Integrated health promotion

A practice guide for service providers

6. Evaluation and dissemination

Evaluation in its simplest form is the process of deciding the worth or value of something. This process involves measurement, observation and comparison with some criterion or standard.[89]

An evaluation may be conducted for a number of reasons including:

- being accountable to key partners and funding bodies
- ascertaining if things went as expected
- determining whether the program has achieved its goal and objectives (and if not, why not?)
- considering whether something was worth the effort or resources
- future planning and identifying opportunities for improvement
- securing additional or future funding
- fulfilling accreditation requirements and making continuous quality improvements
- contributing to the evidence base for quality integrated health promotion practice.

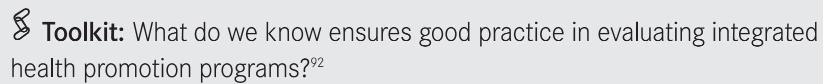
Programs with a mix of interventions lead to multiple outcomes at varying levels. Different levels of change (as represented in Figure 4) will occur according to different time scales, depending on the nature of the program and the type of social or health problem being addressed.[90]

Evaluation should be conducted throughout the life of the program.

Evaluation should be conducted throughout the life of the program. The steps in evaluation planning were discussed briefly in Section 4.2.5. Planning of the overall program should involve the development of an evaluation plan. The evaluation plan sets out and links the goal, objectives and strategies for the program, along with the data collection methods for evaluation (see Table 3). Indicators are used to guide the collection of data that answer the evaluation questions. They show progress and health change and are used at all levels of evaluation. At the most basic level, there are three types of evaluation: process, impact and outcome evaluation (as illustrated in Figure 4).

Table 3: Linking planning steps to the levels of evaluation[91]

Program goal	*is measured by*	Outcome evaluation
Program objective	*is measured by*	Impact evaluation
Health promotion interventions and capacity building strategies	*is measured by*	Process evaluation



Toolkit: What do we know ensures good practice in evaluating integrated health promotion programs?[92]

- **Participation:** At each stage of the evaluation, those that have a legitimate interest in the program should be involved.
- **Multiple methods:** Evaluation strategies should draw on a variety of disciplines and, where possible, employ a range of information gathering methods.
- **Resourcing:** A minimum **10 per cent** of the total financial resources from the integrated health promotion program should be devoted to evaluation strategies.
- **Levels of evaluation:** There should be a mix of process, impact and outcome information used to evaluate integrated health promotion programs.
- **Capacity building:** Practitioners should be involved in workforce development opportunities to gain expertise in the evaluation of integrated health promotion programs.
- **Dissemination and Sharing:** Dissemination and opportunities for sharing information on evaluation methods used (for example, through conferences, workshops, the Internet and other methods) need to be actively supported.

Resources for evaluation and quality in integrated health promotion are listed in Section 7. Below is a description of each of the levels of integrated health promotion evaluation.

6.1 Process evaluation

This level of evaluation covers all aspects of implementing a program. This means focusing on the implementation of interventions and capacity building strategies and reviewing documentation of the program reach and the capacity of the system to deliver quality integrated health promotion action.[93]

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More specifically, reach performance indicators for integrated health promotion should be reported for any health promotion interventions and capacity building strategies that are part of the integrated health promotion program. Reach is the number of key stakeholders, settings[94] or members of the community affected by the program. See Section 5 for further explanation of reach for every health promotion intervention and capacity building strategy.

? Checklist: the six main questions to be asked about the program during process evaluation[95]

- ☑ What is the capacity of the key partners involved in the program to fulfil the program goals and objectives?
- ☑ Is the program reaching the target or interest group?
- ☑ Are all parts of the program reaching all parts of the target or interest groups?
- ☑ Are participants satisfied with the program?
- ☑ Are all activities of the program being implemented?
- ☑ Are all materials and components of the program of good quality?

6.2 Impact evaluation

The relationship between implementing interventions and capacity building strategies and seeing outcome change is often complex, can be difficult to trace, and is likely to take place over a period of time beyond the time-scale of most evaluation timetables.

