Department of Health

health

Evaluation framework for health promotion and disease prevention programs

State Government Victoria

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Contents

Introduction

Aim of the framework

This framework aims to improve the evaluation of health promotion and disease prevention programs by:

- providing guidance on how to write an evaluation plan (included in this document)
- including an example of a good evaluation plan (through the Health Promoting Communities: Being Active and Eating Well (HPC:BAEW) evaluation plan)
- specifying some agreed parameters for good evaluation, for example, identifying a good study design for impact evaluation (included in this document)
- specifying an agreed list of indicators ('the indicators'), which allows comparison of the impacts and outcomes of different programs.

Complementary activities

This framework should be complemented by the following actions:

- evaluation plans that are developed jointly by program staff, key stakeholders and staff with evaluation or research expertise
- a commitment from management and staff to support quality evaluation, so that evaluation plans are written simultaneously with program plans and before program implementation or tendering
- a commitment from management and staff to use the results of evaluations in future program design.

Link with the Integrated Health Promotion Resource Kit

The language used in this document is consistent with the language of 'integrated health promotion' as used in the resource kit (Department of Human Services 2003a) and evaluation guides (Department of Human Services 2003b, Round et al. 2005). However, not all sectors employ this language, and different sectors may apply different terminologies. To increase understanding, definitions and explanations are given throughout this document where differences in use may arise.

This framework is designed to complement the integrated health promotion evaluation resources (Department of Human Services 2003b, Round et al. 2005), and readers are referred to these resources for further details.

Limitations

This framework may not be appropriate in all cases, and flexibility is required when writing evaluation plans that must meet the evaluation requirements of specific programs. Large-scale evaluations are not required for all programs, and it may be appropriate to simplify the evaluation plan in terms of number of questions asked, range of indicators measured and complexity of study design. (See the section 'Identify resources for the evaluation' in Step 2, and Step 3 for more information.)

Why develop an evaluation plan?

Definition

The terms 'evaluation plan' and 'evaluation framework' are often used interchangeably.

An evaluation plan should be developed for all new programs before they are implemented. The evaluation plan should be written alongside the overall program plan. It should allow 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 on 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
- cost the evaluation.

The six steps outlined in this guide are based on the framework used in the *Planning for effective health promotion evaluation* resource (Round et al. 2005), with some modifications. Flexibility can be exercised in the headings used, provided the key issues/parameters covered here are included.

The six steps in the evaluation framework for health promotion and disease prevention programs are:

1. **Describe the program**
2. **Evaluation preview**
3. **Focus the evaluation design**
4. **Data collection**
5. **Data analysis and interpretation**
6. **Disseminate lessons learned**

Step 1.
Describe the program

This section should briefly outline what the program is, including its goals and objectives, target groups, the policy context, supporting evidence and key assumptions. These issues should have been addressed as part of your program planning, and you should summarise the detail here to focus the evaluation.

The links between program planning and evaluation:

- **goal is measured by outcome evaluation**
- **objective is measured by impact evaluation**
- **how well your interventions/activities/ strategies are implemented is measured by process evaluation.**

The description of the program should also include the 'program logic' and consider how the program is addressing health inequalities.

Program logic

Definition

The term 'program logic' is frequently used interchangeably with the terms 'program theory', 'logic model' and 'causal model'.

Why should you use program logic?

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. Logic models can also provide a theoretical framework for your program design when evidence is less robust. Models such as 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 (US Department of Health and Human Services 2002).

See Figure 1 Program logic: Underlying intention of the Health Promoting Communities: Being Active and Eating Well initiatives as an example program logic model that is applicable to a whole-of-community health promotion program for nutrition and physical activity.

Program logic outline

Program logic models can also include a column on the left to identify inputs, or the resources needed to operate the program (this is not included in this example). See Figure 1 Program logic: Underlying intention of the Health Promoting Communities: Being Active and Eating Well initiatives. Models can also include a column after activities to define outputs, or 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 Some example key activities, outputs and reach indicators—for process evaluation).

