Participatory Quality Development

How to get started: Three tips from Quality Action

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1. Familiarize yourself with participation

To get started with PQD, it helps to explore its concepts with your project team, especially stakeholder participation. PQD will be of most benefit if your team (or your organisation) is genuinely committed to increasing participation in HIV prevention activities. Who supports participation already? Who do you need to bring on board? Who needs to be kept informed?

There are explanations and references in the theory part of PQD, which you can use for introductory talks and discussions. The main advantages of participation are:

- activities can be better targeted and respond better to the cultural and social environment
- more ownership and contribution by stakeholders, especially the target group
- increased innovation and 'out of the box' thinking

Possible drawbacks are:

- preparation time needed to introduce the concept of participation and using the methods in the toolkit
- unexpected outcomes may require re-negotiating with funders and other stakeholders

A good starting point for introducing participation and at the same time practicing a method from the tool kit is Circles of Influence. As a stakeholder mapping exercise it introduces the 'levels of participation'. Applying Circles of Influence to the project (or the work of the organisation as a whole), gives you a snapshot of where you stand with participation. It makes it easier to decide as a team where you want to increase (or decrease) the level of stakeholder participation. For example, if your team decides to increase the participation of the target group in the planning of an intervention, you can then select a PQD method to achieve it (e.g. Rapid Assessment or Project Advisory Group).

2. Start small and build on successes

Quality improvement can seem like an additional burden. It is important to experience the benefits early. When you decide to embark on it with your team, make sure you start small. Being too ambitious can be stressful and lead people to reject the whole concept. It is then difficult to introduce quality improvement again later. The participative methods in the PQD toolkit require different levels of preparation, time and resources. Start with a simpler one, such as Circles of Influence, Rapid Assessment or SMART goals. When your team is eager for more, consider introducing a more comprehensive method such as Enquiries and Concerns Register or ZiWi. The success of using each method depends a lot on how well it is facilitated. Take care to organise effective facilitation, so that using the methods is always goal-oriented.

Using SMART or ZiWi to develop clear goals can make evaluation much easier and more enjoyable. Rapid Assessment and Focus Group are sufficient for evaluating most community-based activities. It is especially important not to overstretch the capacity of the organisation to do evaluation.

Focusing on participation and using the PQD methods has the potential to change the way the team – and the whole organisation - thinks and works together. Depending on your starting point, this process will take quite some time. Each time you have applied one of the methods, note the improvements you made to your work. This can help everyone to understand what role quality improvement using PQD can play.

3. Combining PQD with other quality improvement tools

PQD is a quality development tool. It is based on the assumption that broadening the range of perspectives through participatory processes leads to critical reflection on how things are currently done, and to new ideas for doing them better. Although PQD offers methods to improve each phase of the project cycle (Needs Assessment, Planning, Implementation, Evaluation), it is not designed to give an overall quality assessment of your project. There are no ratings or scores.

If you think that your team and stakeholders need to have such a quality overview of the project before they can decide which aspects to improve through participatory methods, it may be useful to apply a more structured tool first. Quality Action offers a range of tools that can be used for this purpose (e.g. *Succeed*, QIP or PIQA). Please consult the www.qualityaction.eu and look for the Tool Selection Guide in particular.

Participatory Quality Development - Introduction and Overview

Michael T. Wright, Martina Block, Hella von Unger

1. Background

Community-based health promotion and prevention (setting approach) are the main focus of international efforts to address the health needs of those who are socially disadvantaged. In line with the Ottawa Charter[1], this approach is designed to empower citizens to recognise the positive and negative influences on their health and well-being and to bring about positive change. Such interventions cannot be dictated "from the top", but need to be situated locally and driven by the interests of the local community. [2]. A high degree of community participation contributes to increasing the effectiveness and sustainability of health interventions[3]. This usually requires capacity building for the "target groups" and the creation of structures that enable people to understand the causes of their health problems and to develop appropriate solutions to address those problems[4].

Community-based health promotion and prevention presents a particular challenge for quality development, because the typical low-threshold interventions can hardly be standardised[5]. The working environment is also characterised by a great variety of stakeholders and intervention methods in order to ensure that a wide range of people are reached in various settings[6].

