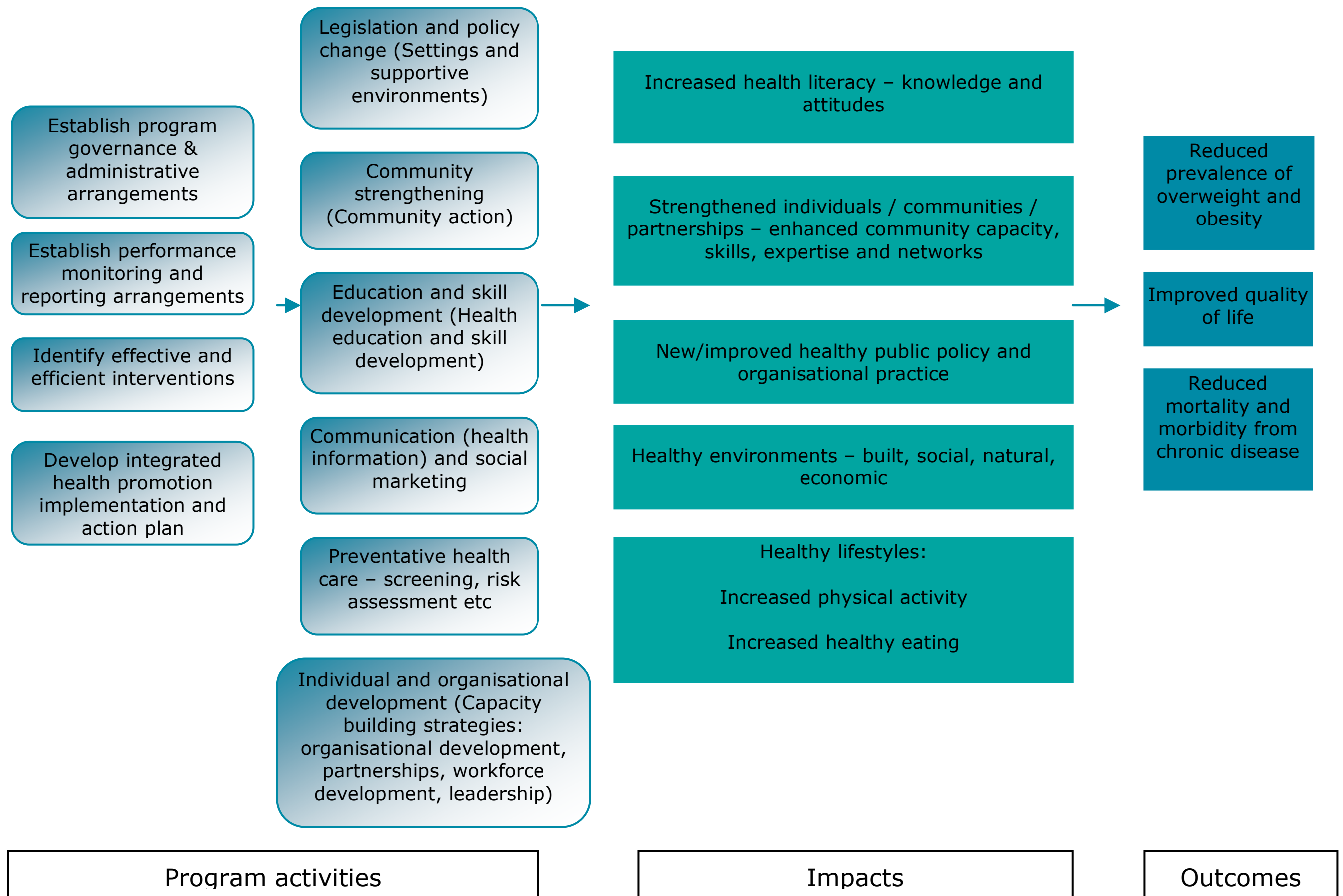
# Example evaluation plan for the Health Promoting Communities: Being Active and Eating Well (HPC:BAEW) Community Demonstration Projects