Outputs link to your process evaluation indicators. Impacts and outcomes should link to your impact and outcome indicators. See Table 3 Example impact and outcome indicators for nutrition, physical activity and obesity programs for an example.

Definition

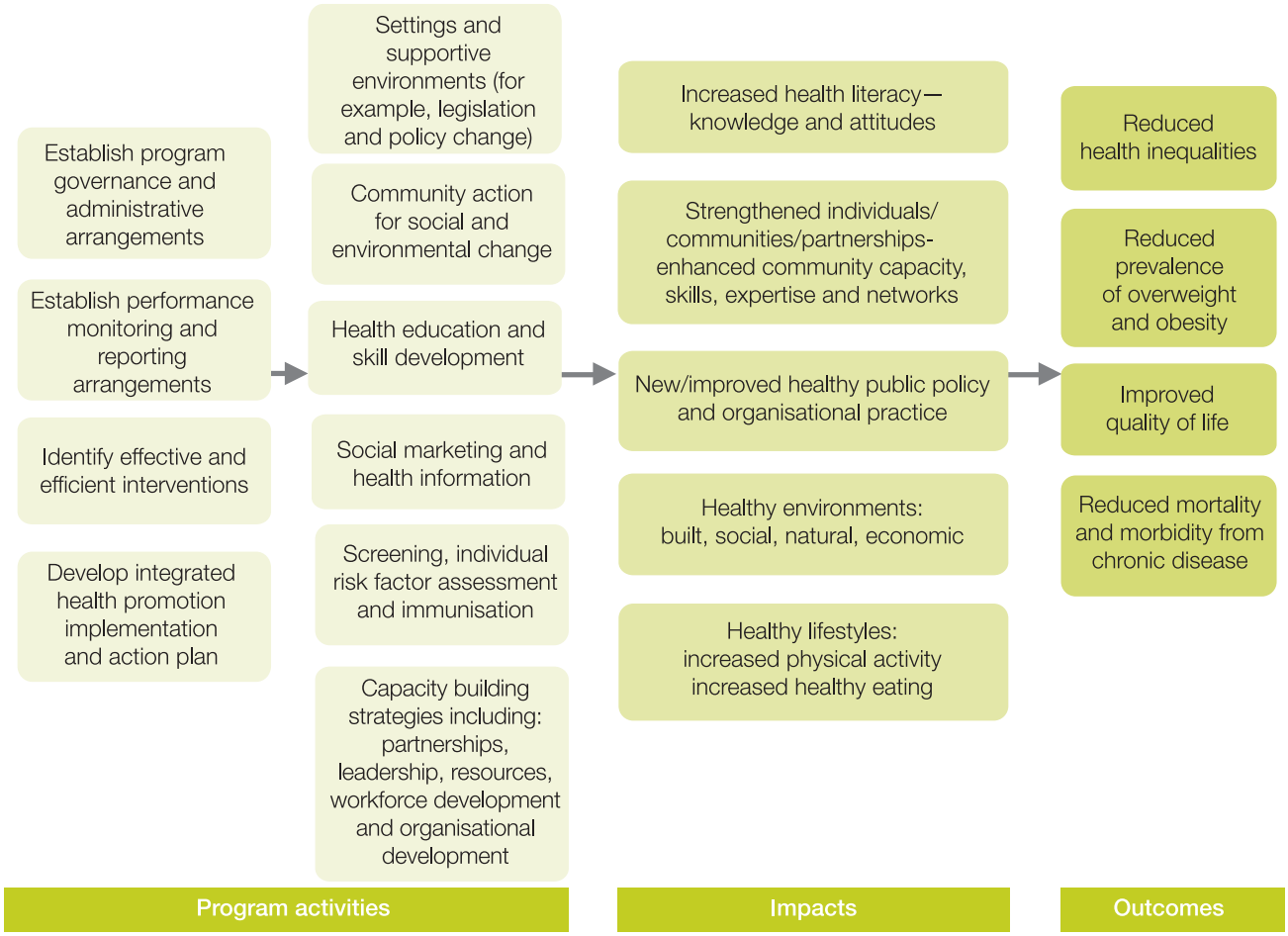
Different definitions for impacts and outcomes are evident in the evaluation literature. Here, we define impact as the intermediate effect that health promotion programs have on populations, individuals or their environments (Round et al. 2005). Outcome is defined as the long-term effect of programs and may include reductions in incidence or prevalence of health conditions, changes in mortality, sustained behaviour change, or improvements in quality of life (Round et al. 2005).

