Evaluation framework for health promotion projects

For Chronic Disease Prevention (CDP) Unit staff

This document forms the basis of the evaluation framework for the health promotion projects of the CDP Unit. It is complemented by an example plan and a list of agreed indicators. These have been developed for nutrition and physical activity projects in the first instance but it is envisaged that, in future, an agreed list of indicators will be developed for each of the key work areas of the Unit.

The aim of this framework is to improve the evaluation of health promotion projects funded by the CDP Unit. It aims to achieve this by:

- *Providing guidance to staff on how to write an evaluation plan (included as part of this document)*
- *Providing an example of a good evaluation plan (the HPC:BAEW evaluation plan)*
- *Specifying some agreed parameters for good evaluation, e.g. what is a good study design for impact evaluation? (included in this document)*
- *Specifying an agreed list of indicators for our projects, including details of how to measure the indicators (the indicators). This will allow greater opportunity to compare the impacts and outcomes of different projects.*

It is acknowledged that this framework cannot be a one-size-fits all and flexibility will be required in tailoring the example plan to meet the evaluation requirements of specific projects. Further, it needs to be complemented by the following actions:

- *Evaluation plans need to be developed jointly by program staff, key stakeholders and staff with evaluation expertise.*
- *A commitment from management and staff to support quality evaluation by requiring that evaluation plans be written at the same time as project plans and before project implementation or tendering.*
- *A commitment from management and staff to use the results of evaluations in future program design*

The language used in this document is consistent with the language of "Integrated Health Promotion" as used in the resource kit[1] and two evaluation guides[2, 3]. However, it is acknowledged that not all sectors speak this language and that the new Health Promotion Framework[4], which is currently out for discussion, uses some different language in order to make it more accessible to sectors outside of health promotion and health. To increase understanding, definitions and explanations are given throughout the document where differences in use are evident.

This framework is designed to complement the Integrated Health Promotion evaluation resources[2, 3] and readers are referred to these resources for further details. Other resources have also been used in writing this framework – particularly those of the Metropolitan Health & Aged Care Services (MHACS) Evaluation Support Unit (http://intranet 2.csv.au/ahs/esu.htm).

It is envisaged that this document will require ongoing updates as it is trialled with new projects and as its audience expands beyond CDP. So please provide feedback directly to Michelle Haby or Lynn Holt (contact details on last page).

Department of Human Services

An evaluation plan[a] should be developed for all new programs before they are implemented. The evaluation plan needs to be written alongside the overall program plan and allows you to:

- Identify the objectives of the evaluation,
- Clarify roles and responsibilities of those involved in the evaluation,
- Determine the most appropriate evaluation strategy/design,
- Clarify assumptions / evidence upon which program design and implementation were based,
- Outline how a program intends to produce results,
- Design the most appropriate evaluation questions to measure the impact of the objectives,
- Determine the most appropriate data collection methods,
- Outline how the evaluation results will be disseminated, and
- Cost the evaluation.

The 6 steps outlined in this guide are based on the framework used in the "Planning for effective health promotion evaluation" resource [3], with some modifications. But flexibility can be exercised in the headings used as long as the key issues/parameters covered here are included.

Step 1. Describe the program

This section should briefly outline what the program is, including its goal and objectives, target groups, the policy context, supporting evidence and key assumptions. It should also include the 'program logic' and consider how the program is addressing health inequalities.

Program logic[b]

See figure 1 as an example program logic model that is applicable to a whole of community health promotion program for nutrition and physical activity. Using a program logic model in the program planning and evaluation planning stages can assist you to identify the activities, impacts and outcomes that need to be evaluated. Models like this can be developed for smaller components or objectives of the program, or they can be used to represent all programs across a community or state.[5]

Program logic models can also include a column on the left to identify inputs (resources needed to operate the program) – this is not included in this example (figure 1). Models can also include a column after activities to define outputs (the types, levels and targets of services to be delivered by the program) – these are not included here but can be found in Table 2. The second column of program activities is based on the language used in the new Health Promotion Framework[4]. The language in brackets comes from the Integrated Health Promotion Resource Kit[1]. Note also that different definitions for impacts and outcomes are evident in the evaluation literature. Here, we define **impact** as the intermediate effect that health promotion programs have on populations, individuals or their environments[3]. **Outcome** is defined as the long-term effect of programs and may include reductions in incidence or prevalence of health conditions, changes in mortality, sustained behaviour change, or improvements in quality of life[3].

