

Planning for effective health promotion evaluation



**Planning for effective
health promotion evaluation**
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Acknowledgments

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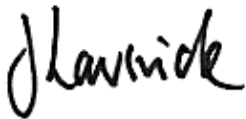
Foreword

The Ottawa Charter (WHO 1986) defines health promotion as a process of enabling people to increase control over, and to improve, their health. Health promotion aims to improve individual and population-wide health outcomes. The Victorian Government has highlighted integrated health promotion as an approach to improving population health and addressing issues that cause significant disease burden in our communities.

To establish that a health promotion program has achieved the desired outcomes, evaluation must take place to measure relevant changes in populations, individuals or their environments.

This resource for effective health promotion evaluation has been developed in conjunction with the School of Health and Social Development, Deakin University, and will contribute to the department's commitment to quality health promotion program delivery across Victoria.

It supports the guiding principles of integrated health promotion by providing a planning framework for evaluating health promotion practice. The resource will assist anyone working in health promotion to evaluate their health promotion program/plans more effectively. Improved health promotion practice will ultimately lead to improved health and wellbeing outcomes.



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Introduction

Evaluation is often conducted for accountability purposes. However, the benefits of evaluation are more wide-reaching than meeting accountability requirements. Evaluation is crucial for assessing the effect your program/strategy has had within the local community, its cost effectiveness, whether you achieved what you expected, and identifying opportunities for improvement.

In addition, evaluation enables practitioners more systematically to document, disseminate and promote effective practice (Garrard et al 2004). The evidence base for health promotion is dominated by relatively large intervention trials conducted by universities and other research organisations. Smaller, community-based initiatives can be very effective, but are rarely included in the published evaluation literature. Evaluation and documentation of these interventions will help to provide a more balanced evidence base for effective action to improve health and wellbeing (Garrard et al 2004) and with new online information and communication systems, such as the Quality Improvement Planning System (QIPPS), there are increasing opportunities to share such evidence.

This resource has been developed by the School of Health and Social Development, Deakin University, as part of the Evaluation Skill Development Project funded by the Department of Human Services Primary and Community Health Branch. It contributes to the branch's commitment to support capacity building in the health promotion sector and builds on two key department documents: *Integrated health promotion resource kit*; and *Measuring health promotion impacts: a guide to impact evaluation in integrated health promotion*.

The Primary and Community Health Branch has funded the primary health care sector to support internal organisational change processes required for improved health promotion practice. The department has also implemented a range of external statewide and regional capacity building strategies, including the five-day *Core Health Promotion Short Course* (funded through the Public Health Group and Regional offices) and *Health Promotion Planning Workshops for Community and Women's Health Services*, to complement these internal strategies. While the quality of planning for health promotion is increasing through the use of a common planning framework and these workforce development activities, the standard of evaluation skills remains variable. Reviews of Primary Care Partnerships (PCPs) and Community and Women's Health health promotion plans have indicated the need to improve the capacity of practitioners in the development and implementation of evaluation processes. The evaluation report of the Core Health Promotion Short Course (Keleher, H et al 2003) equally identified qualitative and quantitative research skills, to support evaluation and needs assessment, as the most commonly identified need by practitioners and managers interviewed.

This resource will assist agencies, organisations and partnerships to evaluate more effectively their health promotion programs/plans. It supports the principles of integrated health promotion and, in doing so, considers the needs of all parties involved in planning, delivering and evaluating health promotion programs. The resource provides a framework for planning an effective approach to evaluating health promotion practice, and is consistent with the current department integrated health promotion policy context and current planning and reporting requirements for the branch's funded health promotion programs.

Evaluation is always dependent on a range of factors, including the program/strategy implementation methods, delivery mode and agency budget. This resource cannot address each of these issues separately; however, it provides an overall guide to developing an evaluation plan. In addition, it provides evaluation tools that practitioners can select that are most appropriate to the projects and the contexts within which they operate. More detailed support is provided through the numerous publications and Internet sites that are listed in this resource.

Policy context for integrated health promotion planning and evaluation

In Victoria, the term 'integrated health promotion' is defined as agencies and organisations from a range of sectors working in collaboration with local communities, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.

The statewide objectives of integrated health promotion are to:

- reorient the primary health care system to be population-focused and underpinned by the social model of health
- consolidate and enhance health promotion infrastructure and resources to reduce duplication and fragmentation of effort
- contribute to the health promotion evidence base for priority issues and population groups
- increase the potential for sectors other than health to be involved in quality health promotion service delivery
- strengthen the capacity of the service system in Victoria to plan, implement and evaluate integrated health promotion programs.

