Contest of Best Practices tackling Social Inequalities in Cancer Prevention

Work Package 5, Contest Report

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Contents

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Abbreviations

BP	Best Practice
CHAFEA	Consumers, Health, Agriculture and Food Executive Agency
DG	Directorate General
ECAC	European Code Against Cancer
EU	European Union
EC	European Commission
iPAAC	Innovative Partnership for Action Against Cancer
WHO	World Health Organization

Executive summary

Contest of best practices tackling social inequalities in cancer prevention is an initiative emerged in the framework of iPAAC Joint Action (JA) - Innovative Partnership for Action Against Cancer. The iPAAC JA aims at implementing innovative approaches in cancer control, including prevention.

Current programmes on health promotion and early detection of cancer yield different results according to social group, having different impact amongst individuals, and thus may generate social inequalities in health. Across Europe, actions are undertaken seeking to reduce these inequalities.

In line with European Commission's good-practice-sharing approach, this contest identifies effective interventions reducing social inequalities in cancer prevention, it disseminates them among European partners involved in cancer control, with the purpose of transferring knowledge, inspiring similar solutions, and facilitating replication in other health systems and settings.

Finally, this report sets out this initiative's rationale, it explains methodology undertaken, and summarises outcomes obtained. A visit to the corresponding website will allow interested readers to learn further details on best practices selected and contest consecutive steps.

1 Background

The Innovative Partnership for Action Against Cancer (iPAAC) Joint Action, co-funded under the 3rd European Health Programme (DG Santé), brings together 24 European countries and 44 partners whose main objectives are to implement innovative approaches to cancer control. The iPAAC Joint Action officially started on 1 April 2018 and it is coordinated by the National Institute of Public Health Slovenia (NIJZ).

In the field of cancer prevention and population-based screening programmes, the project aims to strengthen the principles of the European Code Against Cancer (ECAC) as well as to optimise population screening programmes by integrating **social equality** as a crucial cross-cutting issue (figure 1).

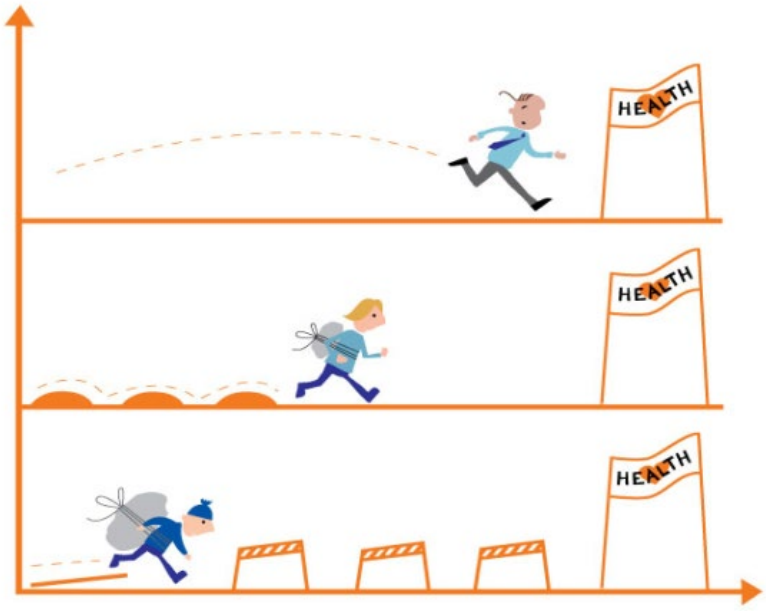

Figure 1. From: Norwegian Ministry of health and care services. National strategy to reduce social inequalities in health. Report No. 20 (2006–2007).

Many **cancer risk and protection factors** such as tobacco consumption, diet, alcohol, exercise, screening, vaccination etc. are **socially conditioned**. In general, those who pertain to lower socioeconomic groups are more exposed to cancer risk factors and less to protector ones. As a result, socially disadvantaged groups in all EU countries are at higher risk for most of the common cancers [1]. Successful cancer prevention practices with an equity perspective requires not only an individual outlook but also a public health approach, addressing actions to the whole population with additional emphasis on socially vulnerable groups [2].

In this light, and according to recommendations from previous Cancer Control Joint Action Policy Paper on Tackling Social Inequalities in Cancer Prevention and Control for the European Population [3], FISABIO (Foundation for Healthcare and Biomedical Research in Valencia Region, Spain) launched on May 2019 a **Contest of Best Practices tackling social inequalities in cancer prevention**, including both health promotion and cancer screening programmes. The aims of this contest are:

- To **identify and compile** relevant European experiences,
- To **disseminate** them among European countries in order to promote and facilitate their implementation in different health systems and services,
- To contribute to the **exchange and replication** of best practices on equality in cancer prevention.

This initiative adds to the efforts undertaken by the European Commission in preventing and managing non-communicable diseases through a good-practice-sharing approach, focusing exclusively and specifically on cancer prevention and screening, from a social standpoint.

The European Commission 3rd Health Programme states that, in order to promote health, prevent diseases, and foster supportive environments for healthy lifestyles, **good practices should be identified and disseminated**, and their **uptake**

promoted, addressing in particular the key lifestyle related risk factors with a focus on the EU added value [4].

Documenting and sharing “Best Practices” (BP) provides an opportunity to acquire insight on **lessons learned** and to continue learning about how to **improve and adapt** strategies through feedback, reflection and analysis in order to implement larger-scale, sustained, and more effective interventions [5].

The term "best practice" has been defined as follows, based on the review of the *Guide for documenting and sharing “best practices” in Health Programmes* (WHO – Regional Office for Africa) [5], documents and manuals concerning good practices compilation procedure available at the *EC Health and Food Safety Best Practice Portal* [6] as well as at the Spanish Ministry of Health [7]:

> *A best practice is an **innovative and relevant** intervention or organisational/managerial model implemented in a real life setting which has been favourably **assessed** in terms of adequacy (**ethics** and evidence) and **equity**, as well as **effectiveness and efficiency**. Additional criteria are important in determining best practices: ability to be transferred to other settings, sustainability, inter-sectorial collaboration and public involvement.*

A description on how practices were collected and assessed can be found bellow in this document.

2 Methodology

Preliminary actions and contest-related procedures extended from February 2019 to February 2020 (figure 2), according to the following sequence of events:

Figure 2. Call for experts and Contest steps.

2.1 Call for experts

As a preliminary step, a C*all for Experts* (Annex 1) was organized and published at iPAAC website on February 2019. Further promotion was ensured by social media and targeted mailing to international experts' circles. This call aimed at selecting and involving independent experts in the evaluation of proposals submitted within the contest.

According to their professional experience, experts on social inequalities, cancer prevention, health promotion or population-based cancer screening programmes, from scientific, academic or public policy management sectors, were invited to fill in an *Expert Application Form* (Annex 2) and become members of **Contest Evaluation Board**, in charge of peer-review process.

Candidates' were evaluated according to:

- Knowledge and expertise on social and equity disciplines, epidemiology, public health, other scientific disciplines relevant to the topic;
- Professional experience in a multidisciplinary scientific environment;
- Published scientific papers relevant to the subject;
- Participation in collaborative projects;
- Ability to work in English

Designation of experts was conducted ensuring independence and avoiding potential conflicts of interest. Annex 3 includes a list of external members of the Evaluation Board.

2.2 Contest of Best Practices

In May 2019, the contest was launched through iPAAC website and disseminated in collaboration with iPAAC partners Cancer Society of Finland and Institute of Health Information and Statistics of the Czech Republic (UZIS - Ustav Zdravotnickych Informaci a Statistiky Ceske Republiky) (figure 3).

Rules for participation, practical information and evaluation criteria were gathered in a *Submitter's Guide* (Annex 4), and published at the project web page (www.ipaac.eu) together with a *Best Practice Application Form* (Annex 5). The form was structured in different sections, compiling information on compliance of mandatory criteria, intervention description and self-assessment.