Health inequalities

In regards to health inequalities, it is important for the program to be clear about how population-wide approaches are used to reduce unequal health outcomes and to ensure that

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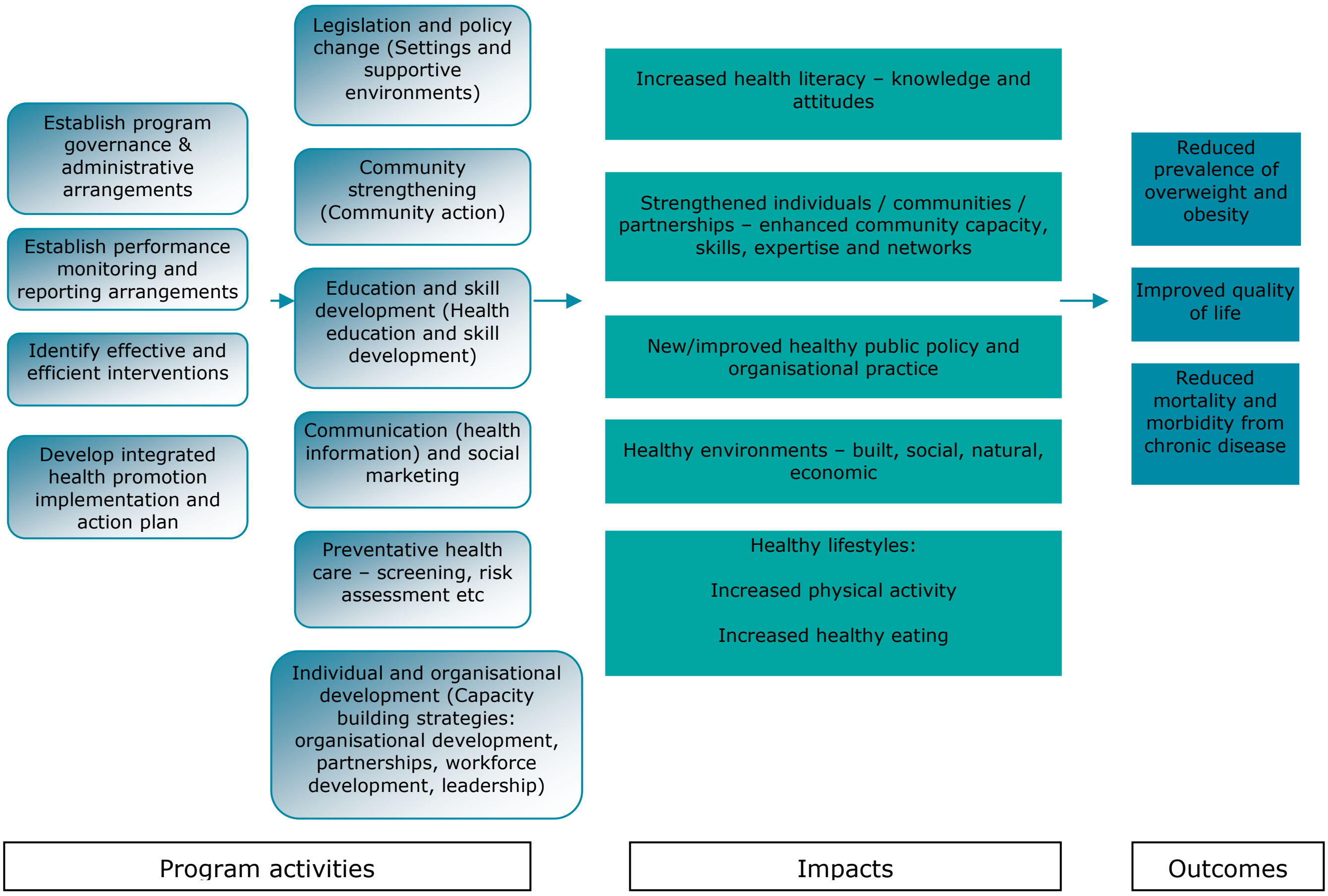
[a] The term evaluation framework is also used extensively, including by the Evaluation Support Unit of MHACS.