Health Promotion Priorities 2007–2012

From 2007 to 2012, to provide greater direction and leadership for health promotion in Victoria, the Department of Human Service has established key topics and one setting as priorities for integrated health promotion.

1. Promoting physical activity and active communities
2. Promoting accessible and nutritious food
3. Promoting mental health and wellbeing
4. Reducing tobacco-related harm
5. Reducing and minimising harm from alcohol and other drugs
6. Safe environments to prevent unintentional injury
7. Sexual and reproductive health

Neighbourhood Renewal sites were also confirmed as one of the priority settings for health promotion practice from 2007.

How does the department use program evaluation?

Evaluation is not just about accountability to the department for funding. Good evaluation of integrated health promotion is needed to build the evidence base for integrated health promotion programs as an effective methodology to reduce demand for health services and improve health outcomes.

Evaluation is important for the department, agencies, practitioners and other key stakeholders 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
- fulfilling accreditation requirements and making continuous quality improvements
- contributing to the evidence base for quality integrated health promotion practice.

All of these factors are taken into consideration to inform integrated health promotion policy development and implementation in the future.

Using this resource

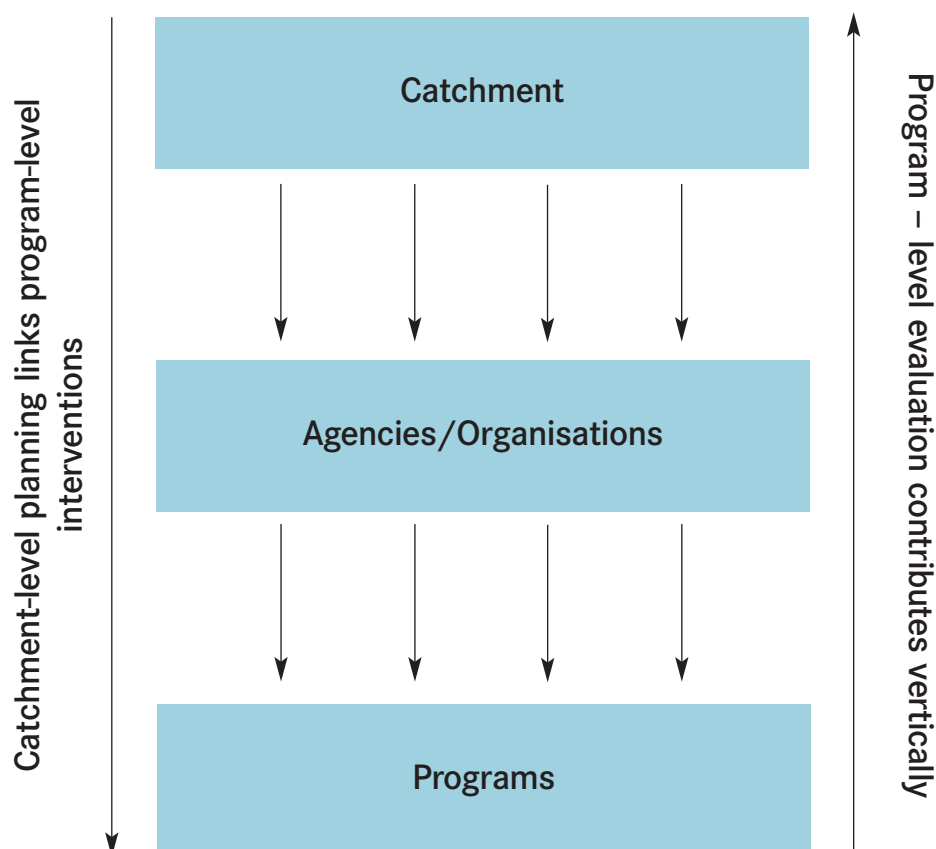
This resource is one of four Department of Human Services documents that support health promotion practice within the current policy environment. The first is the *Integrated health promotion resource kit* which provides a comprehensive guide to planning for effective integrated health promotion. The second, *Measuring health promotion impacts: a guide to impact evaluation in integrated health promotion*, assists with designing appropriate impact evaluation methods and develop impact indicators for health promotion programs. The third, *Environments for Health*, considers the broad determinants of health by using the four domains (built, social, natural and economic environment) and is the planning framework that guides the development of Municipal Public Health Plans by local governments.

This fourth resource has been developed to provide a framework for agencies/organisations to develop comprehensive evaluation plans. These should be completed in conjunction with **planning** health promotion programs/priorities. Users of this evaluation resource are encouraged to refer to the resource kit and a range of other integrated health promotion material available via the department's health promotion website: www.health.vic.gov.au/healthpromotion

Steps for developing an evaluation plan are provided, together with guidelines for completing each step. This is followed by two examples of evaluation planning.