Impact evaluation considers how a program will have an impact on people's health.[96] The relationship between implementing interventions and capacity building strategies and seeing outcome change is often complex, can be difficult to trace, and is likely to take place over a period of time beyond the time-scale of most evaluation timetables.[97]

For these reasons, when assessing the effects of integrated health promotion programs, the more immediate changes in populations, individuals or their environments are considered. These changes are known as impacts and relate to judgements about whether the **objectives** of the program have been achieved.

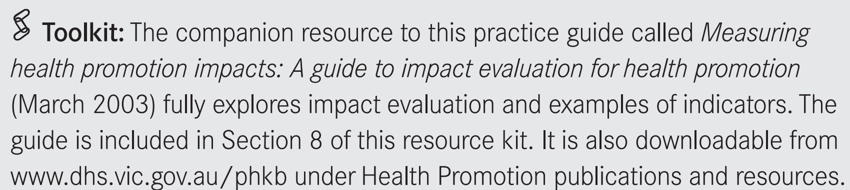
Depending on the objectives of the particular program, impacts include improved:

- **Health literacy:** health related knowledge, attitudes, motivation, confidence, behavioural intentions and personal skills concerning healthy lifestyles, as well as knowledge of where to go and what to do to obtain health services.
- **Social action and influence:** the results of efforts to enhance the actions and control of social groups over the determinants of health, including community participation, community empowerment, social norms and public opinion.
- **Healthy public policies and organisational practices:** implementation of policy statements, legislation and regulations, resource allocation, supportive organisational practices and settings experiencing enhanced engagement with integrated health promotion programs.

Other impacts include those relating to **healthier lifestyles, more effective health services, and healthier environments.** However, it is important to note that these are considered 'second level' impacts that may emerge at a later stage than the more immediate impacts described above.

Specifically, second level impact changes also include:

- Personal behaviours, such as stopping smoking or increasing participation in physical activity, which may increase or decrease the risk of ill health. These are summarised as **healthy lifestyles.**
- Access to appropriate provision and use of health services, which is acknowledged as an important determinant of health status and is represented by **effective health services.**
- **Healthy environments,** which consist of the physical, economic and social conditions that can have a direct impact on health, as well as support healthy lifestyles (for example, work to improve access to fresh fruit and vegetables in remote areas and to create smoke-free public places).[98]



Toolkit: The companion resource to this practice guide called *Measuring health promotion impacts: A guide to impact evaluation for health promotion* (March 2003) fully explores impact evaluation and examples of indicators. The guide is included in Section 8 of this resource kit. It is also downloadable from www.dhs.vic.gov.au/phkb under Health Promotion publications and resources.

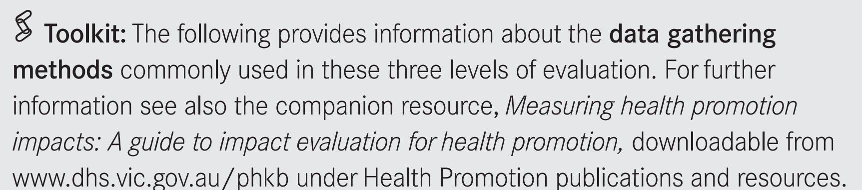
6.3 Outcome evaluation

Outcome evaluation measures the long-term effects of the program and, therefore, the program goal for that priority issue.

Outcome evaluation measures the long-term effects of the program and, therefore, the program goal for that priority issue. These effects are usually expressed as outcomes, such as mortality, morbidity, disability, quality of life and equity, reflecting the endpoint of integrated approaches. At the end of the evaluation process, it should be possible to:

- assess whether a program has achieved its program goal
- understand and define the important conditions required to ensure successful implementation (and therefore best practice in integrated health promotion action)
- determine if these conditions can be reproduced in different circumstances.

Further details specific to the reporting of integrated health promotion programs (based on the partnerships' or agency's evaluation processes) refer to the PCP community health plan implementation agreement and the community and women's health program guidelines at http://www.dhs.vic.gov.au/phkb



Toolkit: The following provides information about the **data gathering methods** commonly used in these three levels of evaluation. For further information see also the companion resource, *Measuring health promotion impacts: A guide to impact evaluation for health promotion,* downloadable from www.dhs.vic.gov.au/phkb under Health Promotion publications and resources.