The second column of program activities is based on the language used in the Integrated Health Promotion Resource Kit (Department of Human Services 2003a).

The design of your program logic and language used is flexible. The important point for evaluation purposes is that your inputs and activities match the expected impacts and outcomes. For example, you may expect an impact on physical activity, but none of your activities is actually aimed at changing physical activity levels. This should highlight the need to reconsider your activities or change your impacts.

Other examples of, and alternative approaches to, program logic models can be found in the W.K. Kellogg Foundation *Evaluation handbook* (1998) and *Logic model development guide* (2004).

Figure 1 Program logic: Underlying intention of the Health Promoting Communities: Being Active and Eating Well initiatives



Health inequalities

Regarding health inequalities, the program must be clear about how population-wide approaches are used to reduce unequal health outcomes and to ensure that they do not inadvertently widen inequalities. Targeted interventions are often used in conjunction with population-wide approaches to minimise this risk and further equality goals (Boyd 2008).

Step 2.
Evaluation preview

Step 2 involves these components:

- engaging stakeholders
- clarifying the purpose of the evaluation
- identifying key questions
- identifying resources for the evaluation.

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, for example, to determine future funding.

Engage stakeholders

More information on this can be found in the *Planning for effective health promotion evaluation* resource by Round et al. (2005: p. 9). List your key stakeholders here and consider including them in your evaluation planning, for example, by asking them to help in constructing the program logic.

Clarify the purpose of the evaluation

More information on this can be found in the *Planning for effective health promotion evaluation* resource by Round et al. (2005: pp. 9–10).

Identify key evaluation questions

Evaluation questions should be formulated in key areas (for example, reach, appropriateness, implementation, effectiveness, efficiency and/or maintenance). The number of key questions should be limited to 12–15 at most, but may be as few as two or three. 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 Some generic questions for evaluation of health promotion programs for some example questions that can be adapted for specific programs. Other headings that can be used for evaluation questions include: need for program, reach, effectiveness, adoption, implementation and maintenance (RE-AIM), efficiency and appropriateness.

For more information about the RE-AIM framework for evaluation see Glasgow et al. (1999).

Identify resources for the evaluation

It is important to consider the scope 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. This may also be necessary if the program is being implemented in a new site or setting. This may be particularly important if you want to use the evaluation to obtain additional funding.

If a program has been run several times and has been shown, through impact evaluation, to be effective, performance monitoring is likely to be sufficient. For these programs, a few agreed indicators of process, impact and outcome (where possible) should be specified in performance agreements (for example, service agreements) to ensure collection of data on these indicators (also known as key performance indicators); that is, data collection can be incorporated into routine practice.

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) have affected the implementation? What proportion of the target group has received the program? Has the uptake of the program varied by socio-economic position, Indigenous status, non-English speaking background and/or rural/metropolitan 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 the greatest inequalities? 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 be maintained 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?

Step 3.
Focus the evaluation design

Step 3 involves these components:

- specifying the study design
- specifying data collection methods
- locating and developing data collection tools.

The quality of an evaluation depends upon the strength of evidence that is collected in response to the evaluation questions.