A highly promising approach to promoting high quality, empirically sound community-based health promotion and prevention is participatory health research (PHR). PHR focuses explicitly on empowerment, capacity building and participation. Health problems are investigated and appropriate interventions are developed in collaboration between researchers, service providers, funding bodies, community members, and other stakeholders[7]. PHR is new to Germany, being more common in countries and regions with longer traditions of participatory research, such as North America, the UK, Scandinavia, and Latin America[8 9].

We had the opportunity to investigate the feasibility of participatory quality development using a PHR approach within the scope of two national demonstration projects in Germany. The first project[10] was implemented on behalf of the Federal Ministry of Health in collaboration with Deutsche AIDS-Hilfe e.V. (DAH) [German AIDS Service Organisation], and was funded by the Federal Centre for Health Education (BZgA). The second project[11], a collaboration between our research group and the Berlin-Brandenburg Association for Health Promotion (GBB) [Gesundheit Berlin-Brandenburg e. V.], was funded within the prevention research funding stream of the Federal Ministry of Education and Research. In both projects, we developed and tested methods for improving the quality of health promotion and prevention interventions using participatory approaches. The first project implemented in collaboration with DAH focussed on HIV/AIDS prevention. The second project implemented in collaboration with GBB comprised a wide range of services and service organisations engaged in prevention and health promotion. The simultaneous implementation of the two research projects created an especially beneficial situation for investigating participatory methods under extremely different conditions. The participatory quality development concept presented here is main the result of the two research projects.

2. Definition of participatory quality development

Participatory quality development is understood to be the continuous improvement of health promotion and prevention activities through equitable collaboration between service organisations, target groups, funding bodies and other potentially important stakeholders. This collaboration is characterised by strong participation and involvement of all stakeholders, especially the target groups, in the four phases of developing an intervention: needs assessment, project planning, implementation and evaluation/analysis (see Figure 1)[12].

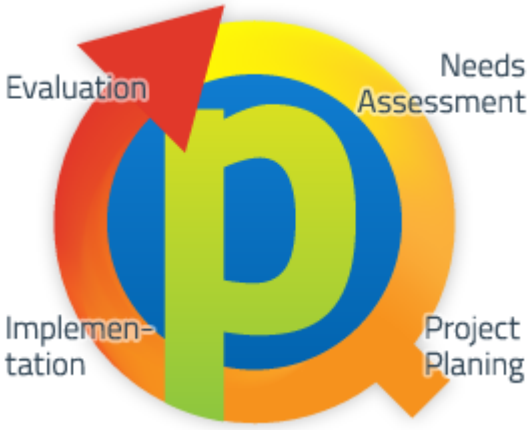

Figure 1: The participatory quality development cycle

Participatory quality development depends significantly on the local knowledge of the stakeholders and assists them in utilising, reflecting and expanding this knowledge. For this purpose, it employs participatory data collection and project planning methods that are tailored, feasible, useful, participatory and evidence-based.

Tailored methods are adapted to the specific local conditions, i.e. to the composition of the target group, the mission and values of the service organisation as well as the available capacity and infrastructure.

Feasible methods mean that the time needed for the application of the methods is proportional to the practical results. They do not require too much time, they are limited to what is absolutely necessary and they can thus be integrated into daily work routines without much effort.

Useful are those methods that produce results which can be translated directly into action for the on-going improvement of work processes.

Participatory methods are those that give primacy to the subjective observations of service users (target group) without neglecting the perspective of the service providers. The local knowledge of (potential) users is to be included as far as possible in all project phases.

Evidence-based means that the methods promote taking a critical look at the health promotion and prevention activities using proven methods of local inquiry.

2.1 Local knowledge, local theories

Local knowledge is understood to be the local stakeholders' existing insights about the target group and its living environment. Those who possess insider knowledge about the life of the target group are considered experts in this regard. They are usually themselves members of the target group, but they may also be other persons who are in close contact with the target group and are therefore more likely to understand their situation (depending on the setting and the target group, e.g. outreach workers, shopkeepers in the local district, trainers at sports clubs, publicans/barkeepers, etc.).