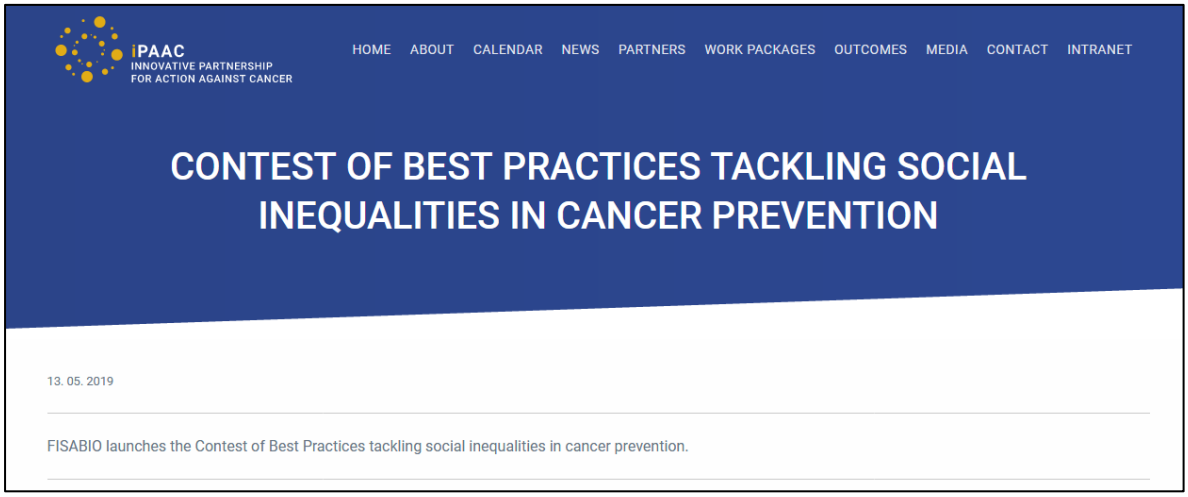

Figure 3. Samples of communication and dissemination efforts.

Proposals assessment was conducted on a **peer-review** basis, considering a set of compulsory and basic criteria stated in the above-mentioned *Submitter's Guide*. Evaluation Board in charge of proposals review was integrated by **external independent professionals** resulting from the Call for Experts and, additionally, by members of the contest **management team**. Every reviewer was provided with

Assessment Guidelines (Annex 6) establishing framework references and including detailed explanations on criteria, as well as evaluation charts.

In order to be accepted for evaluation, practices ought to meet each of the following **compulsory criteria**: relevance [8], equity [3, 9] and effectiveness, as defined in reference documents (*Submitter's Guide* and *Assessment Guidelines*). Interventions were further assessed according to **basic criteria** (not being compulsory to meet all of them): gender perspective [11], efficiency, ethics, sustainability, inter-sectors collaboration, transferability, innovation, evidence/theory based, and public engagement.

Failure to comply with the mandatory criteria resulted in proposal's exclusion from the contest. Furthermore, each basic criterion was assessed on a scale from 0 to 5 according to specific definitions (figure 4). Proposals achieving an overall score of 27 points or higher achieved a "Best Practice" acknowledgement.

Awarded score *(please tick only one box).*

0 – Proposal fails to address the criterion or cannot be assessed due to missing or incomplete information.	○
1 – Poor. The criterion is inadequately addressed or there are serious inherent weaknesses.	○
2 – Fair. The proposal broadly addresses the criterion, but there are significant weaknesses.	○
3 – Good. The proposal addresses the criterion well, but a number of shortcomings are present.	○
4 – Very good. The proposal addresses the criterion very well, but a small number of shortcomings are present.	○
5 – Excellent. The proposal successfully addresses all relevant aspects of the criterion. Any shortcomings are minor.	○

Justification/argument (max 750 characters):

Figure 4. Assessment scale overview.

3 Contest results.

Practices and interventions from several European countries were submitted, including Belgium, France, United Kingdom, Italy, Slovenia and Spain (figure 5). Overall, fifteen proposals participated in this contest; six out of fifteen interventions addressed principles stated in the European Code Against Cancer and therefore were classified under health promotion category; in addition, eight proposals focused on secondary prevention actions and were included in the domain of cancer screening (figure 6). One single practice approached both primary and secondary prevention simultaneously.

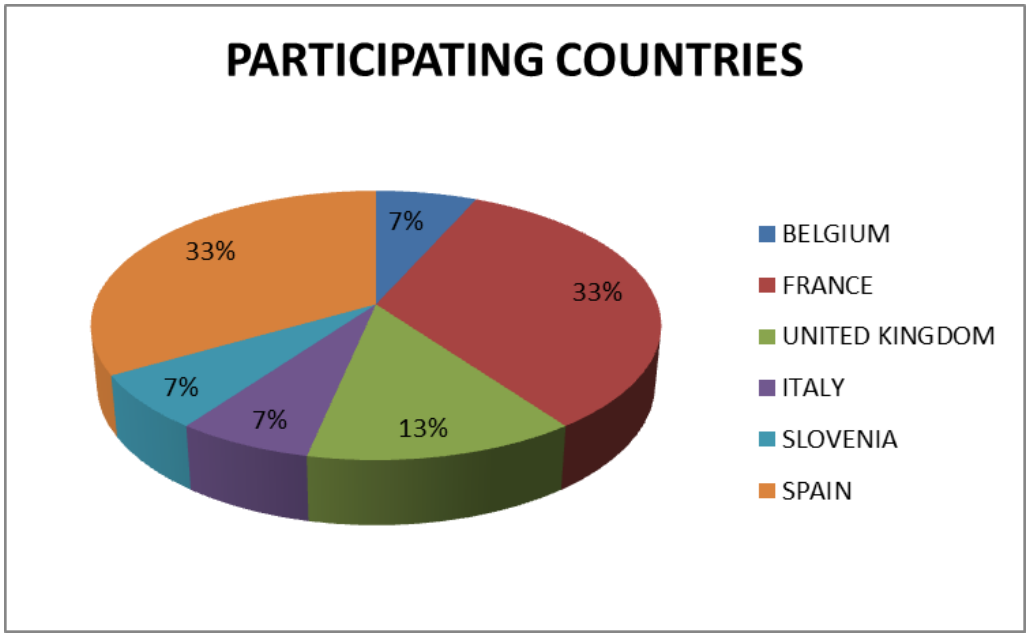

Figure 5. Distribution of participating countries.

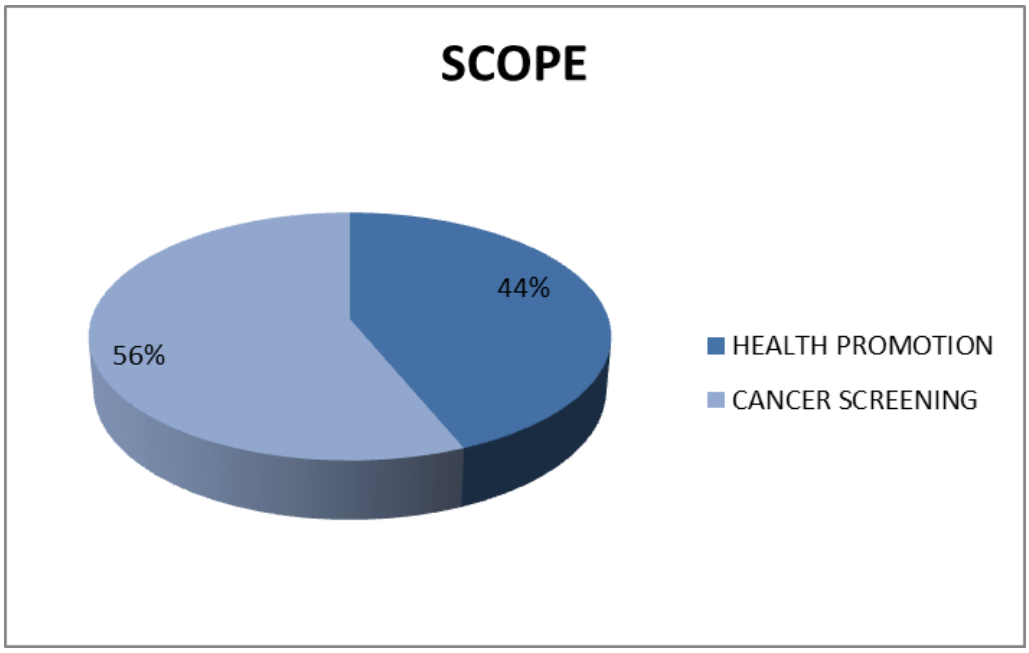

Figure 6. Distribution of topics.