## Step 1. Describe the program

The prevalence of overweight and obesity is increasing in Victoria. Through its 'Go for your life' initiative the Victorian Government aims to increase level of physical activity and healthy eating by Victorians, and to promote stronger, healthier communities. The *'Go for your life' Health Promoting Communities: Being Active and Eating Well* (HPC:BAEW) community demonstration projects are a project of 'Go for your life'. Five projects have been funded for four years from 2006-07 to 2009-10 to increase healthy eating and physical activity levels in children, families, older adults and other target groups in areas of socio-economic disadvantage. A mixture of place-based approaches and targeted sub-population interventions are being used within the projects to address health inequalities [1]. The goal of these initiatives is to increase physical activity and healthy eating and promote healthy weight at a whole-of-community level within the 5 Primary Care Partnerships (PCPs) community demonstration sites by 2010. The initiatives are being delivered by 5 PCPs and include Westbay PCP, Southern Grampians Glenelg PCP, Kingston Bayside PCP, Campaspe PCP and South East PCP. The supporting evidence in children comes from the results of the Colac HPC:BAEW initiative that achieved a reduction in the weight gain of 1kg in children in intervention vs control communities using a mix of strategies [2]. Evidence for a similar approach in adolescents (East Geelong – 'It's your move!') is currently being gathered by Deakin University. There is no evidence for this kind of approach in adults.

An outline of 'what is supposed to happen' through the implementation of the HPC:BAEW project is presented in Figure 1. This is the 'program logic' that documents the linkages between program activities, impacts and outcomes.

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




Note: The second column of program activities is based on the language used in the new Health Promotion Framework[3]. The language in brackets comes from the Integrated Health Promotion Resource Kit[4].

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

## Stakeholders

The department will involve the HPC:BAEW Project Advisory Group (PAG) in this evaluation process.

## Purpose of the evaluation

The purpose of the evaluation program is to comprehensively and effectively coordinate, implement and disseminate the evaluation of the five community demonstration projects.

The evaluation program objectives include:

1. To evaluate the impacts and outcomes of the five community projects (impact evaluation) and provide a combined analysis of key findings;
2. Assess the extent to which the initiatives have been implemented (process evaluation);
3. To provide support and contribution to quality evaluation planning in the five PCPs to generate practice based evidence of community level interventions for increased physical activity and healthy eating; and

4. To increase the capacity of Victorian communities to adopt and maintain innovations learnt from the 'Go for your life' HPC:BAEW demonstration initiatives.

## Key questions

In order to address the objectives of the evaluation, a number of key evaluation questions have been formulated (Table 1).

*Table 1. Key questions for evaluation of the HPC:BAEW program*

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

### Resources for the evaluation

There are two main sources of funding for this evaluation:

1. The evaluation budgets of the PCPs – this will be used to collect process data and some impacts, and
2. The state-wide evaluation budget to ensure collection of impact and outcome data in intervention and comparison communities.

Other resources available for the evaluation include some evaluation support at Head Office.

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

Two main evaluation methods will be used to evaluate the HPC:BAEW program. These are process evaluation and impact/outcome evaluation. The methods and key indicators for each of these will be described in turn.

### Process evaluation

The main methods used will be review of key program documents to assess the extent to which the activities identified in Figure 1 have been implemented, and data collection by PCPs 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, will be 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.

Data collection tools / data sources for process evaluation:

- Key documents include Project Advisory Group minutes, DHS contract management records, PCP action plans, PCP progress reports to DHS, PCP evaluation plans.
- Other qualitative methods will 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"*[5]).
- Reach will be established from attendance records and documentation of stakeholders and settings by PCP project manager

Outputs and reach indicators that will be considered in the process evaluation to measure the extent of implementation are presented in Table 2.

*Table 2. Key activities, outputs and reach indicators for the program – for process evaluation*

| ACTIVITIES | OUTPUTS / REACH INDICATORS |
|---|---|
| 1. Establish program governance and administrative arrangements | ▪ Contracts with project implementators established<br>▪ Project Advisory Group / Steering Group established<br>▪ Contract with evaluators established |
| 2. Establish performance monitoring and reporting arrangements | ▪ Project milestones identified, or<br>▪ Key indicators identified for program monitoring and reporting |
| 3. Identify effective and efficient interventions | ▪ Evidence reviewed<br>▪ Interventions selected |

| ACTIVITIES | OUTPUTS / REACH INDICATORS |
|---|---|
| | ▪ Evidence incorporated into action plan |
| 4. Develop integrated health promotion implementation and action plans | ▪ Community assessment conducted and reported<br>▪ 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<br>▪ Key marketing channels/methods (e.g., newspaper, Internet, telephone helpline, point of sale displays etc.) identified<br>▪ Marketing materials developed<br>▪ Campaigns implemented in targeted areas<br>▪ Proportion of target group aware of funded 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.[3] 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

The main method used will be 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 will be determined by the external evaluator but 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.