Within the scope of participatory quality development, hypotheses about the target group's health status are formed on the basis of this local knowledge. Based on this foundation, a local theory can be developed, which contains the following:

- A description of the characteristics of the local health problem
- An explanation of the local causes of the health problem
- Conclusions for the development of adequate interventions

In contrast to a "universal" scientific theory, a local theory does not claim to explain large-scale social dynamics or processes. Accordingly, local theories are less abstract, but also less comprehensive. The aim of a local theory is to provide a plausible explanation for a health problem in a specific context (setting). To accomplish this, the concrete, tangible manifestations of the problem and its underlying behaviours and conditions are described. Specific interventions to resolve or mitigate the problem can then be derived from the description.

Local knowledge and local theories are often implicit (unspoken) and rarely exist in a structured, written form. Implicit insights and explanations are made explicit and verified by applying participatory data collection and evaluation methods.

2.2 Local evidence

Another component of participatory quality development is the production of local, practice-based evidence.

In the health sciences, it is generally advised that interventions be evidence-based. This means that sufficient scientific proof (evidence) should be collected on the efficacy of interventions before they are implemented on a large scale. Many regard experiments (randomized controlled trials) as providing the standard for testing efficacy. However, experiments are rarely feasible in health promotion and prevention, especially if not only behavioural but also structural aspects are to be taken into account[13]. There are also considerable problems in applying the results of experiments into the everyday lives of communities and service organizations. These problems are often discussed in terms of the difference between efficacy and effectiveness and in terms of issues related to the translation of scientific findings into practice. There is also a need to generate empirical data on the effects of interventions

in an on-going way under real life circumstances in order to support a sustained strategy of quality improvement on the ground.

The concept of practice-based evidence was developed to address the limits often imposed by the demands for an evidence-based practice[14]. The two concepts differ in terms of how evidence is generated and applied. In evidence-based practice, "proof" is generated according to scientific standards, with a focus on quantifiable, measurable effects. By contrast, practice-based evidence derives information on the effectiveness of interventions from the structures and the logic of the practical work, thus taking into account the specific factors associated with the particular time, place, and people where the interventions are being conducted. Here scientific standards can be useful, particularly regarding issues of characterizing and measuring effects, but the standards need to be adapted to the needs and logic of the specific setting. This localizing of evidence holds the promise of producing new insights which can be immediately integrated into practice, thus contributing to a process of on-going improvement.

Thus, participatory quality development produces primarily local evidence. This means that indications for the effectiveness of interventions are tested in a particular context, at a particular point in time and at a particular location in order to improve a service organisation's work in situ.

2.3 Collaboration in participatory quality development

Collaboration is a core marker of participatory quality development. The emphasis here is on the participation of all stakeholders who are important for the planning, implementation and evaluation of health promotion and prevention projects. The collaboration between target group, funding body and service organisation lies at its heart: It is in this "three-way relationship" that specific activities are conceptualised and carried out. In many cases, other stakeholders also contribute substantially to decision-making[15] (see Figure 2).

Figure 2: "Three-way relationship" in participatory quality development

By building collaboration among stakeholders, participatory quality development aims to create a situation where contributing stakeholders can name their often diverging interests and negotiate solutions together[16]. Strong participation by all stakeholders can only be guaranteed if it is made clear who contributes to decision-making processes (and to what extent).

2.4 Definition of participation

Participation in connection with participatory quality development means not only taking part but also being involved in decision-making processes (decision-making power). This includes the power to define and thus have an influence on which health problems should be addressed through health promotion and prevention activities. The more influence people exercise in a decision-making process, the stronger is their participation.

This definition follows from the Ottawa Charter's central demand to position citizens' self-determination at the core of health promotion. It is also based on many years of debate in the field of urban planning, and later also in collaborative development work, about the role of citizens in the implementation of interventions aimed at improving their environment. This debate has been influenced significantly by the work of the American Sherry Arnstein, who attempted to explain the reasons for the success of citizens' initiatives in an article published in 1969[17]. In her conclusion, she states that sustainable changes improving the day-to-day life of residents can only be realised if the residents have the opportunity to influence their living conditions.