Among health promotion interventions (figure 7), healthy diet was the main protection factor adressed; tobacco, as well as physical activity and body weight were the core of several proposals. Other cancer risk factors such as radon and sun exposure or cancer-causing subtances were not reflected in submitted proposals.

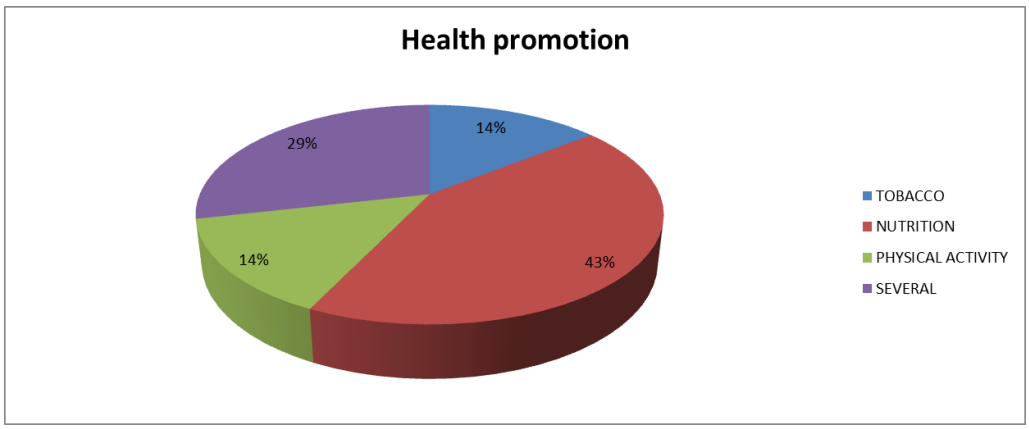

Figure 7. Distribution of health promotion issues.

As for secondary prevention, practices were mainly focused on bowel cancer screening programmes, whereas several interventions addressed specifically cervical cancer screening or different programmes at the same time (figure 8). No practices were submitted on breast cancer early detection.

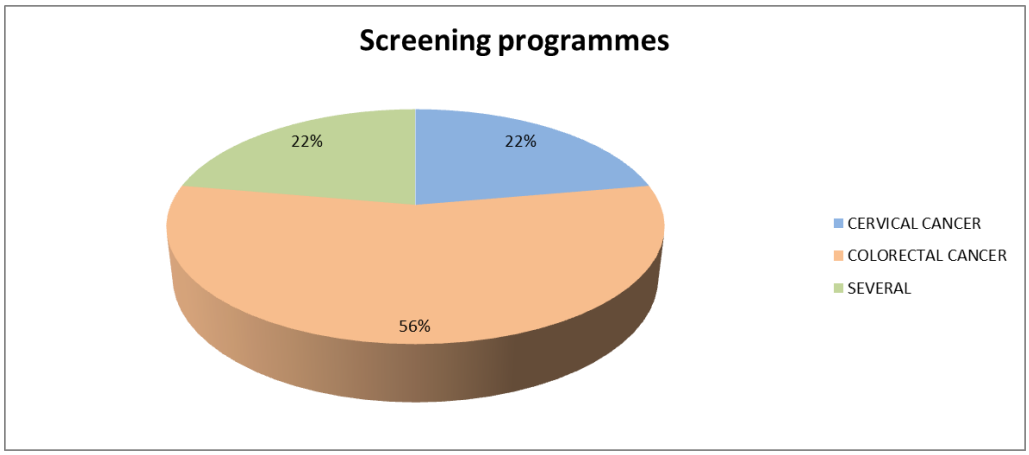

Figure 8. Distribution of screening programmes.

Table below summarizes information on proposals acknowledged as “Best Practice”.

Table 1. Acknowledged Best Practices.

Topic	Title	Aim	Organisation	Country
Cancer screening.	**Improving informing decision making in the Flemish cancer screening programs for persons with a disability.**	Improve informed decision making of people with a disability by improving digital accessibility to cancer screening information.	Centre for Cancer Detection.	Belgium
Cervical cancer screening.	**GP-endorsed cervical screening text reminders in London.**	Reduce age inequalities in cervical screening uptake.	England/Improvement/ Public Health England.	United Kingdom
Colorectal cancer screening.	**Effects of evidence-based strategies to reduce the socioeconomic gradient of uptake in the English NHS bowel cancer screening programme.**	Decrease SES gradient in bowel cancer screening uptake.	Public Health England.	United Kingdom

Topic	Title	Aim	Organisation	Country
Colorectal cancer screening.	**Primary care involvement as a key to reduce inequalities in the colorectal cancer screening.**	Involve primary care staff members in order to increase participation rates and decrease access inequalities.	Basque Country Regional Ministry of Health.	Spain
Colorectal cancer screening.	**Slovenian national colorectal cancer screening – Svit Programme.**	Increase participation of people with lower level of education, male population and communities with the lowest response.	National Institute of Public Health.	Slovenia
Health promotion and cancer screening.	**Bringing cancer prevention closer to the most vulnerable population.**	Promote a favourable attitude of deprived population towards cancer (primary and secondary) prevention.	Alzira Local Centre for Public Health.	Spain

Topic	Title	Aim	Organisation	Country
Health promotion – Diet, nutrition.	**Nutri-Score.**	Improving consumer information at the point of purchase so that they can make healthier food choices, by providing at-a-glance interpretation of the overall nutritional quality of the food.	Nutritional epidemiology research team - Paris 13 University.	France
Health promotion – Diet, nutrition.	**OPTICOURSES programme, participatory workshops (demand side).**	Improve the nutritional quality to price ratio of food for people living in deprived areas.	French National Institute for Agricultural Research, INRA.	France
Health promotion – Diet, nutrition and physical activity.	**Vivons en Forme (Let's live healthy) program.**	Prevent overweight and obesity in children and reduce social inequalities by promoting healthy lifestyles among vulnerable families.	Fédérons les villes pour la Santé-FLVS.	France

Topic	Title	Aim	Organisation	Country
Health promotion – Physical activity.	**Programme for prescribing health assets for physical activity.**	Increase physical activity practice, especially among women and low-education population.	Public Health Directorate. Valencia Regional Ministry of Health.	Spain
Health promotion – Tobacco.	**TABADO.**	Evaluate the transferability of TABADO (smoking cessation program addressed to students in vocational training centres).	French National Cancer Institute	France

Full information on these interventions and associated documents are available at the contest webpage (figure 9).

Figure 9. Banner at iPAAC website linking to contest webpage.

4 Final remarks.

This contest, conducted in the framework of iPAAC Joint Action WP5, has allowed identification and dissemination of health and social interventions reducing inequalities in cancer prevention. This action facilitates implementation and replication of good practices in different health systems and services.

References

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6. European commission public health best practice portal. European Commission, DG Health & Food Safety Web site. https://webgate.ec.europa.eu/dyna/bp-portal/.