Evaluation can be conducted at three levels: program, agency/organisation and catchment (partnership). The principles of evaluation remain the same, regardless of the level you are evaluating. This resource refers to 'program' evaluation throughout, to cover all three levels of evaluation in the Victorian context.

Figure 1: Levels of intervention and evaluation



Overview of program planning and evaluation

The department's Integrated health promotion resource kit describes a common planning framework for successful program planning and evaluation. These components are:

- vision setting
- priority setting and problem definition
- solution generation
- capacity building (support and resources)
- planning for evaluation and dissemination.

Figure 2: Program management for integrated health promotion program – linking impacts to outcomes

Program management for integrated health promotion involves managing the total set of actions, including:

1. Planning	Vision setting Priority setting and problem definition	3. Evaluation and dissemination
	Solution generation	
	Capacity building – support and resourcing for quality program delivery	3(a). Process evaluation
	Planning for evaluation and dissemination	
2. Implementation	Implementation of a mix of health promotion interventions and capacity building strategies to achieve the program goal and objectives	
3(b). Impact evaluation including:		
Health literacy	Social action and influence	Healthy public policy and organisational practice
Healthy lifestyles	Effective health services	Healthy environments
3(c). Outcome evaluation including:		
Quality of life, functional independence, equity, mortality, morbidity, disability		

(Adapted from King 1996, Nutbeam 1996 & Nutbeam 2000)

This common planning framework emphasises a social determinants of health approach at every step. It also highlights the hierarchy of process, impact and outcome evaluation and the different elements that can be measured at each stage of evaluation.

While the focus of this resource relates to evaluation, it is important to recognise that effective program planning is crucial to undertaking evaluation. Readers are, therefore, reminded to refer to the *Integrated health promotion resource kit* in planning their integrated health promotion projects.

Key evaluation considerations

Evaluation can be resource intensive, so it is crucial that the purpose, extent and nature of any evaluation are clearly and carefully considered and articulated during all stages of the program management framework provided above. It is clear that it is not possible, or sensible, to evaluate every aspect of every program incorporating input from every stakeholder. Decisions on the extent and nature of an evaluation are critical, and this resource includes support for readers in making these decisions.

Types of evaluation

There are three broad types of evaluation: process, impact and outcome.

When do I use each type of evaluation?

Process evaluation is used to assess the elements of program development and delivery, that is, the quality, appropriateness and reach of the program. This type of evaluation can be used during the entire life of the program, from planning through to the end of delivery. During planning and piloting stages, process evaluation will focus on the quality and appropriateness of the materials and approaches being developed. Once the program is in the implementation stage, process evaluation can be 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. These can then be quickly resolved with minimal impact on the program. More information about process evaluation can be accessed in Hawe et al. (1990) *Evaluating health promotion: a guide for workers*.

While the department requires only one type of process indicator (reach) reporting, including other process indicators will help refine your program by identifying enablers and barriers to successful program planning and implementation. Other process indicators include client satisfaction and facilitator reports. Process evaluation data is critical in understanding, interpreting and explaining much of the data collected through impact and outcome evaluation.

Impact evaluation is used to measure immediate program effects and, therefore, can be used at the completion of stages of implementation (that is, after sessions, at monthly intervals and/or at the completion of the program). This type of evaluation assesses the degree to which program objectives were met. Therefore, it is important that program objectives are developed and written in a way that enables later judgements about whether and to what extent they have been achieved. Writing 'SMART' objectives is covered below. Figure 2 indicates a number of areas that can be assessed through impact evaluation: changes in health literacy, behaviours or behavioural intentions, social action, service delivery, organisational change, environmental change or policy development. For more information about impact evaluation refer to *Measuring health promotion impacts: a guide to impact evaluation in integrated health promotion* (Department of Human Services 2003b) or Hawe et al. (1990).