Based on the results of the above-mentioned research projects and following the work of Sherry Arnstein and other researchers[18], we have developed a staged participation model. This makes it possible to describe participatory processes in health promotion and prevention in greater detail at the project level. Participation is not an "either/or" decision, but rather a developmental process, which can be realised to varying degrees, depending for example on the conditions of the project's operating environment and the target group's living conditions. By applying the staged model, it can be reflected which level of participation is appropriate to the prevailing conditions and objectives. The task is to strive for the highest possible level of participation on the part of front line staff and target group representatives. In many cases, however, only a minimal level of participation is feasible at the beginning of the work[19] (see Figure 3).

Participatory quality development places a major emphasis on the participation of target groups and of front line staff, because these stakeholders possess local knowledge and contribute significantly to the success of interventions. It is also these stakeholders who are often not involved in the development of quality assurance methods.

Level 9	**Community-owned initiatives**	**Goes beyond participation**
Level 8	Decision-making authority	Participation
Level 7	Partial delegation of decision-making authority	
Level 6	Shared decision-making	
Level 5	Inclusion	Preliminary stages of participation
Level 4	Consultation	
Level 3	Information	
Level 2	Instruction	Non-participatory level
Level 1	Instrumentalisation	

Figure 3: Levels of participation in health promotion and prevention

3. Participatory quality development in practice

The participatory quality development approach is primarily directed at local service providers and community representatives from the target groups most involved in the development and implementation of health promotion and prevention activities. By applying participatory methods, they are to be enabled to improve the quality of their work. The methods are not dictated "from the top" – but are determined by those who are on the ground. Both service providers and community representatives are able to build up capacities - are thus empowered: The service providers acquire new skills and gain more self-confidence in assessing and systematically improving their work, whereas the community members are increasingly enabled to give voice to their situation and to make efforts to bring about the necessary changes to improve their lives and to influence the structures designed to help them.

Participatory quality development is focussed on the learning processes of the service providers and the community representatives. The methods are selected and applied on the basis of the problem as well as the skills and interests of the stakeholders. This means that there is no predefined "package" of quality development measures or a predefined procedure that needs to be implemented to meet the participatory quality development criteria. Instead, a great variety of tried and tested methods are made available, which can be used by the service providers and the community representatives to answer their own questions about the quality of their work. The following aids are provided for selecting and applying the methods:

- The methods are classified according to project phases:
    1. needs assessment
    2. project planning
    3. implementation
    4. evaluation/analysis (see Figure 1)
- Summarised information is provided on each method to specify the time required fields of application, steps, etc.
- The possible applications of the method are illustrated on the basis of practical examples

The range of internationally developed and tested participatory data collection and interpretation methods is vast. In our research project we focussed on methods that have proved effective in participatory health research and meet the requirements of health promotion and prevention projects. Another aim of the method development was to depict the range of participation possibilities: Some methods require a high degree of commitment on part of the project staff and the target group, whereas others require a low level of participation (see Figure 4).