7. Good practices in Spanish national health system. Spanish Ministry of Health Web site. https://www.mscbs.gob.es/organizacion/sns/planCalidadSNS/BBPP.htm.

8. European code against cancer. International Agency for Research on Cancer, WHO Web site. https://cancer-code-europe.iarc.fr/index.php/en/.

9. Braveman P, Gruskin S. Defining equity in health. *Journal of epidemiology and community health (1979)*. 2003; 57(4):254-258. http://dx.doi.org/10.1136/jech.57.4.254. doi: 10.1136/jech.57.4.254.

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Annex 1. *Call for Experts*

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Call for experts on social inequalities in cancer prevention.

Scope

FISABIO (the Foundation for the Promotion of Health and Biomedical Research in Valencia Region, Spain), **invites independent experts to assist with the evaluation** of Best Practices tackling social inequalities in cancer prevention, in the framework of the Joint Action *Innovative Partnership for Action against Cancer* (iPAAC).

Background

The **iPAAC Joint Action,** co-funded under the 3rd European Health Programme (DG Santé), brings together 24 European countries and 44 partners whose main objectives are to develop and implement innovative approaches to advances in cancer control.

The iPAAC Joint Action officially started on 1 April 2018 and it will last for three years. It is coordinated by the National Institute of Public Health Slovenia (NIJZ). More information about the iPAAC Joint Action can be obtained by visiting the official website (www.ipaac.eu).

In the field of cancer prevention and population-based screening programmes, the project aims to strengthen the principles of the European Code against Cancer (ECAC) as well as to optimise population screening programmes by **integrating social equality as a crucial cross-cutting issue**.

In this light, FISABIO will launch at the beginning of 2019 a **Contest of Best Practices tackling social inequalities in cancer prevention**, including both health promotion and cancer screening programmes. The aim of this contest being to:

- **Identify and compile** relevant European experiences,
- **Disseminate** them among European countries in order to promote and facilitate their implementation in different health systems and services,
- Contribute to the **exchange and replication** of best practices on equality in cancer prevention.

The assessment of best practices will be carried out by the **panel of specialists selected through this call for experts**.

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Aim of the call

The present Call for Experts is addressed to **involve independent experts in the evaluation of proposals** submitted within the Contest of Best Practices tackling social inequalities in cancer prevention.

Experts on social inequalities, cancer prevention, health promotion, and/or population-based cancer screening programmes from scientific, academic and/or public policy management fields are welcome and they are invited to provide a sound methodological support to the Best Practices Contest evaluation stage.

Candidates' relevant areas of experience and skills

- Applicants will be evaluated on the following areas of knowledge and expertise: social and equity disciplines, epidemiology, occupational medicine and hygiene, environment and health, public health, health policy, health promotion, other scientific disciplines relevant to the topic;
- Professional experience in a multidisciplinary scientific environment, preferably in an international context;
- Published scientific papers on social inequalities in health and/or cancer prevention;
- Participation in collaborative projects related to the specific topics;
- Ability to work in English[1]: applicants must be able to read English and report in English, in writing and orally.

Selection procedure

Candidates' relevant areas of experience and skills will be evaluated in order to identify the most suitable experts. Each application will be assessed by at least two members of the Evaluation Board against the applicants' relevant areas of experience and skills. The Board will proceed to nomination according to the professional experience of the applicant. The process will also have to ensure independence of the experts (in particular, avoiding potential conflicts of interest) and, as far as possible, balanced geographical and gender distribution.

Estimated work burden – Fees and reimbursement

As a rule, **3 to 5 proposals** will be distributed to each of the selected specialists, together with an **assessment template and guidelines**. Selected experts are expected to work at distance following specific recommendations and procedures that will be detailed at a later stage. The

[1] 'Ability to work in English' corresponds to level B2 or above, as set out in the Council of Europe reference document for the European Language Portfolio ('Common European Framework of Reference: Learning, Teaching, and Assessment'). For more information please refer to http://europass.cedefop.europa.eu/en/resources/european-language-levels-cefr

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estimated overall work burden will be of approximately **1.5 working days**, full time, within a 30-day period. The evaluation process is expected to be concluded by **May 2019**.

Proposals shall extend up to a maximum of five pages and they will be assessed against specific quality criteria. Two different independent professionals will evaluate each proposal.

Experts' cooperation will be acknowledged in every publication resulting from this work. Nevertheless they will receive no fees for their contribution.

Submission of applications

Independent experts and professionals willing to apply are invited to express their interest by completing and sending their Expert Application Form to ipaac-bp@gva.es

Further supporting documents might be requested at a later stage.

The deadline for submitting applications for the present Call is February 28, 2019.

Conclusion of the procedure - Publication of results

The Evaluation Board of this Call for Experts will publish the results of the selection procedure on the iPAAC web site no later than 30 days after the deadline of the Call.

Additionally, applicants will be informed by e-mail.

Personal data

Personal data submitted by the applicants will be collected, processed and published in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council.

Information about the Call for Experts

Experts may ask for further information and details exclusively by E-mail to the following contacts at The Foundation for the Promotion of Health and Biomedical Research of Valencia Region, Spain (Fisabio):

ipaac-bp@gva.es

Annex 2. *Expert Application Form*

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Call for experts on social inequalities in cancer prevention
APPLICATION FORM

Personal and professional details

Title (Mr., Mrs., Dr., Prof., etc.):

First name:

Last name:

Gender:

☐ Female ☐ Male

Name of your organisation:

Legal status of your organisation:

☐ Public body

☐ Research organisation

☐ Secondary or higher education establishment

☐ Non-profit organisation

☐ Enterprise

Department:

Position in organisation:

Telephone number:

E-mail:

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Description of the profile (max. 300 words):

Relevant previous projects (up to 5) during the last five years:
(Please include at least: project title, year and funding institution and programme)

Relevant publications (up to five) during the last five years:

I declare there is no conflict of interest .

I certify that the information provided is true.

Personal data submitted by the applicants will be collected, processed and published in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council.

Annex 3. *Results on the Call for Experts.*

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Call for experts on social inequalities in cancer prevention. Call results

February 4, 2020

Background

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In the field of cancer prevention and population-based screening programmes, the project aims to strengthen the principles of the European Code against Cancer (ECAC) as well as to optimise population screening programmes by **integrating social equality as a crucial cross-cutting issue**.

In this light, iPAAC partner FISABIO launched in 2019 a **Contest of Best Practices tackling social inequalities in cancer prevention**, including both health promotion and cancer screening programmes. The aim of this contest being to:

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Previous to the contest, a **Call for Experts** was organized in order to appoint independent reviewers and to involve them in the contest assessment stage. The selected specialists became part of the Evaluation Board, otherwise integrated by members of the contest management team.

Call for experts - Publication of results

After selection procedure, the following experts were designated to provide support throughout the contest of best practices' evaluation stage:

Dr Flavia SESTI

Global health and health cooperation unit, Italian National Institute for Health, Migration and Poverty (NIHMP), Italy,

Dr Isabel PEÑA-REY

Screening Programs, Dirección Xeral Saúde Pública. Consellería de Sanidade. Regional Ministry of Galicia, Spain,

Dr Montserrat GARCÍA

Cancer Screening Unit, Cancer Prevention and Control Program, Institut Català d'Oncologia, Spain,

Dr Teresa SPADEA

Epidemiology Unit, Policies for inequalities and vulnerable groups, ASL TO3 Piedmont Region, Italy.

Should you need further information please contact
Contest management team at ipaac-bp@gva.es

Annex 4. *Submitter's Guide*

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Submitter's Guide.

Contest of Best Practices tackling Social Inequalities in Cancer Prevention.