Qualitative methods include:[99]

1. Focus groups

These are semi-structured discussions, usually with 6–8 participants, and led by a facilitator. There is usually a prepared list of broad questions, themes or areas to be covered in the discussion, which might or might not be shared with the participants at the start of the interview. The proceedings are recorded by a note taker or by audio taping with later transcription.

Applications: Useful in gathering in-depth information about an issue from a small group of people, particularly concerning their beliefs, attitudes and concerns. They are also often used to pre-test program materials and to identify issues for use in later quantitative survey work.

Strengths: They provide opportunities to ask for elaboration or explanation, giving in-depth information. Ideas can be shared and discussed. They are more efficient than one-on-one interviews and require a minimum of specialised skills to implement.

Limitations: Some people can dominate a group, so good facilitation skills are necessary. They can tend to be subjective and there is the potential for facilitator bias. They are not suitable for sensitive or personal issues where participants may be unwilling to discuss these in a group. The data can be difficult to analyse and the results cannot be generalised to a broader population.

2. In-depth interviews

Generally an unstructured or semi-structured interview schedule conducted one-on-one in person or via the telephone. The interviewer generally follows an outline, but has flexibility to vary questions.

Applications: Useful for investigating sensitive issues with a small number of people. They provide the opportunity to get an in-depth understanding of the issues, attitudes and language.

Strengths: They allow people to raise issues of concern or interest and to speak in their own words. The confidential environment allows for greater depth and for development of a sense of rapport, and avoids peer influence. The interviewer has the opportunity to probe responses and to explore new issues.

Limitations: Individual interviews are more expensive and time consuming than focus groups. The greater flexibility brings with it a broader range of responses and so can make data coding and analysis more complex than group interviews. The results cannot be generalised to populations. Interviewers need training to be effective and to avoid biased or leading questioning.

3. Open-ended survey questions

A mail or telephone survey where there is a standard set of questions that allows respondents to answer in their own words.

Applications: Open-ended questions allow for greater depth and exploration of issues or for explanation of answers to closed questions.

Strengths: Because all respondents answer the same questions, there is the potential to generalise to the population. Open-ended questions provide depth and have the potential to be quantified.

Limitations: While using a fixed set of questions allows for a level of generalisation, it removes flexibility. Analysis of responses can be time consuming and expensive.

4. Journals

Stakeholders record their activities, experiences, reactions or thoughts in a diary or journal, maintained for an agreed period, such as for the life of the program or for a designated section of it. Journals provide a detailed description of the selected aspect of the program and give ongoing documentation by the selected stakeholders.

Applications: They are used primarily for process evaluation, although some short-term change (impact) may be recorded.

Strengths: Journals can provide information that had not been expected or planned for. They provide an ongoing record of people's experiences with the program and can cause participants to be more focused and reflective in their involvement in the program. They can put other evaluation findings in context and are relatively inexpensive to prepare.

Limitations: They are time consuming to prepare and not everyone feels comfortable or confident in writing down their thoughts or observations. Observations are subjective. Analysis can be time consuming and therefore expensive.

5. Observation

Unobtrusive observation involves the researcher undertaking a low-ley observation of the activities in the program, without doing or saying anything to influence behaviours of those being observed. 'Participant as observer' involves the researchers taking a more active role with participants, engaging in the activities and processes, but known to be an evaluator.

Applications: Observation is useful for understanding the context without asking the participants to explain it. It offers an alternative perspective to data developed through interviews with participants. It may be used as a preliminary stage to further data collection, particularly where the researcher is from a different background.

Strengths: Observation provides data other than self-report and gives information on behaviour, non-verbal communication and the physical and social environment. The researcher/evaluator is immersed into the context of the program.

Limitations: Observation can be time-consuming and expensive and observers need significant training. It can be seen as intrusive by program staff and participants and can lead to role conflict in the researcher in terms of their participation in the activity of the program.