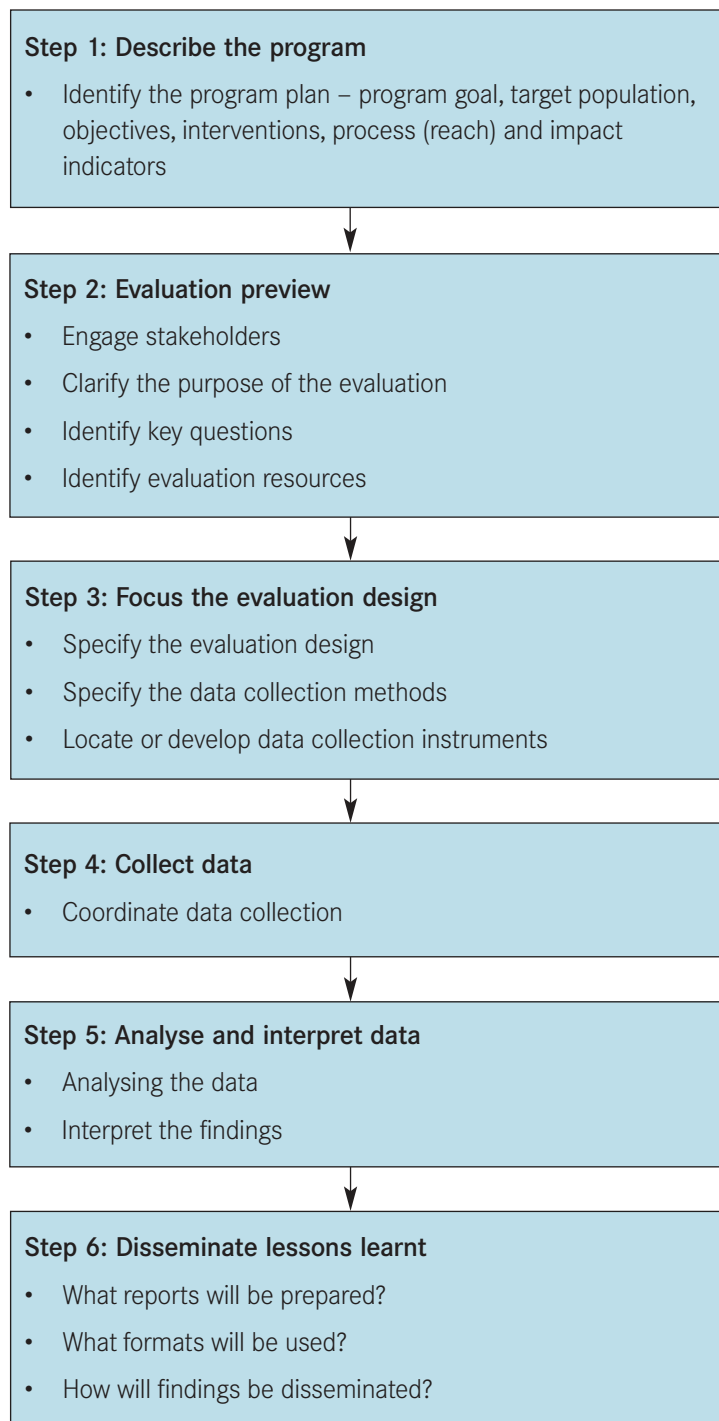
Outcome evaluation is used to measure the longer-term effects of programs and is related to judgements about whether, or to what extent, a program goal has been achieved. The long-term effects may include reductions in incidence or prevalence of health conditions, changes in mortality, sustained behaviour change, or improvements in quality of life, equity or environmental conditions.

This resource focuses on process (reach) and impact evaluation. While agencies/organisations/partnerships are not required to undertake outcome evaluation, they are encouraged to document any relevant outcome findings where possible.

Evaluation planning framework

Evaluation planning is conducted in **parallel with program planning**. This interaction improves both the program and the evaluation (Garrard et al 2004). There are many guidelines that can assist you in developing an evaluation plan. The evaluation planning framework developed by Garrard et al. (2004) in the *Planning for healthy communities: reducing the risk of cardiovascular disease and type 2 diabetes through healthier environments and lifestyles* is used as the basis of this resource. This framework assists in identifying the stages of evaluation development and implementation and is described in the evaluation planning guide:

Figure 3: Evaluation planning guide



Agencies/organisations/partnerships are encouraged to develop evaluation plans based on these steps.

Step 1. Describe the program: Identify the program plan – program goal, objectives, interventions, and process (reach) and impact indicators

As mentioned, the quality of an evaluation is influenced by the quality of program planning, particularly whether program goals and objectives have been developed in a way that supports later judgements about the extent to which they have been achieved.

The Integrated health promotion resource kit (Department of Human Services 2003a) discusses the intersections between program planning and evaluation, as illustrated in figure 4 (adapted from Hawe et al. 1990).

Figure 4: Links between program planning components and evaluation categories

Goal	<i>is measured by</i>	Outcome evaluation
Objectives	<i>are measured by</i>	Impact evaluation
Interventions/strategies	<i>are measured by</i>	Process evaluation

Writing program goals and objectives

Planning for integrated health promotion action must begin with being clear about broad priorities and using these to develop program goals and objectives. Writing goals and objectives is fundamental to guiding evaluation processes. In measuring program impacts and outcomes, it is important to re-visit the original program goals and objectives. This will be difficult if they are unclear or not shared amongst the program team. An overview of goals and objectives is provided in the *Integrated health promotion resource kit* (Chapter 4). Hawe et al. (1990) also provide detailed information on preparing program goals and objectives.