Background

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Many **cancer risk and protection factors** such as tobacco consumption, diet, alcohol, exercise radiation, screening, vaccination etc. are **socially conditioned**. In general, those who pertain to lower socioeconomic groups are more exposed to cancer risk factors and less to protector ones. As a result, socially disadvantaged groups in all EU countries are at higher risk for most of the common cancers. Successful cancer prevention practices with an equity perspective requires not only an individual outlook but also a public health approach, addressing actions to the whole population with additional emphasis on socially vulnerable groups.

In this light, FISABIO (the Foundation for the Promotion of Health and Biomedical Research in Valencia Region, Spain) launches through the present call the **Contest of Best Practices tackling social inequalities in cancer prevention**, including both health promotion and cancer screening programmes. The aims of this contest are:

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This initiative adds to the efforts undertaken by the European Commission in preventing and managing non-communicable diseases through a good-practice-sharing approach, focusing exclusively and specifically on cancer prevention and screening, from the perspective of social inequalities.

The European Commission 3rd Health Programme states that, in order to promote health, prevent diseases, and foster supportive environments for healthy lifestyles, good practices should be identified and disseminated, and their uptake promoted, addressing in particular the key lifestyle related risk factors with a focus on the EU added value[1].

Documenting and sharing "Best Practices" affords one the opportunity to acquire knowledge about **lessons learned** and to continue learning about how to **improve and adapt** strategies and activities through feedback, reflection and analysis in order to implement larger-scale, sustained, and more effective interventions[2].

Based on the review of the *Guide for documenting and sharing "best Practices" in Health Programmes* (WHO – Regional Office for Africa)[2], documents and manuals concerning good practices compilation procedures available at the *EC Health and Food Safety Best Practice Portal*[3] and at the Spanish Ministry of Health[4], the term "best practice" has been defined as follows:

A best practice is an **innovative and relevant** intervention or organisational/managerial model implemented in a real life setting which has been favourably **assessed** in terms of adequacy (**ethics** and evidence) and **equity**, as well as **effectiveness and efficiency**. Additional criteria are important in determining best practices: ability to be transferred to other settings, sustainability, inter-sectorial collaboration and public involvement.

Practices submitted to the present contest will be evaluated, according to the above definition and reviews, against the **criteria** set further in this document.

Best Practices selected within this framework will be **disseminated through iPAAC website** in order facilitate their transfer and scaling-up.

[1] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014R0282&from=EN

[2] https://www.afro.who.int/sites/default/files/2017-06/Guide_for_documenting_and_Sharing_Best_Practice_-_english_0.pdf

[3] https://webgate.ec.europa.eu/dyna/bp-portal/

[4] https://www.mscbs.gob.es/organizacion/sns/planCalidadSNS/BBPP.htm

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FOR ACTION AGAINST CANCER

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Practical information

Specific rules:

- Practice(s) must be submitted by organizations that have designed and/or implemented them.
- Institutions willing to submit their practice are invited to complete and send their Application Form to ipaac-bp@gva.es
- The application form is structured in four different sections:
  A. Checklist for compulsory criteria (it will allow applicants to check whether mandatory criteria are met)
  B. General information (summary, title, person in charge, keywords, duration…)
  C. Description of the practice.
  D. Self-evaluation chart.
- **Deadline** for submission is **10th August 2019.**
- All information must be submitted in English.
- Personal data will be collected, processed and published in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council.
- If needed, further information and details should be requested exclusively by email through the following address: ipaac-bp@gva.es

Evaluation

Submitted practices will be assessed against the following criteria:

Compulsory criteria	*Basic criteria*
Relevance *Equity* *Effectiveness*	*Gender perspective* *Efficiency* *Ethics* *Sustainability* *Intersectorial collaboration* *Transferability* *Innovation* *Evidence and/or theory based* *Public Engagement*

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Compulsory criteria

Practices must meet each of the following three compulsory criteria in order to be accepted for evaluation:

1. *Relevance.*

This criterion refers to the strategic context the practice falls within. It must be under the scope of the following reference policies:

- European Code against Cancer (Annex 1).
- Council recommendation on cancer screening (Annex 2).

2. *Equity.*

Equity in health means equal opportunity to be healthy, for all population groups. Equity in health thus implies that resources are distributed and processes are designed in ways most likely to move toward equalising the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts. This refers to the distribution and design not only of health care resources and programmes, but of all resources, policies, and programmes that play an important part in shaping health, many of which are outside the immediate control of the health sector [5]

According to *"CanCon Policy Paper on tackling social inequalities in cancer prevention and control for the European population"*[6](Annex 3), the practice should address specific social inequalities and aim to reduce them.

- The practice is designed, and resources are allocated, considering individual as well as population needs.
- The relevant dimensions of equity are adequately and actively considered throughout the process of implementing the practice (e.g. age, gender,

[5] Bravemen, P, Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health* 57: 254-258. https://jech.bmj.com/content/57/4/254

[6] Peiró R, Molina-Barceló A, De Lorenzo F, Spadea T, Missinne S, Florindi F, Zengarini N, Apostolidis K, Coleman M.P, Allemani C, Lawler M. Policy Paper on Tackling Social Inequalities in Cancer Prevention and Control for the European Population. En: Federichi A, Nicoletti G, Van den Bulcke M editores. Cancer Control Joint Action Policy Papers. National Institute of Public Health, Slovenia and Scientific Institute of Public Health, Belgium; Belgium, 2017. ISBN: 978-961-7002-27-0.

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socioeconomic status, cultural background, geographic area, vulnerable groups).

- It reduces specific existing barriers and improves access to services for all population groups with special emphasis on socially vulnerable groups.
- The practice makes recommendations or guidelines to reduce identified health inequalities.
- The practice is built upon a bio-psychosocial model approach (considering e.g. family and personal history, support networks, socio-economic context, work and living conditions).

3. *Effectiveness.*

The practice has proven to be successful in achieving the objectives related to tackling social inequalities in cancer prevention.

- Addressed needs and problems are documented, allowing for a comparison between starting-point and endpoint.
- The indicators to measure the planned objectives are clearly described.
- The outcomes found are the most relevant given the objective, background and target population group.
- The evaluation outcomes demonstrate beneficial impact and they are linked to the stated objectives.
- Possible negative effects have been identified and stated.

Basic criteria

Practices will be assessed against the following criteria even though it is not mandatory to meet them all:

4. *Gender perspective.*

Gender refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men[7]

The practice specifically addresses gender-related inequalities as a cross-cutting issue.

[7] https://www.who.int/gender-equity-rights/understanding/gender-definition/en/

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- Gender-stratified data are considered for initial analysis and steers the practice approach.
- The analysis of results has been carried out taking into account the gender dimension.
- The experience promotes, through its actions or recommendations, the empowerment of women and men as self-care agents.

5. *Efficiency.*

It measures the extent to which the practice objectives have been successfully met under real conditions at the lowest possible cost.

- The practice has been evaluated from an economic point of view.
- The practice includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.

6. *Ethics.*

The practice guarantees ethical values.

- The practice must be respectful of the basic bioethical principles of Autonomy, Nonmaleficence, Beneficence and Justice.
- The practice includes measures aimed at protecting the rights of individuals, according to national and European legislation.
- Conflicts of interest (including potential ones) are clearly stated, including measures taken.
- Relevant information is adequately presented to patients/persons, ensuring conscious and informed decision making.

7. *Sustainability.*

The practice can be implemented over a long period of time with no (or minor) additional resources, adapting to social, economic and environmental context:

- The practice has institutional/financial support, an organizational and technological structure and stable human resources.
- The practice presents a financial report.
- The practice provides training of staff in terms of knowledge, techniques and approaches in order to sustain it,

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- A sustainability strategy has been developed taking into account a range of contextual factors (e.g. health and social policies, innovation, cultural trends and general economy, epidemiological trends).
- A contingency plan has been drawn up.