The methods used to measure individual level impacts include anthropometric assessment and questionnaires of health behaviours, health literacy and quality of life pre and post intervention in both intervention and comparison groups. The data collection tools for height, weight and waist circumference are a tape measure, scales and a stadiometer (device to measure height).

Methods to assess changes in public policy, communities, and environments include policy and environment audits and 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.

Key impact and outcome indicators are identified in Table 3. Details of data collection tools / data sources and questions used in the tool 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. 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.

To check whether programs are having an impact on populations facing greatest inequality, demographic data will be collected on socioeconomic position, Indigenous status, non-English speaking background and rural/metro locations. This will allow analysis of impacts and outcomes by health inequality.

*Table 3. Impact and outcome indicators*

| IMPACTS AND OUTCOMES | INDICATORS |
|---|---|
| 1. Increased health literacy | To be advised |
| 2. Strengthened individuals / communities / partnerships | **Level of partnership synergy**<br><br>**Social Support through social networks**<br>▪ Social networks & support structures<br>▪ Social & community participation |
| 3. New/improved healthy public policy and organisational practice | **school policy**<br>▪ Proportion of schools complying with the recommended canteen/food service guidelines or general healthy eating principles.<br>▪ School/service/workplace policies supporting healthy eating and physical activity<br>▪ School curriculum supporting HE and PA for all levels and grades.<br>▪ 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<br>**Pre- schools**<br>To be advised<br>**Work place policy for breast feeding, availability of healthy food choices**<br>To be advised |
| 4. Increased physical activity | **Proportion meeting the recommended levels of physical activity**<br>**Proportion using active transport**<br>**Proportion participating in organised activity/sport** |

| IMPACTS AND OUTCOMES | INDICATORS |
|---|---|
| | **Sedentary behaviour / children's screen time**<br>Time spent using electronic media |
| 5. Increased healthy eating | **Proportion meeting recommended levels of fruit and vegetable consumption**<br>**Breastfeeding**<br>▪ Proportion of children aged 3.5 years who were ever breastfeed and those who were exclusively breastfed at 3 and 6 months<br>**Quantity of sugar sweetened beverages consumed**<br>**Quantity of water consumed**<br>**Consumption of energy dense foods**<br>▪ 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<br>▪ Proportion of Municipal Public Health Plans that include promotion and support for access to community gardens encouraging production of fresh fruit and vegetables<br>**Accessible local recreation spaces**<br>Portion of children and young people living in neighbourhoods with good parks, playgrounds and play-spaces and recreational facilities<br>Perceptions of safety<br>**Transport limitations**<br>**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**<br>**General Health Status (0-13yrs)**<br>Australian Early Development Index (AEDI)<br>**Quality of life utility instrument**<br>▪ Assessment of Quality of Life (AQoL) Mark 2 – adult and adolescent version.<br>**No increase in teasing, stigmatisation, dieting practices or dissatisfaction with body weight** |

## Step 4. Collect data: coordinate the data collection

Refer to Planning for effective health promotion evaluation resource.[5] The specific tasks, timelines and responsibilities will be determined jointly by the state-wide evaluator and the individual PCPs.

## Step 5. Analyse and interpret data

Refer to Planning for effective health promotion evaluation resource.[5] The specific analyses will be determined by the state-wide evaluator but will include a mix of qualitative and quantitative methods.

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

A final technical report will be prepared with 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 of evaluation results

A mix of dissemination methods will be used. These will include provision of the technical report, or summary reports for different audiences, to key stakeholders. Where possible, this will be accompanied by a face-to-face briefing/presentation. Publication of the results (by the evaluators) in a peer-reviewed journal will be encouraged and supported by the Department.

# References


1. Boyd M. People, Places, Processes: Reducing health inequalities through balanced health approaches. Published for the web in April 2008 by the Victorian Health Promotion Foundation, 15-31 Pelham Street, Carlton 3056. [cited 15 April 2008]; Available from: www.vichealth.vic.gov.au/inequalities
2. Sanigorski AM, Bell AC, Kremer PJ, Cuttler R, Swinburn BA. Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. *International Journal of Obesity* 2008; 32: 1060-1067.
3. 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.
4. Department of Human Services. *Integrated health promotion resource kit*. Victorian Government Department of Human Services: Melbourne, 2003.
5. Round R, Marshall B, Horton K. *Planning for effective health promotion evaluation* Victorian Government Department of Human Services: Melbourne, 2005.


| 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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