The **goal** is a statement about long-term outcomes or benefits. These are broad statements that relate to improving health and wellbeing status through changes in mortality, disability, quality of life or equity. The program goal is evaluated in outcome evaluation.

Most health promotion programs will have a single goal, although more complex programs may have more than one.

Objectives describe the ways in which you plan to operationalise and achieve your goal. They state what changes and achievements must occur for the goal to be reached and what the program is meant to achieve immediately after its completion. It is, therefore, crucial that your objectives are clear and concise. The objectives address the factors that cause or contribute to the priority health issue that is covered in the goal. A careful analysis of the determinants of the priority health issue is the starting point for developing objectives. Program objectives are evaluated by impact evaluation.

A good tool for developing sound objectives that will guide program development and evaluation is to ensure they are SMART:

Specific (clear and precise)

Measurable (amenable to evaluation)

Achievable (realistic)

Relevant (to the health issue, the population group and your organisation)

Time specific (time frame for achieving your objective)

Within the department's integrated health promotion planning template these SMART characteristics are usually developed through the combination of the objectives and its associated impacts.

Identifying impacts

Once the objectives have been set, you need to estimate the likely impacts of the objectives. Developing impact indicators is an important aspect of program planning and evaluation.

As outlined in *Measuring health promotion impacts: a guide to impact evaluation in integrated health promotion* (Department of Human Services 2003b, p. 5), impact is defined as, ‘the immediate effect that health promotion programs have on people, stakeholders and settings to influence the determinants of health. Health promotion programs may have a range of immediate effects on individuals and on social and physical settings.’ Integrated health promotion programs should specify impact indicators for program activities, giving a more concrete statement of the changes to be achieved within the objectives. These indicators should specify the type of change that is expected and the percentage of people or settings for which that change is anticipated.

Impact evaluation considers how a program will have an impact on the factors that have been identified as having an influence on people’s health. It does not seek to track long-term change in people’s health status or environments (‘outcomes’) – this is often beyond the time-scale of projects and is contributed to by a number of projects.

Depending on the objectives of the particular program, impacts include **improved health literacy, social action and influence, and healthy public policies and organisational practices**. At a later stage you may also see impacts relating to **healthier lifestyles, more effective health services and healthier environments**. These impacts are visible in Figure 2. To read more about these impacts, see the Integrated health promotion resource kit (pp. 65 and 66).

The key questions to consider when identifying impacts include:

- How are we going to know when we have reached our objective?
- What impact indicators will be appropriate to measure the degree to which the objective was met?

Answers to these questions form the basis of **impact** evaluation.

Health promotion interventions

Health promotion interventions are actions taken to achieve the program objectives. Effective health promotion generally involves a mix of interventions at multiple levels, from the individual through to populations, although single programs may target only some of these levels.

Key questions to consider include:

- What strategies and actions are going to help us meet our stated objective?
- How am I going to assess whether the interventions were appropriate to the target group, to the organisation/agency, and to achieving the objective?
- Are all parts of the project/program reaching all parts of the target group?
- What worked well and what could be done differently next time?

Answers to these questions form the basis of **process** evaluation and will assist you in refining your program. While agencies/organisations/partnerships are only asked to report **reach** as a measure of process, collecting other process data can assist you to refine your program. Process evaluation data, particularly on appropriateness and quality of the program’s interventions, as well as the extent of program implementation and reach, are critical if data on program effectiveness, gathered during impact evaluation, is to be understood and interpreted.

Identifying reach

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, or members of the community affected by the program (Department of Human Services 2003a).

Estimating who your program will reach will allow you to assess the extent to which your program has engaged with the target audience. You can use narrative to highlight how your estimated reach was achieved or, if not, to identify possible explanations. Recommendations for further action may also be presented. Refer to the *Integrated health promotion resource kit* (Chapter 5) (DHS 2003a) for more information and examples of reach indicators.

Program appropriateness and quality

As well as program reach, process evaluation addresses the quality and appropriateness of the program and of the processes undertaken during its implementation. It addresses questions such as:

Are participants satisfied with the project? For example:

- Do participants feel comfortable in the program?
- Do they feel listened to, understood?
- Are other participants friendly?
- Are topics relevant? Interesting?
- Is the pace too fast or too slow? Is it too difficult or too easy?
- Are staff interested, approachable, sincere?
- Is the presenter someone participants could relate to? (for example, ethnicity, age, experience)
- Are the venue location and facilities suitable?
- Are the cost and timing of program activities suitable?