8. *Intersectoral collaboration.*

Ability of the practice to foster collaboration among the different sectors involved:

- The practice has been jointly implemented by several sectors.
- A multidisciplinary approach is supported by the agents involved.
- A continuum-of-care approach is encouraged through collaboration between social, health and/or other services.
- The practice sets up coordination arrangements involving all different stakeholders (e.g. professional associations, public institutions, educational establishment, employers).

9. *Transferability.*

This criterion refers to the practice capacity to being transferred to other settings or scaled up to a broader target population/geographic context.

- The practice uses instruments that allow for replication (e.g. a manual with a detailed activity description).
- The description of the practice includes all organizational elements, identifies the limits and the necessary actions that were taken to overcome legal, managerial, financial or skill-related barriers.
- A communication strategy and a plan to disseminate the results has been developed and implemented.
- The practice has already been successfully transferred.
- The practice shows adaptability to difficulties encountered during its implementation.

10. *Innovation.*

Novel approach to health challenges.

- The practice widens scientific knowledge or offers new methodology or proceedings.

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11. *Evidence and/or theory based.*

Scientific excellence or other evidence (e.g. grey literature) was used and analysed in a conscious, explicit and thoughtful manner:

- The intervention is built on a well-founded theory/principles and is evidence-based.
- The relevant concepts are stated and explained.

12. *Public Engagement.*

All societal actors work together during the whole process in order to align the practice to the needs of society.

- The structure, organization and content (also evaluation outcomes and monitoring) of the practice was defined and established together with the target population and social actors involved.
- Elements are included to promote empowerment of the target population (e.g. strengthen their health literacy, ensuring the right skills, knowledge and behaviour).
- Outcomes and results have been shared and disseminated among the target population.
- The practice encourages the creation and strengthening of community alliances and promotes social responsibility.

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Annex 1: European Code Against Cancer.

EUROPEAN CODE AGAINST CANCER

12 ways to reduce your cancer risk

1. Do not smoke. Do not use any form of tobacco.
2. Make your home smoke free. Support smoke-free policies in your workplace.
3. Take action to be a healthy body weight.
4. Be physically active in everyday life. Limit the time you spend sitting.
5. Have a healthy diet:
   - Eat plenty of whole grains, pulses, vegetables and fruits.
   - Limit high-calorie foods (foods high in sugar or fat) and avoid sugary drinks.
   - Avoid processed meat; limit red meat and foods high in salt.
6. If you drink alcohol of any type, limit your intake. Not drinking alcohol is better for cancer prevention.
7. Avoid too much sun, especially for children. Use sun protection. Do not use sunbeds.
8. In the workplace, protect yourself against cancer-causing substances by following health and safety instructions.
9. Find out if you are exposed to radiation from naturally high radon levels in your home. Take action to reduce high radon levels.
10. For women:
    - Breastfeeding reduces cancer risk. If you can, breastfeed your baby.
    - Hormone replacement therapy (HRT) increases the risk of certain cancers. Limit use of HRT.
11. Ensure your children take part in vaccination programmes for:
    - Hepatitis B (for newborns)
    - Human papillomavirus (HPV) (for girls).
12. Take part in organized cancer screening programmes for:
    - Bowel cancer (men and women)
    - Breast cancer (women)
    - Cervical cancer (women).

Find out more at: https://cancer-code-europe.iarc.fr/index.php/en/

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Annex 2: Council recommendation on cancer screening.

Screening tests which fulfil the requirements of the recommendation are:

- Pap smear screening for cervical cancer precursors.
- Mammography screening for breast cancer in women.
- Faecal occult blood screening for colorectal in men and women.

The Council of the European Union recommends that Member States:

1. Implementation of cancer screening programmes
(a) offer evidence-based cancer screening through a systematic population-based approach with quality assurance at all appropriate levels.
(b) implement screening programmes in accordance with European guidelines on best practice where they exist and facilitate the further development of best practice for high quality cancer screening programmes on a national and, where appropriate, regional level;
(c) ensure that the people participating in a screening programme are fully informed about the benefits and risks;
(d) ensure that adequate complementary diagnostic procedures, treatment, psychological support and after-care following evidence-based guidelines of those with a positive screening test are provided for;
(e) make available human and financial resources in order to assure appropriate organisation and quality control;
(f) assess and take decisions on the implementation of a cancer screening programme nationally or regionally depending on the disease burden and the healthcare resources available, the side effects and cost effects of cancer screening, and experience from scientific trials and pilot projects;
(g) set up a systematic call/recall system and quality assurance at all appropriate levels, together with an effective and appropriate diagnostic and treatment and after-care service following evidence-based guidelines;
(h) ensure that due regard is paid to data protection legislation, particularly as it applies to personal health data, prior to implementing cancer screening programmes.
2. Registration and management of screening data
(a) make available centralised data systems needed to run organised screening programmes;
(b) ensure by appropriate means that all persons targeted by the screening programme are invited, by means of a call/recall system, to take part in the programme;

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(c) collect, manage and evaluate data on all screening tests, assessment and final diagnoses;
(d) collect, manage and evaluate the data in full accordance with relevant legislation on personal data protection.
3. Monitoring
(a) regularly monitor the process and outcome of organised screening and report these results quickly to the public and the personnel providing the screening;
(b) adhere to the standards defined by the European Network of Cancer Registries in establishing and maintaining the screening databases in full accordance with relevant legislation on personal data protection;
(c) monitor the screening programmes at adequate intervals.
4. Training
Adequately train personnel at all levels to ensure that they are able to deliver high quality screening.
5. Compliance
(a) seek a high level of compliance, based on fully informed consent, when organised screening is offered;
(b) take action to ensure equal access to screening taking due account of the possible need to target particular socioeconomic groups.
6. Introduction of novel screening tests taking into account international research results
(a) implement new cancer screening tests in routine healthcare only after they have been evaluated in randomised controlled trials;
(b) run trials, in addition to those on screening-specific parameters and mortality, on subsequent treatment procedures, clinical outcome, side effects, morbidity and quality of life;

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(c) assess level of evidence concerning effects of new methods by pooling of trial results from representative settings;
(d) onsider the introduction into routine healthcare of potentially promising new screening tests, which are currently being evaluated in randomised controlled trials, once the evidence is conclusive and other relevant aspects, such as cost-effectiveness in the different healthcare systems, have been taken into account;
(e) consider the introduction into routine healthcare of potentially promising new modifications of established screening tests, once the effectiveness of the modification has been successfully evaluated, possibly using other epidemiologically validated surrogate endpoints.
7. Implementation report and follow-up
Report to the Commission on the implementation of this Recommendation within three years of its adoption and subsequently at the request of the Commission with a view to contributing to the follow-up of this Recommendation at Community level.

More information on:

https://ec.europa.eu/jrc/sites/jrcsh/files/2_December_2003%20cancer%20screening.pdf

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Annex 3: CanCon Policy Paper on tackling social inequalities in cancer prevention and control for the European population.

Recommendation 7: Implement proportionate universalism policies to develop and maintain living environments favouring compliance with the European Code Against Cancer.
Recommendation 8: Improve equitable access and compliance with cancer screening programmes.

Find out more at:

https://cancercontrol.eu/archived/uploads/PolicyPapers27032017/CanCon_Policy_Papers_FINAL_Web.pdf

Annex 5. *Best Practice Application Form*

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iPAAC Contest of Best Practices tackling social inequalities in cancer prevention
APPLICATION FORM

A. Checklist

Please check that your practice meets the compulsory criteria by answering the following questions.