[b] The term program logic is frequently used interchangeably with the terms program theory, logic model and causal model. See resource 3 in the Evaluation Support Unit's Toolkit on their website for further examples and alternative approaches.

they do not inadvertently widen inequalities. Often, targeted interventions are used in conjunction with population-wide approaches to minimise this risk and further equality goals [6].

Figure 1. Underlying intention of the HPC:BAEW initiatives.



Step 2. Evaluation preview: Engage stakeholders, clarify the purpose of the evaluation, identify key questions and identify evaluation resources

This section should identify the key stakeholders involved; clarify the aspects of the program that are to be evaluated and the purpose of the evaluation, including who will use the results and how, e.g. to determine future funding.

Key questions

Evaluation questions should be formulated in key areas (e.g. reach, appropriateness, implementation, effectiveness, efficiency, and/or maintenance). The number of key questions should be limited to 12-15 at most. A good evaluation question addresses a specific area of concern and is amenable to some type of measurement – which you will need to include in Step 3. See Table 1 for some example questions that can be adapted for specific programs[c].

[c] See also resource 5 in the Evaluation Support Unit's Toolkit for further examples under the headings need for program, reach, appropriateness, adoption, implementation, effectiveness, efficiency and maintenance

Table 1. Some generic questions for evaluation of health promotion programs

QUESTION FOCUS	QUESTIONS
Process	▪ Has the program been implemented as intended? ▪ What factors (both positive and negative) impacted on the implementation ▪ What proportion of the target group has received the program? ▪ Has uptake of the program varied by socioeconomic position, Indigenous status, non-English speaking background and/or rural/metro location? ▪ Have program participants (staff, community organisations, community members) been satisfied with the program? ▪ How effective were contracting and subcontracting arrangements that were established to support program implementation and evaluation?
Impacts and outcomes	▪ Have the program impacts and outcomes been achieved? ▪ What impact has the program had on populations facing greatest inequality? ▪ What unanticipated positive and negative impacts/outcomes have arisen from the program? ▪ Have all strategies been appropriate and effective in achieving the impacts and outcomes? ▪ What have been the critical success factors and barriers to achieving the impacts and outcomes? ▪ Is the cost reasonable in relation to the magnitude of the benefits? ▪ Have levels of partnership and collaboration increased?
Implications for future programs and policy	▪ Should the program be continued or developed further? ▪ Where to from here? ▪ How can the operation of the program be improved in the future? ▪ What performance monitoring and continuous quality improvement arrangements should exist into the future? ▪ How will the program or the impacts of the program be sustained beyond the funding timeframe? ▪ Will additional resources be required to continue or further develop the program?

Resources for the evaluation

It is important to consider the needs of the evaluation when deciding on resources for your evaluation. If the program is new and innovative it may be necessary to evaluate it more intensively, using a stronger study design[d]. This may be particularly important if you want to use the evaluation to obtain additional funding. If a program has been run a number of times and has been shown, through impact evaluation, to be effective, it is likely to be sufficient to do a process evaluation to ensure that the program is being implemented as planned. For

[d] This may also be necessary if the program is being implemented in a new site or setting.

these programs, agreed indicators of process/impact/outcome should be specified in the evaluation framework and performance monitoring mechanisms should be used to ensure collection of data on these indicators (also known as key performance indicators), i.e. data collection can be incorporated into routine practice.