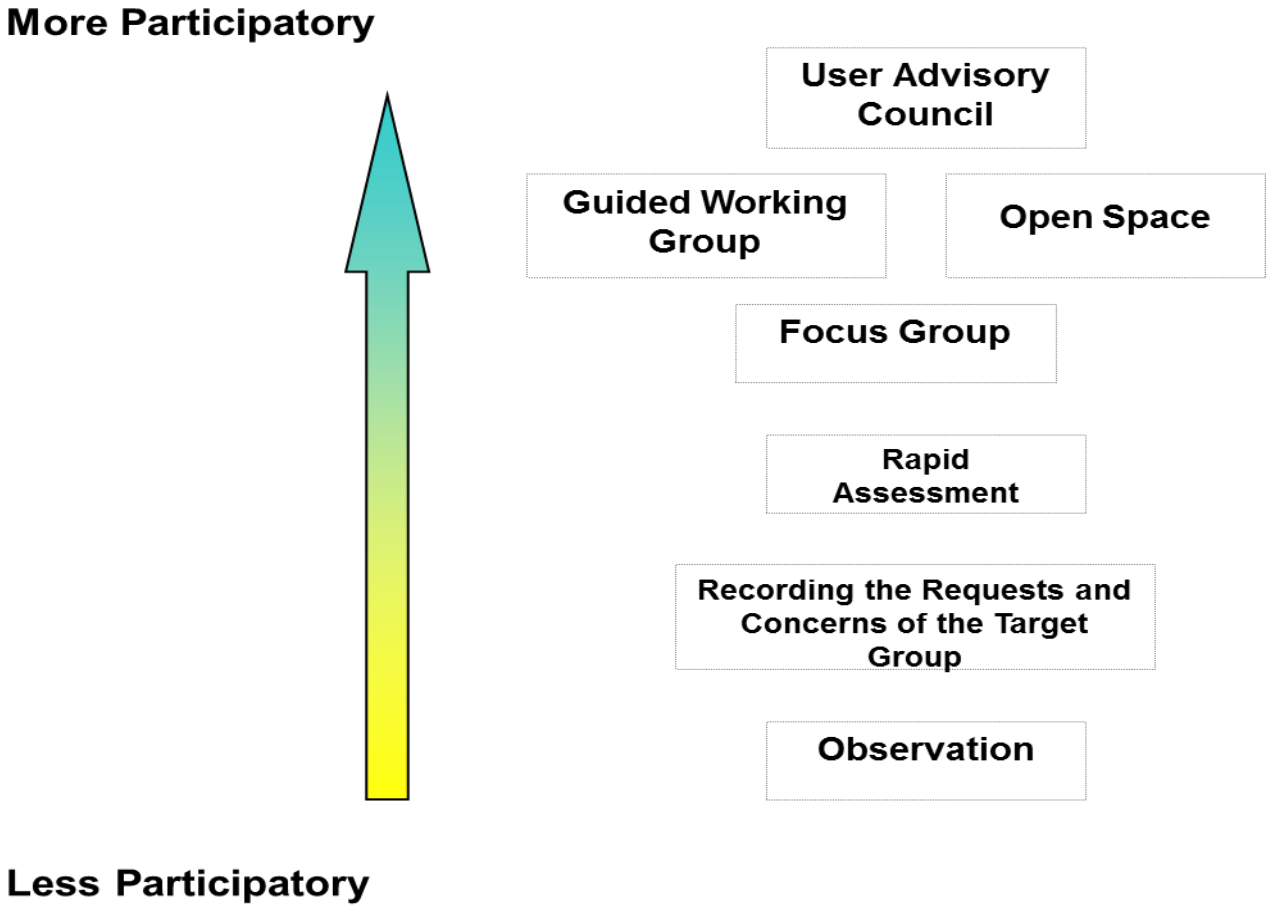

Figure 4: Selection of participatory methods according to the level of potential participation on the part of target group members

In the research projects, these methods were made available in three different ways: Firstly, the service providers and community representatives were familiarised with the application of participatory methods as part of workshops. Secondly, additional guidance was available on site for a limited number of projects in order to develop and implement a "tailored" participatory quality development strategy. Thirdly, Internet handbooks were produced, which can be used and further developed by the users[20]. Methods were developed and tested within the scope of the workshops and the consultation sessions; the results of these processes were processed and compiled in media-compatible way for publication in the Internet handbooks.

The locally controlled selection and application of potential participatory methods is dependent on the problem, skills and interests of the local actors means that the participatory quality development process is individualised. However, the various methods all share the objective of improving work through new insights gained from participatory methods. Below are two examples:

3.1 Example: AIDS-Hilfe Bielefeld e. V.21

AIDS-Hilfe Bielefeld e. V. received consultation from Hella von Unger as part of the research project in collaboration with Deutsche AIDS-Hilfe between June 2006 and December 2007. The consultation was aimed at evaluating a prevention campaign of "Herzenslust Bielefeld". "Herzenslust Bielefeld" is part of an initiative of the Regional Association of AIDS Service Organisations in North Rhine-Westphalia, consisting of male volunteers engaged in HIV prevention in the gay scene. The first step was to outline the objectives and strategies of the Herzenslust campaign, followed by the development of an evaluation design, which envisaged a comparison of both the various event venues (where the campaign sessions took place) and various perspectives (in terms of triangulation): guests, Herzenslust workers, observers from the audience (. The guests were interviewed by means of a short questionnaire (rapid assessment), the Herzenslust workers took down their observations and self-assessments on a sheet, and the "external" observers recorded their observations on an observation sheet. The data was collected and processed by Herzenslust workers of AIDS-Hilfe Bielefeld. In the course of the evaluation, the various subjective observations and feedbacks were compared. This helped identify the strengths and weaknesses of the intervention and suggest improvements.