In order to maximise the value of information collected for evaluation it is important to:

- **choose a strong study design**
- **identify valid and reliable information sources and data collection tools**
- **use rigorous data collection methods.**

Study design

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, you should 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 rule out alternative explanations for any observed changes in impact/outcome indicators. If you cannot use a control group, you may be able to compare the change in indicators in your intervention group to statewide or regional trends in these indicators, as measured by the *Victorian Population Health Survey* or similar surveys in children and adolescents, such as the *Victorian Child Health and Wellbeing Survey*.

Data collection tools

Identify reliable information sources and data collection tools to measure your indicators. In determining the most appropriate tools, consider using existing data collection tools that have good validity and reliability (that is, they actually measure what they purport to measure and give consistent results). These should also be comparable, where possible, with existing data collections; for example, the *Victorian Population Health Survey* and the *Victorian Child Health and Wellbeing Survey*. Most programs will not require an extensive list of indicators, and preference should be given to quality rather than quantity.

If these ideas are new to you, we recommend that you seek help from an experienced person with evaluation, epidemiology and/or research skills for this part of the plan.

Data collection methods

Two main evaluation methods are appropriate to evaluate health promotion programs: process evaluation and impact/outcome evaluation. Often both methods will be required. 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, and is useful for:

- tracking the reach of the program
- tracking the level of implementation of all aspects of the program
- identifying potential or emerging problems; that is, whether the program has been delivered as planned and whether modifications to the plan need to be made.[1]

From an equalities viewpoint, it is important to reflect on how program delivery has engaged with key populations facing the greatest inequalities. Process evaluation should measure whether this was achieved, for example, by measuring reach specifically for these key populations.

Key methods for process evaluation

The main methods used for process evaluation include reviewing key program documents to assess the extent to which the activities identified in your program have been implemented, other qualitative methods (for example, focus groups), and data collection to measure program reach.

'Reach' is the percentage of key stakeholders, settings or members of the community affected by the program, that is:

$$\frac{\text{number affected}}{\text{number eligible}} \times 100$$

Some aspects of reach (for example, program attendance) may 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 steering group or advisory group minutes, contract management records, project action plans, progress reports[2] and 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* (Round et al. 2005) and the *How to use qualitative research evidence when making decisions about interventions* tool (Holt 2009).

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 Some example key activities, outputs and reach indicators—for process evaluation for some example outputs and reach indicators that may be considered in the process evaluation to measure the extent of implementation. The list of activities comes from the program logic (Figure 1 Program logic: Underlying intention of the Health Promoting Communities: Being Active and Eating Well initiatives). This will be complemented by the qualitative data collected in the process evaluation.

1 This process can be described as 'action research' because the results of the process evaluation lead to changes in the program.

2 It is important that these, or other documents, include a description of the strategies or activities undertaken, because they may have changed from what was written in the action plan.

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 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. Settings and supportive environments (for example, legislation and policy change)	Percentage (of those eligible) and range of stakeholders involved in new/improved legislation and policy change (reach)
6. Community action for social and environmental change	Percentage (of those eligible) and range of stakeholders/settings involved (reach)
7. Health education and skill development	Percentage (of those eligible) and range of stakeholders/settings involved (reach)
8. Social marketing and health information	Evidence on effective social marketing messages and methods reviewed Key marketing channels/methods identified (for example, newspaper, Internet, telephone helpline, point-of-sale displays and so on) Marketing materials developed Campaigns implemented in targeted areas Percentage of target group aware of funded social marketing/health information activities and resources (reach)
9. Screening, individual risk factor assessment and immunisation	Percentage of target group participating in each activity (reach)
10. Capacity building strategies, including: partnerships, leadership, resources, workforce development and organisational development	Percentage (of those eligible) and range of stakeholders/settings involved (reach)

Note: Definitions for activities 5–10 are available in the Integrated Health Promotion Resource Kit (Department of Human Services 2003a).

Impact/outcome evaluation

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

Methods

The main method used is a 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 state or regional average may also be an appropriate comparison, rather than having a specific control group.