Step 3. Focus the evaluation design: Specify the evaluation design, data collection methods and locate and develop data collection instruments

The quality of an evaluation depends upon the strength of evidence that is collected to answer the evaluation questions. In order to maximise the value of information collected for evaluation it is important to:

- Choose a study design that gives the best level of evidence possible given practical and financial limitations. For example, to establish the effectiveness of an intervention it is important to include pre and post measures in the same subjects and include an appropriate comparison to ensure that changes can be attributed to the program – this helps rules out alternative explanations for any observed changes in impact/outcome indicators.
- Identify reliable information sources and data collection tools. In determining the most appropriate tools, consideration should be given to using existing data collection tools that have good validity and reliability (i.e. they actually measure what they purport to measure and give consistent results). They should also be comparable, where possible, with existing data collections, e.g. the Victorian Population Health Survey and the Victorian Child Health & Wellbeing Survey.

If this is new to you we recommend that you seek the help of someone with evaluation, epidemiology and/or research skills for this part of the plan.

Two main evaluation methods are appropriate to evaluate health promotion programs. These are process evaluation and impact/outcome evaluation. The methods and key indicators for each of these will be described in turn.

Process evaluation

Process evaluation covers all aspects of the process of delivering a program. It is useful in tracking the reach of the program and the level of implementation of all aspects of the program, and in identifying potential or emerging problems, i.e. whether the program has been delivered as planned and whether modifications to the plan need to be made[e].

From an equalities focus, it is important to reflect on how program delivery has engaged with key populations facing greatest inequality in culturally appropriate ways, and process evaluation should measure how this was undertaken.

The main methods used for process evaluation are review of key program documents to assess the extent to which the activities identified in Figure 1 have been implemented, and data collection to measure program reach. Reach is the number of key stakeholders, settings or members of the community affected by the program. Some aspects of reach, e.g. program attendance, are measured as part of the impact/outcome evaluation. Other aspects addressed by process evaluation include the quality and appropriateness of the processes undertaken during its implementation.

[e] This process can be described as action research because the results of the process evaluation lead to changes in the program.

Data collection tools / data sources for process evaluation:

- Key documents include Steering Group or Advisory Group minutes, DHS contract management records, project action plans, progress reports to DHS[f], project evaluation plans.
- Other qualitative methods can be employed, as appropriate, such as open-ended surveys, in-depth interviews, focus groups, narrative and participant observation (see pages 8-12 of *"Planning for effective health promotion evaluation"*[3]).
- Reach can be established from attendance records and documentation of stakeholders and settings by the project manager. Community surveys may also be necessary.

See Table 2 for some example outputs and reach indicators that can be considered in the process evaluation to measure the extent of implementation. The list of activities comes from the program logic (figure 1). This will be complemented by the qualitative data collected in the process evaluation.

Table 2. Some example key activities, outputs and reach indicators – for process evaluation

ACTIVITIES	OUTPUTS / REACH INDICATORS
1. Establish program governance and administrative arrangements	▪ Contracts with project implementators established ▪ Project Advisory Group / Steering Group established ▪ Contract with evaluators established
2. Establish performance monitoring and reporting arrangements	▪ Project milestones identified, or ▪ Key indicators identified for program monitoring and reporting
3. Identify effective and efficient interventions	▪ Evidence reviewed ▪ Interventions selected ▪ Evidence incorporated into action plan
4. Develop integrated health promotion implementation and action plans	▪ Community assessment conducted and reported ▪ Action plans finalised
5. Legislation and policy change	▪ Number and range of stakeholders involved in new/improved legislation and policy change (reach)
6. Community strengthening / action	▪ Number and range of stakeholders/settings involved (reach)
7. Education and skill development	▪ Number and range of stakeholders/settings involved (reach)
8. Communication and social marketing	▪ Evidence on effective social marketing messages and methods reviewed ▪ Key marketing channels/methods (e.g., newspaper, Internet, telephone helpline, point of sale displays etc.) identified ▪ Marketing materials developed ▪ Campaigns implemented in targeted areas ▪ Proportion of target group aware of funded

[f] It is important that these, or other documents, include a description of the strategies used as they may have changed from what was written in the action plan.