1. Does the practice fall under any of the following recommendations? Please indicate all relevant:

☐ **European Code Against Cancer (please see Annex 1 to the Submitter's Guide)**

Please specify under which heading(s) – from 1 to 12:

☐ **Council recommendation(s) on cancer screening (Annex 2 to the Submitter's Guide) for:**

- ☐ Pap smear screening for cervical cancer precursors
- ☐ Mammography screening for breast cancer
- ☐ Faecal occult blood screening for colorectal cancer

Please indicate which specific recommendation(s) your practice is in line with, e.g. 1(a), 2 (b):

☐ **No (the practice is therefore excluded and cannot be accepted for evaluation)**

2. According to "CanCon Policy Paper on tackling social inequalities in cancer prevention and control for the European population" (refer to Annex 3 to the Submitter's Guide), does your practice aim to reduce social inequalities in cancer prevention?

☐ Yes (further information will be requested later in the form)

☐ No (the practice is therefore excluded and cannot be accepted for evaluation)

3. Has the practice shown to be effective in tackling social inequalities in cancer prevention?

☐ Yes (further information will be requested later in the form)

☐ No (the practice is therefore excluded and cannot be accepted for evaluation)

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B. General information

Please answer the following questions within the word limits and choose the relevant option(s) in each case.

1. Please summarise the type of practice you have been involved in (max. 200 words):
Please briefly describe the kind of practice and its main characteristics. Was it held within a health service setting, or independently from healthcare services? Was it an intervention on general population or a specific population group? Or was it about a novel change on organisational/managerial models?

2. General details about the practice

Title of the practice:

Institution(s) that promote(s) it:	
City/municipal/locality:	
Department/province/state:	
Country:	

3. Person in charge

Full name:	
Institution:	
Position:	
E-mail:	
Telephone number:	

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4. Contact person (if different from person in charge)

Full name:	
Institution:	
Position:	
E-mail:	
Telephone number:	

5. Keywords (minimum 5)

6. Duration of the practice

Start date (MM/YYYY):	End date (MM/YYYY):	Expected end date if the practice is ongoing (MM/YYYY):

7. What is the geographical scope of the practice?

☐ International (specify):	
☐ European (specify):	
☐ National (specify):	
☐ Regional (specify):	
☐ Local (specify):	

8. How was the practice funded?

☐ External resources – public (specify):	
☐ External resources – private (specify):	
☐ Own resources	
☐ Other (specify):	

☐ I declare that the economic operator(s) of the practice has (have) no conflict of interest

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9. Which population group(s) are prioritized in this practice?
Mark all that apply.

Gender:

- ☐ Women
- ☐ Men
- ☐ Transgender women
- ☐ Transgender men
- ☐ Other (specify):
- ☐ Not applicable

Socioeconomic level:

- ☐ Low
- ☐ Medium
- ☐ High
- ☐ Other (specify):
- ☐ Not applicable

Cultural/ethnic group:

- ☐ Ethnicity/Cultural background
- ☐ Migrants
- ☐ Country of origin
- ☐ Other (specify):
- ☐ Not applicable

Geographical area:

- ☐ Rural setting
- ☐ Urban setting
- ☐ Particularly deprived areas
- ☐ Other (specify):
- ☐ Not applicable

Age range:

- ☐ Specify:
- ☐ Not applicable

Educational level:

- ☐ Primary education
- ☐ Secondary education
- ☐ University education
- ☐ Post-graduate education
- ☐ Other (specify):
- ☐ Not applicable

Especially vulnerable groups

- ☐ Disability (functional diversity)
- ☐ Incarcerated population
- ☐ Sexual diversity groups
- ☐ Other (specify):
- ☐ Not applicable

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C. Description of the practice

When answering the following questions, please remind it is important to reflect the social equity perspective in all steps.

1. Why did we do it? (200 words)

Please outline the reasons for the development of the practice and describe social or gender inequalities concerning the situation, problem or need that motivated the practice. Please detail how the practice builds upon or is influenced by existing scientific evidence, conceptual frameworks and/or theoretical approaches.

2. What did we look for? (100 words)

What did you want to change by developing the practice? Please describe the action general and specific objectives.

3. How did we do it? (300 words)

Please explain, in 300 words or less, the specific steps that were implemented, emphasizing particular actions deployed to tackle the identified inequalities.

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3. How did we do it? (continuation)

4. What was the target population? (100 words)

5. With whom did we do it? (300 words)
Key actor(s) involved and their contributions to the action development. Please highlight participation mechanisms involving individuals/stakeholders concerned.

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6. Has the practice been assessed or evaluated?

☐ Yes, by an external partner (specify):

☐ Yes, the evaluation was carried out internally.

☐ No

7. Please briefly describe the evaluation methodology (200 words)
Please describe the indicators (quantitative and/or qualitative) developed to monitor the practice and explain how the evaluation was carried out. It is strongly recommended to attach to this form a document describing the evaluation process in more detail.

8. What have we achieved? (300 words)
The most important quantitative and/or qualitative obtained results. Please clearly and precisely summarize the main outcomes regarding achieved improvements, impact and/or eventual negative effects. It is mandatory to attach a document describing the main outcomes in order to prove the practice effectiveness.

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9. How did we sustain it? (200 words)

*Please describe how sustainability was achieved in **economic terms**, in **capacity building and leadership**, and please outline institutional mechanisms that contribute to achieving gender equality and/or social equity.*

10. Has the practice been applied in another context? (200 words)

☐ Yes

☐ No

If yes, please indicate new settings and implementation strategies, barriers found and facilitators:

11. What are the ethical principles underpinning the practice? (100 words)

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D. Self-assessment

Please complete the following self-evaluation chart:

		Please rate from 0 to 10.
Basic criteria	Gender perspective	
	Efficiency	
	Ethics	
	Sustainability	
	Inter-sectorial collaboration	
	Transferability	
	Innovation	
	Evidence and/or theory based	
	Public engagement	

By accepting the following statement, you give your consent to the processing of your personal data:

☐ *I consent to the processing (collection and further processing, including publishing) of my personal data (name, surname, job position, e-mail address, institution, country, telephone number, website of the project/practice) for the purposes of managing the submission and subsequent evaluation of my submitted best practice (s). Submission of the data is made on a voluntary basis and consent can be withdrawn at any time, without any consequences. Data are collected according to the Regulation (EC) No 45/2001 of the European Parliament and of the Council of 18 December 2000.*

☐ ***I certify, understand and agree that the provided information is correct and may be published on iPAAC website.***

Deadline for submission: **10 August 2019**

Please send this registration form to ipaac-bp@gva.es.

For further information please refer to www.ipaac.eu or email ipaac-bp@gva.es.

Annex 6. *Assessment Guidelines*

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Assessment guidelines.

Contest of Best Practices tackling Social Inequalities in Cancer Prevention.

Background

The iPAAC Joint Action, co-funded under the 3rd European Health Programme (DG Santé), brings together 24 European countries and 44 partners whose main objectives are to develop and implement innovative approaches to advances in cancer control.

The iPAAC Joint Action officially started on 1 April 2018 and it will last for three years. It is coordinated by the National Institute of Public Health Slovenia (NIJZ). More information about the iPAAC Joint Action can be obtained by visiting the official website (www.ipaac.eu).

In the field of cancer prevention and population-based screening programmes, the project aims to strengthen the principles of the European Code against Cancer (ECAC) as well as to optimise population screening programmes by integrating social equality as a crucial cross-cutting issue.

Many **cancer risk and protection factors** such as tobacco consumption, diet, alcohol, exercise radiation, screening, vaccination etc. are **socially conditioned**. In general, those who pertain to lower socioeconomic groups are more exposed to cancer risk factors and less to protector ones. As a result, socially disadvantaged groups in all EU countries are at higher risk for most of the common cancers. Successful cancer prevention practices with an equity perspective requires not only an individual outlook but also a public health approach, addressing actions to the whole population with additional emphasis on socially vulnerable groups.

In this light, FISABIO (the Foundation for the Promotion of Health and Biomedical Research in Valencia Region, Spain) launches through the present call the **Contest of Best Practices tackling social inequalities in cancer prevention**, including both health promotion and cancer screening programmes. The aims of this contest are:

- To **identify and compile** relevant European experiences,
- To **disseminate** them among European countries in order to promote and facilitate their implementation in different health systems and services,
- To contribute to the **exchange and replication** of best practices on equality in cancer prevention.