The methods used to measure individual level impacts include questionnaires and other instruments for objective assessments (for example, 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 taken at the level of the setting, community or partnership, rather than for individuals.

Sample size

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 (for example, difference in prevalence of >10 per cent) and weight over the project period (for example, 0.5 kg/m^2 change in BMI or >2 kg in children and >3 kg in adults). Consider how you might attain an adequate response and follow-up rate to ensure maximum validity and generalisability of results.

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

Indicators

For each of the impacts and outcomes you have specified you will need to identify appropriate indicators. Key impact and outcome indicators for nutrition, physical activity and obesity health promotion programs are identified in Table 3 Example impact and outcome indicators for nutrition, physical activity and obesity programs. Details of data collection tools/data sources and questions used in the tool should also be specified when implementing the evaluation plan. When choosing indicators and tools, the usual focus is first to use validated statewide indicators (for example, the *Victorian Population Health Survey*) and then, if needed, use national indicators and other validated tools.

A list of agreed indicators and evaluation tools for nutrition, physical activity and obesity programs is available from the Evidence and evaluation for health promotion and disease prevention website: <www.health.vic.gov.au/healthpromotion/evidence_evaluation/cdp_tools.htm>.

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

Impacts and outcomes	Indicators
Increased health literacy	No agreed indicators available
Strengthened individuals/communities/partnerships	No agreed indicators available
New/improved healthy public policy and organisational practice	No agreed indicators available
Increased physical activity	Proportion of adults aged 18 years and over who did the recommended levels of physical activity in the past week* Proportion of children and young people who do the recommended levels of physical activity every day†
Decreased sedentary behaviour	No adult indicator currently available Proportion of children and young people who use electronic media for more than two hours per day†
Increased healthy eating	Proportion of adults meeting recommended levels of fruit and vegetable consumption* Proportion of children and young people who eat the minimum recommended serves of fruit and vegetables every day†
Increased breastfeeding	Proportion of infants exclusively and fully breastfed at three and six months of age
Decrease in energy-dense, micronutrient-poor foods and drinks	No agreed indicators available
Increased water consumption	No agreed indicators available
Healthy environments—built, social, natural, economic	No agreed indicators available
Reduced prevalence of overweight and obesity‡	Proportion of adults who are overweight or obese Proportion of children and young people who are overweight or obese
Reduced mortality and morbidity	Disability-adjusted life years§
Improved quality of life	No agreed indicators available

* Victorian Population Health Survey (VPHS): <www.health.vic.gov.au/healthstatus/vphs.htm>

† Victorian Child Health & Wellbeing Survey (VCHWS) and Victorian Adolescent Health & Wellbeing Survey (VAHWS): <www.education.vic.gov.au/about/directions/children/newdata.htm>

‡ Measured height and weight is the gold standard for measuring this but is not currently part of an ongoing monitoring system

§ Victorian Burden of Disease Study: <www.health.vic.gov.au/healthstatus/bod.htm>

Health inequalities

To check whether programs are having an impact on populations facing the greatest inequalities, it is important that measures collect demographic data wherever possible and appropriate. This allows analysis of impacts and outcomes by health inequality.

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

- socio-economic position
- Indigenous status
- rural residence
- non-English speaking background.

Socio-economic position

This can be measured in several ways, and each has its advantages and limitations. The two principle methods of defining socio-economic position for the purpose of monitoring progress to reduce inequality are:

- a measure of household income
- area level disadvantage.

Socio-economic disadvantage occurs when an individual's income in a household falls below 50 per cent of the median of the distribution of equivalent disposable income in a country; this concords with Department of Health and Department of Education and Early Childhood Development practice (such as the State of Victoria's Children reports) and with the OECD definition of poverty. Other definitions suggest 60 per cent of median household income. In 2008 this equated to household income of approximately $31,000 per year or less. When using an area level of disadvantage, low socio-economic areas are recognised as those in the lowest two quintiles (lowest 40 per cent) 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 socio-economic position.