Are all the activities of the project being implemented? For example:

- Is the project being implemented as planned?
- Have any unexpected problems arisen?
- Do you need to make some adjustments?

Are the materials/components of the program of good quality? For example:

- What is the readability level of the brochure?
- Are the videos culturally appropriate?
- Are the materials suitable for the target group – size of print, use of language and graphics?

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

Engage stakeholders

The active participation of all major stakeholders is a critical component of successful program planning and evaluation. Without this, it is difficult to develop an evaluation plan that will meet the needs and expectations of all key players – funding bodies, organisational managers, program staff, colleagues, partner organisations, program participants and the community. Engagement with these stakeholders may be through ongoing membership of advisory or management groups, or through shorter-term consultations or meeting arrangements. The focus for this is to reach agreement on the aspects of Step 2 that follow.

Clarify the purpose of the evaluation

Similar to general program planning, planning for an evaluation needs clear direction and vision. That is, you need to set a purpose for the evaluation: what do you want to achieve, what questions need to be answered, who is the evaluation for, what information do they want? Your evaluation purpose will determine the type of evaluation you conduct. For example, if your evaluation purpose is to assess whether the format of a walking group was appropriate to the target population, you are conducting a process evaluation of the walking program. If your purpose is to assess whether the program was effective in increasing participants' awareness of local walking activities or whether they had joined any of these groups or activities, you would be conducting an impact evaluation.

It is critical that the nature and purpose of any evaluation is determined early in the process of program planning and implementation. Key questions that need to be addressed include:

- What is the purpose of the evaluation? Is the program sufficiently innovative to warrant evaluation or is it adequate to monitor the quality of the program implementation? What processes or impacts would be most useful to examine as part of the evaluation?
- How much money has been invested in the program?
- Who is the evaluation for? Who are the key stakeholders? Who will be interested in the results of the evaluation?
- What information do they want?
- What difference would the information make?
- Is there agreement among the key stakeholders concerning these issues?

Answers to these questions will help you select the scale and scope of the evaluation and, therefore, focus your evaluation plan (Central Sydney Area Health Service and NSW Health 1994).

Identifying key questions

Having explored the purpose of the evaluation, a major task now is to develop a set of key questions that the evaluation will answer. It is this list of key questions that will determine the overall approach and scope of the evaluation. There will be many questions that any evaluation could ask – selecting among them is a significant stage of evaluation planning, giving focus and direction to the evaluation. Decisions on which key questions are to be answered by the evaluation will depend on the purpose of the evaluation and the resources, skills, opportunities and time available.

Deciding on resources for program evaluation

It is generally recommended that agencies spend approximately 5–15 per cent of the total program budget on evaluation. This may be shared across agencies participating in integrated health promotion. It is important to consider the needs of the evaluation when deciding on resources for your evaluation. That is, if the program is new and innovative it may be necessary to evaluate it more intensively. This may be particularly important if you want to use the evaluation to obtain additional funding. It would not be necessary or reasonable to conduct extensive evaluations with all implemented programs. For example, if a program has been run a number of times and has been shown, through impact evaluation, to be effective, there may be no need for an impact evaluation every time it is run. It is likely to be sufficient to carry out process evaluation to ensure that the program is being implemented as planned and to conduct impact evaluations only periodically. It is important in planning evaluations that you make strategic choices that will maximise the potential of the evaluation to generate new and worthwhile information.

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

Evaluation design

Having identified the key questions to be answered by the evaluation, you will need to identify what information would be needed to answer these questions and the overall evaluation design that would generate this information.

Evaluation designs include quantitative designs, which rely on collection of numerical data (for example, pre/post surveys with or without a comparison group, trend analysis), and qualitative designs, which rely on collection of written or spoken data (for example interviews, focus groups, case studies, document analysis and participatory action research). Quantitative designs are frequently used to measure impacts, while qualitative designs are useful in process evaluation, but this distinction is not definitive.

Frequently, impact evaluation will look for differences in the target group or community setting before and after the program, and sometimes seek to compare this with a ‘control group’ that did not receive the program. It is not always appropriate, or financially feasible, to conduct such experimental research in the evaluation of integrated health promotion, where the effect of the program in the intervention group is compared to a control group. However, practitioners should try to ensure their

evaluation designs are rigorous. This involves using validated tools where possible and using triangulated evaluation designs (where you incorporate a range of evaluation methods) (Patton 2002).

Data collection methods and instruments

Depending on the evaluation purpose, evaluations can use qualitative or quantitative data collection methods or a combination of both. Each of these broad categories is described below, with indications of suitable resources for more detailed information. ‘Instruments’ are the specific tools used to collect the data. For example, you might select focus groups as your data collection method and develop a set of questions that become the instrument to be used by the evaluator.

