradigm revolution and health promotion. *Canadian Journal of Public Health*, 83(Suppl. 1), S6-S10.

Liss, P.-E., & Nikku, N. (Eds.). (1994). *Health promotion and prevention: Theoretical and ethical aspects*. Stockholm: Forskningradsnamndren.

Macdonald, G. (1997). Quality indicators and health promotion effectiveness. *Promotion & Education*, *4*, 5-8.

Macdonald, G., & Bunton, R. (1992). Health promotion: Discipline or disciplines? In G. Macdonald & R. Bunton (Eds.), *Health promotion: Disciplines and diversity* (pp. 6-19). London: Routledge.

MacDonald, T. H. (1998). The ethics of health promotion. In T. H. MacDonald (Ed.), *Rethinking health promotion: A global approach* (pp. 96-108). New York: Routledge.

McCormick, J. (1994). Health promotion: The ethical dimension. *The Lancet*, *344*, 390-391.

McKenzie, J. F. (1997). *Planning, implementing, and evaluating health promotion programs: A primer*. Boston: Allyn & Bacon.

McKnight, J. L. (1985). Health and empowerment. *Canadian Journal of Public Health*, *76*(Suppl. 1), 37-38.

McLaughlin, C. P., & Kaluzny, A. D. (Eds.). (1994). *Continuous quality improvement in health care*. Gaithersburg, MD: Aspen.

McQueen, D. V. (1996). The search for theory in health behaviour and health promotion. *Health Promotion International*, *11*(1), 27-32.

Milburn, K. (1996). The importance of lay theorizing for health promotion research and practice. *Health Promotion International*, *11*(1), 41-46.

Morgan, M. A. (1992). Reflections on ethical issues in health promotion. *Westminster Affairs*, *5*(3), 4-6.

Naidoo, J., & Wills, J. (1995). *Health promotion: Foundations for practice*. London: Bailliere Tindall.

Naidoo, J., & Wills, J. (1998). Effectiveness and evidence-based practice in health promotion. In *Practising health promotion: Dilemmas and challenges* (pp. 48-67). London: Bailliere Tindall.

National Forum on Health. (Ed.). (1996). *What determines health? Summaries of a series of papers on the determinants of health*. Ottawa, Canada: National Forum on Health.

Nutbeam, D. (1996). Achieving "best practice" in health promotion: Improving the fit between research and practice. *Health Education Research*, *11*(3), 317-326.

Nutbeam, D. (1999). The challenge to provide "evidence" in health promotion. *Health Promotion International*, *14*(2), 99-101.

Nutbeam, D., & Harris, E. (1998). *Theory in a nutshell: A practitioner's guide to commonly used theories and models in health promotion*. Sydney, Australia: National Centre for Health Promotion, University of Sydney.

Ovretveit, J. (1996). Quality in health promotion. *Health Promotion International*, *11*(1), 55-62.

Pellegrino, E. D. (1984). Autonomy and coercion in disease prevention and health promotion. *Theoretical Medicine*, *5*(1), 83-91.

Perkins, E. R., Simnett, I., & Wright, L. (Eds.). (1999). *Evidence-based health promotion*. New York: John Wiley.

Poland, B. D. (1992). Learning to "walk our talk": The implications of sociological theory for research methodologies in health promotion. *Canadian Journal of Public Health*, *83*(Suppl. 1), S31-S46.

Rissel, C. (1994). Empowerment: The holy grail of health promotion? *Health Promotion International*, *9*(1), 39-47.

Rootman, I., Goodstadt, M., Potvin, L., & Springett, J. (Eds.) (in press). A framework for health promotion evaluation. In I. Rootman et al., *Evaluation in health promotion: Principles and perspectives*. Copenhagen, Denmark: European Regional Office of the World Health Organization.

Seedhouse, D. (1997). *Health promotion: Philosophy, prejudice and practice*. Chichester, UK: Wiley.

Shadish, W. R. (1995). Philosophy of science and the quantitative-qualitative debates: Thirteen common errors. *Evaluation and Program Planning*, *18*(1), 63-75.

Simnett, I. (1995). *Managing health promotion: Developing healthy organizations and communities*. Chichester, UK: Wiley.

Smith, B., Sullivan, E., Bauman, A., Powell-Davies, G., & Mitchell, J. (1999). Lay beliefs about the preventability of major health conditions. *Health Education Research*, *14*(3), 315-325.

Speller, V., Learmouth, A., & Harrison, D. (1997). The search for evidence of effective health promotion. *British Medical Journal*, *315*, 361-363.

Stevenson, H. M., & Burke, M. (1992). Bureaucratic logic in new social movement clothing: The limits of health promotion research. *Canadian Journal of Public Health*, *83*(Suppl. 1), S47-S53.

Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, *10*(4), 282-298.

Stone, D. A. (1988). *Policy, paradox, and political reason*. New York: HarperCollins.

Thompson, J. C. (1992). Program evaluation within a health promotion framework. *Canadian Journal of Public Health*, *83*(Suppl. 1), S67-S71.

Tones, K. (1997). Beyond the randomized controlled trial: A case for "judicial review." *Health Education Research*, *12*(2), i-iv.

Vagero, D. (1995). Health inequalities as policy issues—Reflections on ethics, policy and public health. *Sociology of Health and Illness*, *17*(1), 1-19.

Van de Ven, P., & Aggleton, P. (1999). What constitutes evidence in HIV/AIDS education? *Health Education Research*, *14*(4), 461-471.

van Ryn, M., & Heaney, C. A. (1992). What's the use of theory? *Health Education Quarterly*, *19*(3), 315-330.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion*, *6*(3), 197-205.

Wallerstein, N., & Freudenberg, N. (1998). Linking health promotion and social justice: A rationale and two case stories. *Health Education Research*, *13*(3), 451-457.

Watson, J., Cunningham-Burley, S., Watson, N., & Milburn, K. (1996). Lay theorizing about the "body" and implications for health promotion. *Health Education Research*, *11*(2), 161-172.

Whitelaw, S., & Whitelaw, A. (1996). Response: What do we expect from ethics in health promotion and where does Foucault fit in? *Health Education Research*, *11*(3), 349-354.

Wikler, D. I. (1978). Persuasion and coercion for health: Ethical issues in government efforts to change life-styles. *Health and Society*, *56*(3), 297-332.

World Health Organization. (1986). *Ottawa charter for health promotion*. Ottawa, Canada: Author.

World Health Organization European Working Group on Health Promotion Evaluation. (1998). *Health promotion evaluation: Recommendations to policymakers*. Copenhagen, Denmark: World Health Organization.

Ziglio, E. (1997). How to move toward evidence-based health promotion interventions. *International Journal of Health Promotion & Education*, *4*(2), 29-33.

Barbara Kahan, MHSc, is a member of the Centre for Health Promotion at the University of Toronto and principal of Kael Consulting in Regina, Canada.

Michael Goodstadt, PhD, is deputy director of the Centre for Health Promotion at the University of Toronto.