ACTIVITIES	OUTPUTS / REACH INDICATORS
	social marketing/health information activities and resources (reach)
9. Preventative health care e.g. screening, health risk assessments etc	▪ Number of people and proportion of target group participating in each activity (reach)
10. Individual and organisational development	▪ Number and range of stakeholders/settings involved (reach)

Definitions of activities 5-10 are available in Department of Human Services 2007.[4] Activities 5-9 are the five health promotion action areas described on page 11-12 and Activity 10 is an aspect of system support described on page 11. Note: this may be expanded to include other capacity building strategies such as partnerships, workforce development and leadership

Impact/outcome evaluation

This type of evaluation is used to measure intermediate (impacts) and longer-term (outcomes) effects of the program and to check whether programs are having an impact on populations facing greatest inequality.

The main method used is comparison of the intervention group(s) with another group that does not receive the intervention (the control group), with changes in individual level impacts/outcomes measured pre and post intervention in a randomly selected sample of individuals. The appropriate sample size should be determined by an evaluator with appropriate skills or through consultation with a statistician. Sample size calculations should aim to achieve a meaningful level of behaviour change compared to the control group (e.g. difference in prevalence of >10%) and weight over the project period (eg. 0.5kg/m^2 change in BMI or >2kg in children and >3kg in adults). Consideration should be given to attaining an adequate response and follow-up rate to ensure maximum validity and generalisability of results.

Someone with skills in research and/or epidemiology will be able to help you to adjust this study design to fit your evaluation context and budget, while endeavouring to obtain the best level of evidence possible.

The methods used to measure individual level impacts include questionnaires and other instruments for objective assessments, e.g. tools to measure height and weight, pedometers to measure physical activity.

Methods to assess changes in public policy, communities, and environments can include policy and environment audits, tools to assess partnership strength and community capacity building. The difference is that these measures are done at the level of the setting, community or partnership rather than in individuals.

Some example key impact and outcome indicators for nutrition and physical activity health promotion programs are identified in Table 3. Details of data collection tools / data sources and questions used in the tool will also need to be specified when implementing the evaluation plan. For nutrition and physical activity projects these can be found in the indicator table (see supporting document: "Indicators for evaluation and monitoring of N&PA programs"). This table defines a minimum common set of indicators that can be used for evaluation of nutrition and physical activity projects of the CDP Unit. Most projects will not require this many indicators and preference should be given to quality rather than quantity of indicators. When choosing indicators and tools, the focus has been to first use validated state-wide indicators (e.g. the Victorian Population Health Survey) and then, if needed, national indicators and other validated tools.

Table 3. Example impact and outcome indicators for nutrition and physical activity programs.

IMPACTS AND OUTCOMES	INDICATORS
1. Increased health literacy	To be advised
2. Strengthened individuals / communities / partnerships	**Level of partnership synergy** **Social Support through social networks** ▪ Social networks & support structures ▪ Social & community participation
3. New/improved healthy public policy and organisational practice	**school policy** ▪ Proportion of schools complying with the recommended canteen/food service guidelines or general healthy eating principles. ▪ School/service/workplace policies supporting healthy eating and physical activity ▪ School curriculum supporting HE and PA for all levels and grades. ▪ Proportion of schools meeting the mandated levels of PA (P-3: 20-30 mins/day ; 4-6: 3 hours/week of physical education and sport with a minimum provision of 50% of PE; or Federal Government's Active School Curriculum legislation of two hours of physical activity per week for all students **Pre- schools** To be advised **Work place policy for breast feeding, availability of healthy food choices** To be advised
4. Increased physical activity	**Proportion meeting the recommended levels of physical activity** **Proportion using active transport** **Proportion participating in organised activity/sport** **Sedentary behaviour / children's screen time** Time spent using electronic media
5. Increased healthy eating	**Proportion meeting recommended levels of fruit and vegetable consumption** **Breastfeeding** ▪ Proportion of children aged 3.5 years who were ever breastfeed and those who were exclusively breastfed at 3 and 6 months **Quantity of sugar sweetened beverages consumed** **Quantity of water consumed**