When would you use each type?

The selection of data collection methods depends on a number of factors, including the purpose of your evaluation, the questions the evaluation is seeking to answer, financial resources, time and skills. If you want to explore participants’ or workers’ experiences, it would be more appropriate to use qualitative methods. This will allow you to ask ‘how’ and ‘why’. On the other hand, if you want to measure the numbers of participants in a program or measure the degree of change in a health measure (such as Body Mass Index) or behaviour (such as participation in physical activity), then it may be most appropriate to use quantitative methods.

Qualitative methods

When using qualitative methods it is best to use several approaches. This concept is often referred to as ‘triangulation’ and using it strengthens your evaluation (Patton 2002). Triangulation can be achieved using either qualitative or quantitative methods alone, or by combining these methods.

The following section provides a summary of some qualitative methods used in health program evaluation.

Open-ended surveys

An open-ended survey is a standard set of questions that allows the respondents to answer in their own words. They allow for greater depth and exploration of issues or for explanation of closed-ended questions. They can be conducted face-to-face (with individuals or groups), via mail, telephone or electronically. Writing the right kind of question is important. Chapter 7 from Hawe et al. (1990) explores survey methods and questionnaire design. The NT Department of Health and Community Services also provides tips on writing questionnaires (qualitative and quantitative):

http://www.nt.gov.au/health/healthdev/health_promotion/bushbook/volume1/info.html

In-depth interviews

Generally, an unstructured or semi-structured interview is conducted face-to-face or via the telephone. They are often used to gain the views of key individuals involved in a program or to explore sensitive issues with individuals or small groups of people. The interviewer generally follows an outline, but has flexibility to vary questions. Patton (2002) has written an invaluable chapter on qualitative interviewing (chapter 7).

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 may or may not be shared with the participants at the start of the interview. The proceedings are recorded by a note taker or by audiotaping with later transcription (Department of Human Services 2003a). Focus groups are useful in gathering in-depth information, particularly about beliefs, attitudes, concerns, experiences and explanations. They are also useful in identifying issues for later use in quantitative survey work or in exploring the meaning of quantitative data that has been collected. A good description of focus groups has been developed by the Health Communication Unit at the Centre for Health Promotion, University of Toronto:

http://www.thcu.ca/infoandresources/publications/Focus_Groups_Master_Wkbk_Complete_v2_content_06.30.00_format_aug03.pdf

Narrative

Narrative allows you to examine the processes and impacts of your program in an exploratory manner. It allows you to build a story around your project and to explore its facilitators and barriers. You can include photos or other images in conjunction with narrative to provide a complete story of your project.

Narrative is useful in helping you build evaluation **case studies**. Case studies can assist in exploring specific units, which may include schools, communities, cultures, groups or individuals. You collect, organise and analyse data according to these cases. Therefore, the use of case study methodology reflects a complete research process.

You can read more about the use of narrative in *Writing narrative action evaluation reports in health promotion – guidelines, resource kit and case studies* (North and West Metropolitan Region, Department of Human Services 2004), also available online: <http://www.health.vic.gov.au/healthpromotion/downloads/near.pdf>

Narrative can also be generated through **diaries or journals**. Stakeholders can 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. Journals provide a detailed description of the selected aspect of the program and give ongoing documentation by the selected stakeholders (those participating in or implementing the program) and can, therefore, help to map change over time. Diaries are useful in exploring processes and impacts. At the beginning of project implementation, entries may focus on the way the program is progressing and barriers that have arisen. As time progresses, entries may discuss changes that have occurred as a result of program participation.

Participant observation

Participant observation requires the evaluator to become involved in the program being observed. It is extremely useful for building trust with people in their activities or work and developing a detailed understanding of behaviour and reasoning in a situation. There are two forms of participant observation – unobtrusive and obtrusive. Unobtrusive observation involves the evaluator undertaking an observation of the activities in the program, without doing or saying anything to influence behaviours of those being observed. Obtrusive observation or ‘participant as observer’ involves the evaluators taking a more active role with participants, engaging in the activities and processes, while known to be evaluators. A useful introduction to participant observation is available at <http://www.sociology.org.uk/mpohome.htm>

Document analysis

It can be useful to use program files or records to inform your evaluation, particularly when identifying program processes (Patton 2002). For example, you could examine the extent to which your integrated health promotion plan was understood and implemented by team members by conducting a review of individual program plans. Alternatively, you could use successive integrated health promotion plans to map changes over time and consider the links between these changes and program impacts. If your health promotion program aimed to work with and change the way organisations (such as schools, sporting clubs or health organisations) do their core business, then data for process and impact evaluation could be gained by an examining documents such as meeting minutes, newsletters, sales records, written policies and club rules.