Indigenous status

This is usually asked as, 'Are you Aboriginal or Torres Strait Islander?'

Rural residence

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

Non-English speaking background

This 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.

Maximising response rates

Consider how you might maximise response rates. Techniques for doing this can be listed here, for example, providing incentives, using reminder messages (Round et al. 2005). Low response rates are becoming an important issue for community surveys, and a low response rate will impact on the validity and generalisability of the evaluation results. If you cannot be sure of a high response rate, consider whether any data can be collected on non-responders or the general population so that it can be compared to responders to help rule out biases (for example, gender and SES data—known to correlate with some health behaviours). Another approach is to rely on pre-existing statewide data collections, for example, the *Victorian Population Health Survey* (VPHS), for measures of individual level change, and focus your data collection efforts on organisational level measures.

Step 5. Analyse and interpret data

Data analysis involves identifying and summarising the key findings, themes and information contained in the raw data (Round et al. 2005). Specify here what data analysis techniques and computer software you intend to use. If you are not familiar with qualitative or quantitative data analysis, we recommend that you seek the help of persons with evaluation, epidemiology and/or research skills for this part of the plan.

Step 6.
Disseminate the lessons learned

The dissemination of health promotion evaluation findings is crucial in establishing a strong evidence base for health promotion. We need to document not only what worked, but what did not; as well as possible reasons for success and failure (Round et al. 2005). We recommend that you use the 1:3:25 format put forward by the Canadian Health Services Foundation Communication Notes: Reader-Friendly Writing—1:3:25 (Canadian Health Services Research Foundation 2009).

The one (1) in the foundation's 1:3:25 rule indicates *one page of main message bullets*. These are the lessons decision makers can take from your research. This is an opportunity, based on the evaluation results, to convey to decision makers the implications of the evaluation.

The three (3) in the 1:3:25 rule indicates *three pages for the executive summary*. These are your findings condensed to serve the needs of the busy decision maker, who wants to know quickly whether the report will be useful.

The body of the report should fit into 25 pages, plus appendices for highly technical material. Key categories for the report should include: context (or background), methods (or approach), results, conclusions, implications (or lessons) for key stakeholders, and references. The methods section should include the design of the study, program logic, details of the specific methods used (for example, focus groups, surveys), data collection tools and instruments used, details on the sample, the response rate and analysis techniques.

Ensure that the final report is of the highest quality possible, because it will form the basis for preparing summary reports, reports for different audiences, journal papers for publication and so on 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[3]
- communication through new information technologies
- personal face-to-face contacts, including briefings or presentations
- policies, administrative arrangements and funding incentives.

Make time and allocate a budget for dissemination activities. Without comprehensive dissemination, your evaluation results and learnings will have little influence. Work with the funder of the evaluation to ensure that these activities have maximum effect.

3 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.

Business case for new and continuing data collections

For evaluations funded by the Department of Health, a business case for new and continuing data collections is required to be made and submitted to the Data Management and Reform Unit. The unit aims to improve the quality of collected data, and achieve a better balance between the information needs of the Department of Health and the burden of collection to the department and funded organisations. The checklist in Table 4 Evaluation data collection checklist will assist you in this process.

See the Victorian Government Health Information DH & DHS Data Management & Reform site: <www.health.vic.gov.au/hacims/index.htm>.

Table 4 Evaluation data collection checklist

Need to collect information for evaluation has been demonstrated	Yes	No	Relevant stakeholders have been consulted in the development of evaluation methods	Yes	No
All existing sources of potential Department of Health 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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Further information

Evidence and Evaluation team
Prevention and Population Health Branch

Department of Health
50 Lonsdale Street
Melbourne VIC 3000

Phone +61 3 9096 0393
Fax +61 3 9096 9165

Email: evidence.evaluation@health.vic.gov.au