IMPACTS AND OUTCOMES	INDICATORS
	Consumption of energy dense foods ▪ Proportion consuming energy dense snack foods or takeaways
6. Healthy environments – built, social, natural, economic	▪ Proportion of Municipal Public Health Plans that have included healthy by design features to encourage healthy and safe communities ▪ Proportion of Municipal Public Health Plans that include promotion and support for access to community gardens encouraging production of fresh fruit and vegetables **Accessible local recreation spaces** Portion of children and young people living in neighbourhoods with good parks, playgrounds and play-spaces and recreational facilities Perceptions of safety **Transport limitations** **Roads and footpaths**
7. Reduced prevalence of overweight and obesity	▪ Height, weight, BMI, waist circumference
8. Reduced mortality and morbidity	▪ Burden of disease
9. Improved quality of life	**Self reported health** **General Health Status (0-13yrs)** Australian Early Development Index (AEDI) **Quality of life utility instrument** ▪ Assessment of Quality of Life (AQoL) Mark 2 – adult and adolescent version. **No increase in teasing, stigmatisation, dieting practices or dissatisfaction with body weight**

Health inequalities[9]

To check whether programs are having an impact on populations facing greatest inequality, it is important that measures collect demographic data including socioeconomic position, Indigenous status, non-English speaking background and rural/metro locations. This allows analysis of impacts and outcomes by health inequality.

When collecting demographic data, it is important to capture key populations that face greatest inequality so that impacts and outcomes can be analysed to see their effect on reducing inequality. This means individual or household demographic measures including:

- Socio-economic position
- Indigenous status
- Rural residence
- Non-English speaking background

[9] A conceptual guide / resource on health inequalities is currently being developed for CDPU and much of this section may be replaced by a simple reference to that resource.

Socioeconomic position can be measured in a number of ways and each has its advantages and limitations. The two principle methods of defining socioeconomic position for the purpose of monitoring progress to reduce inequality are:

a) By a measure of household income
b) By area level disadvantage.

Low socioeconomic disadvantage is defined as households earning less than 50% of median household income - this concords with DHS practice (such as the State of Victoria's Children reports) and with the OECD definition of poverty. Other definitions suggest 60% of median household income. In 2008, this equates to household income of around $31,000 per year or less. When using an area level of disadvantage, low socioeconomic areas are recognised as those in the lowest two quintiles (lowest 40%) of advantage according to the ABS Index of Relative Socioeconomic Disadvantage (IRSED). It is also possible to use education or employment status as a measure of socioeconomic position as well.

Indigenous status is usually asked as "Are you of Aboriginal or Torres Strait Islander descent?"

Rural residence is usually asked by suburb or postcode and then organising data by whether this places them in a rural or metropolitan local government area.

Non-English speaking background can be asked by whether participants speak a language other than English in the home or by asking country of birth and then analysing data by whether the country is mainly English speaking or not.

Step 4. Collect data: coordinate the data collection

In this section you need to specify:

- what tasks need to be completed
- who will undertake the tasks
- when the tasks should be undertaken
- what resources are required.

Also give some thought as to how you might maximise response rates. Techniques for doing this can be included here, e.g. providing incentives, using reminder messages.[3]

Step 5. Analyse and interpret data

Data analysis involves identifying and summarising the key findings, themes and information contained in the raw data.[3] Specify here what data analysis techniques you will use and what computer software you will use. If you are not very familiar with qualitative or quantitative data analysis we recommend that you seek the help of someone with evaluation, epidemiology and/or research skills for this part of the plan.

Step 6. Disseminate the lessons learnt: consider reports to be prepared, appropriate format, appropriate audience and how the findings will be disseminated

Dissemination of health promotion evaluation findings is crucial in establishing a strong evidence base for health promotion. It is important to document not only what worked, but what didn't work and what some of the reasons for success and failure might be.[3]

At a minimum a final technical report should be prepared and include the following sections:

(a) **Executive summary** states critical issues.