3.2 Example: Child Abuse Prevention Team22

The Child Abuse Prevention Team of the Youth Welfare Office in Berlin's Friedrichshain-Kreuzberg district received consultation on participatory quality development from Martina Block between January 2006 and December 2007. The subject of the consultation was the Prevention Team's work for the prevention of abuse and violence against children. Two objectives were followed: Developing ways to show the effectiveness of the prevention work in the target group and the documentation and consolidation of the prevention work's conceptual framework so as to provide more transparency both within and outside the organisation.

The first step was to clarify the question of what prevention objectives are to be achieved regarding violence and abuse prevention. The Prevention Team exchanged views about their vision and the overall objectives of their work. Partial objectives were specified for each module of the preventive intervention, which were subsequently documented. The team discussions resulted in a more clear definition of the guiding principles underlying the work. Regarding the effectiveness of the intervention, a means of documenting the work was developed. Initially, the documentation was shown to be too scrupulous and the processing of the data generated was extremely time-consuming, so the documentation procedure was revised to make it more suitable for everyday practice. The documentation is being used in terms of a formative evaluation in order to optimise interventions. The consolidation of the existing conceptual elements and those developed within the scope of the consultation resulted in a comprehensive framework for the work of the Prevention Team. A condensed version of this framework was published as a brochure for external presentations.

4. Participatory quality development in comparison to other approaches

Participatory quality development does not reinvent quality assurance, but rather provides an approach that can be combined with a variety of other approaches and models while also sharing some of their characteristics.

Participatory quality development advocates the basic principles of quality assurance as the foundation for successful health promotion and prevention, as specified in frameworks such as the EFQM Excellence Model[23]. This model was developed by the European Foundation for Quality Management (EFQM) as a guide for organisations seeking to continuously monitor and improve the quality of their work. The model is based on a holistic view of an organisation (catchword: Total Quality Management) that is going through a development process with the aim to achieve “excellence” (outstanding performance). Following this model, the organisation uses the results of its work as the basis for improvement in terms of innovations. This approach is centred on a self-evaluation process, in which the organisation regularly and systematically performs detailed checks to see to what extent their quality criteria are being met. Staff and customer satisfaction plays an important role in this effort, requiring a certain level of participation by staff and customers (users, target groups) in quality development processes. A brief summary by its inventors describes the model as follows:

> “The EFQM Excellence Model specifies how customer satisfaction, staff satisfaction and positive effects on society can be achieved through leadership that is committed to strategy, planning, people and resource management as well as quality systems and processes to deliver outstanding business performance.” [24]

Quality is thus the result of several management-related factors that enable an organisation to learn from its experiences.

Participatory quality development does not relieve health promotion and prevention organisations of the need to understand the above-mentioned aspects of the EFQM Excellence Model and the related commitment to organisational development. In many cases, partici-

patory quality development provides the first step towards this understanding, especially in smaller projects that have never discussed the subject of quality assurance in detail.

One problem of the EFQM Excellence Model and other generic quality assurance frameworks is that they do not take account of the discourse that is specific to a particular field of work[25]. Participatory quality development offers the particular benefit of focusing on the characteristics of community-based health promotion and prevention, most notably participation, capacity building and empowerment. Another important aspect is the role of "evidence", which affects not only the discussion about community-based projects, but also all measures taken by the healthcare system. Participatory quality assurance therefore puts special emphasis on creating local processes of knowledge generation that enable the highest possible level of participation of the local population by using participatory data collection and interpretation methods. In short, participatory quality development understands participation as the key principle of quality assurance in the fields of community-based health promotion and prevention. This is why participation should be incorporated into all phases of intervention planning and implementation in order to support the capacity building and empowerment of project staff and users while also expanding the knowledge base for the advancement of this work[26].