Quantitative methods include:

1. Surveys

A structured questionnaire can be distributed to many stakeholders in a relatively short time frame. Respondents select from a fixed set of responses to each question. All respondents address the same questions and the survey can be completed in person or by telephone, fax, mail, email or the Internet.

Applications: Standardised questionnaires are useful when you need to collect information that is quantifiable and can be generalised to the population.

Strengths: Because all respondents address the same questions and select from a fixed set of answers, the results can be generalised to the population (assuming your sample is representative). The standardised nature of the question minimises interviewer bias. It is possible to collect and process large amounts of information in a relatively short time.

Limitations: The fixed set of questions and responses mean that it is difficult to gain an in-depth understanding of the respondents' perspectives. Preparation of survey instruments can be complex, and analysis and interpretation of the data may require input from a statistician. This, together with the costs of distribution and collection of surveys, can make this an expensive method when applied to large samples.

2. Population statistics

Many sets of population data are collected by health and other agencies. These sets range from national data down to data at the local government level.

Applications: Such data allow comparison of the target population with the broader community. Data broken down to the local level are useful in needs assessment.

Strengths: Such data provide information about change on a broad scale and are useful if programs are aimed at a large population. They provide accurate and well-researched information and allow comparisons between local populations and the broader context. They are collected regularly by government and other agencies and are usually easily accessible. They are used by a number of agencies and services and so provide a base for networking and information sharing.

Limitations: Given the broad nature of the data sets, they are not particularly useful in evaluating individual integrated health promotion programs. The data are often collected at a level far broader than the target audience and so relating the data to the work of an agency can be difficult. Also, given their broad nature, they are often influenced by non-program factors.

3. Process tracking forms/reports

Collecting process measures in a standardised manner is a feature of some programs.

Applications: Tracking forms or records are useful to document the processes occurring in a program and to identify areas for improvement.

Strengths: Such forms can be easily incorporated into routine program activities and can be easy to design and use. They can provide accurate information on program processes and decisions.

Limitations: Completing tracking forms can be seen as an added task or a burden by some staff and it is difficult to ensure that they are always completed.

6.4 Dissemination

Dissemination is the active, purposeful process of knowledge transfer. Like evaluation processes, dissemination requires resources, infrastructure and planning and is essential in the feedback link to informing future planning (see Figure 3, Section 4.1). Reviews of the dissemination processes for findings from health promotion practice indicate that these processes are complex, easily underestimated and often devoid of deliberate and systematic approaches. It is also noted that many health promotion programs in the past were not disseminated widely or findings were disseminated prematurely, limiting the full evidence of effectiveness being recognised or shared.[100]

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Key findings and learnings can be disseminated via a range of strategies, such as training through workshops, train-the-trainer and continuing professional education; communication through print; communication through video and computer technologies such as databases of good practice stories, library search systems and

websites; personal face-to-face contacts; consultancies; policies, administrative arrangements and funding incentives; committees and other decision-making structures; and collaborative applied research programs.

The stages of dissemination can be summarised as:

1. Providing and seeking information.
2. Persuasion about the relevance and applicability of the innovation or findings.
3. Making a decision to adopt the findings or try the innovation.
4. Changing practices and using the innovation.
5. Sustaining the changed practice.[101]

Toolkit: For further information on dissemination see two key Australian references called:

King, Hawe and Wise (1996) *From research into practice in health promotion: a review of the literature on dissemination,* Sydney. ISBN: 1 86451 228 8

Oldenburg B et al (1997) *The dissemination effort in Australia: strengthening the links between health promotion research and practice,* School of Public Health, Queensland University of Technology. Publication Identification No. 2182

Members of the Australian Health Promotion Association will be able to download these references from the Association's website at http://www.healthpromotion.org.au

The Department plays an active role in disseminating integrated health promotion practice examples, evidence and tools. See http://www.dhs.vic.gov.au/phkb under Health Promotion for further information. This guide also features a range of good practice examples from PCP funded health promotion programs. It is planned that more examples will be developed and disseminated as updates to the guide.

In 2003–04, the Department will also support the development and dissemination of good practice case studies. These will be disseminated in partnership with VCHA as part of the QIPPS initiative.