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This initiative adds to the efforts undertaken by the European Commission in preventing and managing non-communicable diseases through a good-practice-sharing approach, focusing exclusively and specifically on cancer prevention and screening, from the perspective of social inequalities.

The European Commission 3rd Health Programme states that, in order to promote health, prevent diseases, and foster supportive environments for healthy lifestyles, good practices should be identified and disseminated, and their uptake promoted, addressing in particular the key lifestyle related risk factors with a focus on the EU added value[1].

Documenting and sharing "Best Practices" affords one the opportunity to acquire knowledge about **lessons learned** and to continue learning about how to **improve and adapt** strategies and activities through feedback, reflection and analysis in order to implement larger-scale, sustained, and more effective interventions[2].

Based on the review of the *Guide for documenting and sharing "best Practices" in Health Programmes* (WHO – Regional Office for Africa)[2], documents and manuals concerning good practices compilation procedures available at the *EC Health and Food Safety Best Practice Portal*[3] and at the Spanish Ministry of Health[4], the term "best practice" has been defined as follows:

A best practice is an **innovative and relevant** intervention or organisational/managerial model implemented in a real life setting which has been favourably **assessed** in terms of adequacy (**ethics** and evidence) and **equity**, as well as **effectiveness and efficiency**. Additional criteria are important in determining best practices: ability to be transferred to other settings, sustainability, inter-sectorial collaboration and public involvement.

Practices submitted to the present contest will be evaluated, according to the above definition and reviews, against the **criteria** set further in this document.

[1] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014R0282&from=EN

[2] https://www.afro.who.int/sites/default/files/2017-06/Guide_for_documenting_and_Sharing_Best_Practice_-_english_0.pdf

[3] https://webgate.ec.europa.eu/dyna/bp-portal/

[4] https://www.mscbs.gob.es/organizacion/sns/planCalidadSNS/BBPP.htm

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Evaluation rules:

- Only proposals complying with the compulsory criteria ('relevance', 'equity' and 'effectiveness') will be evaluated by experts. Evaluation will be performed on the basis of the following **basic criteria**:

  1. Gender perspective
  2. Efficiency
  3. Ethics
  4. Sustainability
  5. Intersectorial collaboration
  6. Transferability
  7. Innovation
  8. Evidence and/or theory based
  9. Public engagement.

- An explanation on these criteria has been included, in order to provide the reference framework and perspective.
- Each basic criterion will be assessed on a **scale from 0 to 5**.
- Justification on the score awarded may be described briefly in the corresponding section.
- Proposals achieving an overall score of 27 points or more will be considered "best practice".

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1. *Gender perspective.*

Gender refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men[5]

The practice specifically addresses gender-related inequalities as a cross-cutting issue.

- Gender-stratified data are considered for initial analysis and steers the practice approach.
- The analysis of results has been carried out taking into account the gender dimension.
- The experience promotes, through its actions or recommendations, the empowerment of women and men as self-care agents.

Awarded score *(please tick only one box).*

0 – Proposal fails to address the criterion or cannot be assessed due to missing or incomplete information.	○
1 – Poor. The criterion is inadequately addressed or there are serious inherent weaknesses.	○
2 – Fair. The proposal broadly addresses the criterion, but there are significant weaknesses.	○
3 – Good. The proposal addresses the criterion well, but a number of shortcomings are present.	○
4 – Very good. The proposal addresses the criterion very well, but a small number of shortcomings are present.	○
5 – Excellent. The proposal successfully addresses all relevant aspects of the criterion. Any shortcomings are minor.	○

Justification/argument (max 750 characters):

[5] https://www.who.int/gender-equity-rights/understanding/gender-definition/en/

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2. *Efficiency.*

It measures the extent to which the practice objectives have been successfully met under real conditions at the lowest possible cost.

- The practice has been evaluated from an economic point of view.
- The practice includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.

Awarded score *(please tick only one box).*

0 – Proposal fails to address the criterion or cannot be assessed due to missing or incomplete information.	○
1 – Poor. The criterion is inadequately addressed or there are serious inherent weaknesses.	○
2 – Fair. The proposal broadly addresses the criterion, but there are significant weaknesses.	○
3 – Good. The proposal addresses the criterion well, but a number of shortcomings are present.	○
4 – Very good. The proposal addresses the criterion very well, but a small number of shortcomings are present.	○
5 – Excellent. The proposal successfully addresses all relevant aspects of the criterion. Any shortcomings are minor.	○

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3. *Ethics.*

The practice guarantees ethical values.

- The practice must be respectful of the basic bioethical principles of Autonomy, Nonmaleficence, Beneficence and Justice.
- The practice includes measures aimed at protecting the rights of individuals, according to national and European legislation.
- Conflicts of interest (including potential ones) are clearly stated, including measures taken.
- Relevant information is adequately presented to patients/persons, ensuring conscious and informed decision making.

Awarded score (please tick only one box).

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4. *Sustainability.*

The practice can be implemented over a long period of time with no (or minor) additional resources, adapting to social, economic and environmental context:

- The practice has institutional/financial support, an organizational and technological structure and stable human resources.
- The practice presents a financial report.
- The practice provides training of staff in terms of knowledge, techniques and approaches in order to sustain it,
- A sustainability strategy has been developed taking into account a range of contextual factors (e.g. health and social policies, innovation, cultural trends and general economy, epidemiological trends).
- A contingency plan has been drawn up.

Awarded score (please tick only one box).

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5. *Intersectoral collaboration.*

Ability of the practice to foster collaboration among the different sectors involved:

- The practice has been jointly implemented by several sectors.
- A multidisciplinary approach is supported by the agents involved.
- A continuum-of-care approach is encouraged through collaboration between social, health and/or other services.
- The practice sets up coordination arrangements involving all different stakeholders (e.g. professional associations, public institutions, educational establishment, employers).

Awarded score (please tick only one box).

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6. *Transferability.*

This criterion refers to the practice capacity to being transferred to other settings or scaled up to a broader target population/geographic context.

- The practice uses instruments that allow for replication (e.g. a manual with a detailed activity description).
- The description of the practice includes all organizational elements, identifies the limits and the necessary actions that were taken to overcome legal, managerial, financial or skill-related barriers.
- A communication strategy and a plan to disseminate the results has been developed and implemented.
- The practice has already been successfully transferred.
- The practice shows adaptability to difficulties encountered during its implementation.

Awarded score (please tick only one box).

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7. *Innovation.*

Novel approach to health challenges.

- The practice widens scientific knowledge or offers new methodology or proceedings.

Awarded score (please tick only one box).

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8. *Evidence and/or theory based.*

Scientific excellence or other evidence (e.g. grey literature) was used and analysed in a conscious, explicit and thoughtful manner:

- The intervention is built on well-founded theory/principles and is evidence-based.
- The relevant concepts are stated and explained.

Awarded score (please tick only one box).

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9. *Public Engagement.*

All societal actors work together during the whole process in order to align the practice to the needs of society.

- The structure, organization and content (also evaluation outcomes and monitoring) of the practice was defined and established together with the target population and social actors involved.
- Elements are included to promote empowerment of the target population (e.g. strengthen their health literacy, ensuring the right skills, knowledge and behaviour).
- Outcomes and results have been shared and disseminated among the target population.
- The practice encourages the creation and strengthening of community alliances and promotes social responsibility.

Awarded score (please tick only one box).

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Please complete the following **summary evaluation chart**:

Criteria	Score
Gender perspective	
Efficiency	
Ethics	
Sustainability	
Intersectorial collaboration	
Transferability	
Innovation	
Evidence and/or theory based	
Public engagement	
Total score	