Participatory quality development is therefore a useful addition to generic quality development techniques for community-based health promotion and prevention projects. This applies not only to EFQM and other non-specific models or techniques (e.g. ISO), but also to other methods of quality assurance and organisational development that are widely used in social work, such as supervision, intravision, team meetings, various forms of case documentation, etc. Generic models and procedures also include health-specific variants (e. g. "*quintessence"* by Health Promotion Switzerland[27]) and the Swiss Model for Outcome Classification[28]. All of the above-mentioned methods, models and techniques are rarely used in a (consistently) participatory way. Participatory quality development makes it possible to check the current level of participation, make necessary corrections and discover new opportunities for development to better accommodate the subjective observations of all involved, especially the target group and the project staff. The methods to be used are not standardised, and are instead jointly developed (refined) and adjusted as part of the process.

In this respect, participatory quality development follows the tradition of self-evaluation by allowing data-supported, systematic improvement of services in a low-threshold setting, and is therefore also suitable for monitoring in smaller organisations. Participatory quality development does, however, differ from self-evaluation in social work[29] as follows:

- It includes not only evaluation, but also all phases of project development and implementation.
- In addition to the subjective observations of local service providers, the process also takes account of the subjective observations of other important stakeholders, in particular the target groups.
- It makes specific reference to discussing effectiveness (evidence) across different projects.

Participatory quality development can be used as either an alternative or an addition to external reviews or audits. If the reviewing process is offered as voluntary support for projects – as is the case with QIP, Quality in Prevention[30] – participatory quality development provides a useful addition. Based on the review results, project staff can identify issues, which can then be addressed using participatory methods. A review that is not understood as support, and instead serves as a mandatory external monitoring with potential negative consequences for involved staff members, cannot be reconciled with the principles of participatory quality development. In that case, participatory quality development offers an alternative to the reviewing process.

Participatory quality development conflicts with any kind of quality assurance measures that are dictated "from the top and the outside", i.e. by an authority that is higher than the level of the people on the ground. According to the principle of participatory quality development, the project staff and the target group representatives are at the centre of all efforts to improve services; this means quality development "from below and the inside"[31]. Whenever a higher authority decided not to include the participation of project staff and target group representatives in our research projects, it proved to be a major obstacle to the implementation of participatory quality development.

In terms of epistemology, participatory quality development distinguishes itself from the approach of the experimental evaluation of interventions, as mentioned in the introduction. Based on the discussion about evidence-based medicine (EBM), the demand for experimentally tested social interventions has become established in recent years, especially in English-speaking countries. When using this approach, interventions are scientifically designed, systematised and tested in collaboration with local service providers and target groups under experimental conditions, in line with the process employed in the development of medical interventions. The aim is to develop interventions that can be standardised to be applied on a large scale. By contrast, participatory quality development questions the standardisation of social interventions in general, and instead attempts to support the learning processes of local service providers by supporting suitable structures and methods to enable them to develop effective local solutions to health problems[32].

5. Open questions and outlook

Our research results to date show that participatory research methods can contribute significantly to quality development in community-based health promotion and prevention. Using the concepts and methods of participatory quality development makes it possible to systematically meet the specific requirements of community-based work – most notably participation, capacity building and empowerment – in the effort to improve interventions. This was the first step towards successfully transferring internationally recognized participatory health research methods into German practice. There are further practical and scientific challenges to be overcome in order to establish participatory quality development in the quality assurance landscape. These include, in particular, the application of participatory quality development as a monitoring instrument, the generalizability of results from local participatory processes and the foundation of a participatory, community-based science.

5.1 Application of PQD as a monitoring instrument

The development of the participatory quality development approach took place at the local project level where participation takes place. The next step is to investigate how to apply participatory quality development as part of a generalised strategy across projects in a particular geographical area or topic area. The challenge is to support local learning processes while also developing generalizable quality characteristics and quality objectives. In order to accomplish this, organisations in charge of monitoring/and or funding allocation would need to create opportunities to integrate methods of participatory quality development into their work and to examine the benefits of these methods in monitoring and funding allocation tasks (e.g. within a pilot project). So far, wide-scale approaches have focused almost exclusively on developing and disseminating standardised methods which largely ignore local characteristics and local learning processes and instead put an emphasis on techniques that are applied irrespective of location and setting.