(b) **Program background** describes program purpose, structure, history, key characteristics, and the implementation strategies.

(c) **Evaluation background** describes evaluation purpose, focus, and terms of reference. It also acknowledges the limitations caused by constraints on time, resources, data availability, and so forth. Ideally this section also documents the perspectives of key stakeholders, against which evaluation results are valued.

(d) **Program logic section** documents program logic using both the outcome and theoretical approaches.

(e) **Evaluation methodology** section describes and justifies selected methods (including study design, sampling, and data collection tools and instruments) and examines their strengths and limitations.

(f) **Data analysis** section describes all analytic procedures, along with their assumptions and limitations.

(g) **Findings** section presents acquired facts in order of their relative importance. These facts should clearly be distinguished from opinions, judgements and speculations.

(h) **Conclusions**. Conclusions are the interpretations of data and information in light of collected evidence. Conclusions also reflect the values of the identified stakeholders (e.g. positive, negative, above or below the expectations etc).

(i) **Recommendations**. Recommendations advise policy-makers, decision-makers, and program managers about the proposed actions based on collected evidence. If applicable, recommendations should present alternative actions together with their possible implications in terms of cost and possible effects. Realistic and implementable recommendations are usually developed in consultation with key stakeholders.

It is important to ensure that this technical report is of the highest quality possible as it will provide the basis for preparing summary reports, reports for different audiences, journal paper/s for publication etc as needed.

Dissemination strategies

A mix of dissemination strategies can be used, including:

- training
- communication through print, including a technical report, summary reports for different audiences and peer-reviewed journal articles[h].
- communication through new information technologies
- personal face-to-face contacts, including briefings or presentations
- policies, administrative arrangements and funding incentives.

References

1. Department of Human Services. *Integrated health promotion resource kit*. Victorian Government Department of Human Services: Melbourne, 2003.
2. Department of Human Services. *Measuring health promotion impacts: a guide to impact evaluation in integrated health promotion*. Victorian Government Department of Human Services: Melbourne, 2003.
3. Round R, Marshall B, Horton K. *Planning for effective health promotion evaluation* Victorian Government Department of Human Services: Melbourne, 2005.
4. Department of Human Services. *Developing a new framework for promoting health and wellbeing in Victoria: a discussion paper*. Victorian Government Department of Human Services: Melbourne, 2007.
5. US Department of Health and Human Services. *Physical activity evaluation handbook*. US Department of Health and Human Services, Centers for disease Control and Prevention: Atlanta, GA, 2002.
6. Boyd M. People, Places, Processes: Reducing health inequalities through balanced health approaches. [cited; Available from: www.vichealth.vic.gov.au/inequalities

[h] Where possible publication of the results in a peer-reviewed journal is encouraged and supported by the Department to contribute to the health promotion evidence base.

A business case for new and continuing data collections is required to be made. The contact person for RRHACS is:

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The following checklist has been prepared by Darren Harris, Strategic Policy and Evaluation Unit, MHACS to facilitate the process.

Evaluation data collection checklist			
Need to collect information for evaluation has been demonstrated	**Yes** No	Relevant stakeholders consulted in development of evaluation methods	**Yes** No
All existing sources of potential DHS data have been reviewed	**Yes** No	Requirements for ethics committee approval have been considered	**Yes** No
Data collection has been designed to minimise burden	**Yes** No	Roles and responsibilities for data collection have been specified	**Yes** No
Frequency and duration of data collection has been specified	**Yes** No	Scope of data collection activities is congruent with available funding	**Yes** No
Method of reviewing evaluation information has been identified	**Yes** No	Appropriate standards of measurement have been adopted	**Yes** No
Method of validating evaluation information has been specified	**Yes** No	Guidelines to assist data collection and reporting have been provided	**Yes** No

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File: Evaluation framework for CDPU projects V1.doc

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