5.2 Generalizability of participatory processes:

This challenge has a practical and scientific aspect. The practical aspect is related to the above-mentioned question of monitoring. In addition to local indicators of the benefits of participatory quality development, generalizable indicators also need to be created to illustrate the benefits of participatory quality development for an entire field of work or subject area (e.g. HIV prevention with adolescents or health promotion in day-care centres). This necessity raises a scientific (epistemological) question: What results of participatory processes can be generalised and on what level? Local knowledge and local evidence are useful concepts to describe learning at in a specific place, but how can local findings be systematically compiled and disseminated to expand the overall level of knowledge in a particular field of work?

5.3 Foundation of a participatory, community-based science

Unlike experimental quantitative methods, participatory health research has yet to define generally recognized scientific standards[33]. The German Network for Participatory Health Research (PartNet) and the International Collaboration for Participatory Health Research (ICPHR) have been established for this purpose. The ICPHR is producing position papers defining various aspects of PHR. Analogous to the Cochrane Collaboration, an international organisation created primarily for setting standards in the field of quantitative health research; the ICPHR is designed to address quality-related issues in PHR. The authors of this article are substantially involved in both projects.

The challenges in the implementation and advancement of a participatory approach to quality development can only be overcome if service providers, target group representatives, funding bodies and researchers have the commitment to critically evaluate the currently limited level of community participation in most health promotion and prevention projects and to jointly develop new opportunities for participatory collaboration.

[1] WHO, 1986
[2] Greenwood et al., 1993; Minkler & Wallerstein, 2003

[3] US Department of Health and Human Services, 2003; Israel et al., 1998; Israel et al., 2006
[4] Israel et al., 2006; Viswanathan et al., 2004; US Department of Health and Human Services, 2003
[5] cf. Advisory Council, 2007
[6] Kilian et al., 2004
[7] cf. Criteria for CBPR by Israel et al., 2003
[8] see overview by Wright, 2004; cf. Viswanathan, et al. 2004; Gernmann, et al. 1996; Klinger & Steigerwald, 1998
[9] Unger, von et al., 2007
[10] "Structures for Strengthening Evaluation and Quality Assurance in the Primary Prevention Work of AIDS Service Organisations", project number: GZ Z2/25.5X/2006, period: 01/05/2006 – 31/08/2008.
[11] "Using Experience – Deepening Knowledge – Improving Practice. Participatory Development of Quality Assurance and Evaluation in Health Promotion with Socially Disadvantaged Populations", project number: GFEL01062904/ 01EL0416, period: 01/05/2005 – 31.12.2008.
[12] cf. "Public Health Action Cycle" in Rosenbrock & Gerlinger, 2004
[13] Advisory Council, 2007
[14] e.g. Green, 2006; Olsen et al., 2007
[15] cf. Deinet et al., 2008
[16] cf. Seibold et al. 2008; Roberts, 2004; Wandersman et al., 1997
[17] Arnstein, 1969
[18] in particular Hart, 1997; Trojan, 1988
[19] see Public Health Research Group Berlin, 2008 for examples
[20] Public Health Research Group Berlin, 2008; Public Health Research Group & Deutsche AIDS-Hilfe, 2008)
[21] Our special thanks go to Peter Struck, Managing Director of AIDS-Hilfe Bielefeld, and his colleagues for this example
[22] Our special thanks go to Ilse Haase and Elke Markert from the Child Abuse Prevention Team for this example
[23] EFQM, 2007
[24] EFQM, quoted in Federal Ministry of Family Affairs, Senior Citizens, Women and Youth, 2000, p. 9
[25] cf. Wright & Block 2005
[26] cf. Laverack & Labonte, 2000
[27] Health Promotion Switzerland, 2008
[28] acc. to Spencer et al., 2007
[29] e.g. König, 2000
[30] Kliche et al., 2006
[31] cf. Rosenbrock, 2008
[32] cf. Wright, 2006
[33] cf. Unger, von et al., 2007

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