Quantitative methods

Quantitative methods are particularly useful if you want to measure change across time or across groups, such as change in knowledge, intentions, behaviours or health status (impacts or outcomes) or to be able to generalise results from a sample to the whole of the population group involved. Quantitative methods can be used together with qualitative methods which help **explain** any impacts or outcomes identified through the quantitative data. The section on ‘Evaluation tools’ page 46 provides some starting points in identifying instruments others have developed and used.

Surveys

Quantitative surveys differ from those used in qualitative research. If you want to count responses, calculate frequencies, be able to make generalisations, or compare different groups, then you will need to use closed-ended questions that provide only a limited range of ways of responding to the questions, such as tick box or numerical responses. These enable quantification of the impacts/changes/effects of interest. Chapter 7 from Hawe et al. (1990) will assist you to use survey methods and develop your questionnaire design.

Other numerical data

There are many sets of data that can be collected as ‘numbers’; examples include participation numbers, membership levels, sales figures, vehicle numbers, body mass index, levels of physical activity (for example, measured as steps per day), population health survey data, quality of life and depression levels. If you are collecting quantitative data, you should seek to identify whether there are any standardised formats for collecting such data, or other suitable tools that you could use.

Service data

Service-specific data can be used to identify numbers of people attending your service, their demographics and programs used. This information can be useful in supplementing other evaluation data. Computer programs like Microsoft Excel can assist you to undertake basic descriptive data analysis (such as average, highest, lowest).

At this stage you may also develop some indicators for determining the success of your project. Some topic-specific methods for indicator development are included in the ‘Tools for evaluation’ section at the end of this document. For a generic discussion of indicator development, see the South Australian Community Health Research Unit website: <http://www.sachru.sa.gov.au/contactus.htm>

Observational data

Observational data can be collected by watching or assessing individuals or groups. For example, if you want to assess the effectiveness of a media campaign on SunSmart you could observe and measure skin protection behaviours. Other examples of observations that could be recorded using quantitative data include community use of walking paths or cycle paths, environmental behaviour, traffic numbers, passenger numbers, and physical activity levels during recess in a school.

Selecting evaluation participants

When selecting data collection measures and instruments it is important to consider how many of your program participants you want to participate in the evaluation and how you are going to select them. Numbers of participants will depend on your evaluation resources and data collection methods.

There are a number of ways of selecting participants and your choice will depend, again, on your resources and the evaluation approaches you are using. Broadly speaking, you can either:

- select a group of participants using pre-determined criteria (for example, every second participant or all participants) or a random sample of participants. If selection criteria are used, it is important to ensure that they do not create a bias in which participants are selected to provide information for the evaluation. Random sampling and criterion-based sampling can be complex and time consuming, however, it ensures a degree of representativeness of the sample and ability to generalise the results.

or

- select participants in a non-random manner, for example, invite people to participate in the evaluation or use a convenience sample, such as those people who attend the last session of the program, or interview the key stakeholders in a program. Such non-random selection methods are generally quicker and easier, but do not allow you to generalise your findings to other participants in the program or to other members of the community.

Step 4. Collect data: coordinate the data collection

This stage is where your evaluation plan is put into action. The way you collect data and the types of data you collect will depend on the evaluation design and data collection methods you selected in the previous step.

You need to coordinate data collection by specifying:

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

Pilot testing of any instruments you plan to use is essential for data collection. This allows processes and materials to be modified prior to data collection (for example, trialling the list of discussion themes or questions for a focus group at least once prior to using it to collect data).

Data collection can often be hampered by poor response rates. You can increase the response rate by:

- including a stamped envelope for mail surveys
- providing an incentive to participate in program evaluation
- giving participants some ownership in the evaluation process
- using reminder messages, such as postcards or emails.

Step 5. Analyse and interpret data

Data analysis involves identifying and summarising the key findings, themes and information contained in the raw data. This process allows you to identify processes, impacts and, in the longer-term, outcomes. Qualitative data requires a different type of analysis from that needed to analyse quantitative data. Data analysis and interpretation is an often under-valued task but is crucial to ensuring that the data collected can be used to inform the evidence base and refine the program. Allocating sufficient time and resources to data analysis and interpretation is, therefore, important.

Qualitative data analysis

Most commonly, the analysis of qualitative data involves identifying themes in the data – broad categories of comments or information or ‘big’ ideas. Such an analysis involves studying the data to identify what you consider the major themes to be and then classifying and grouping the data according to these themes, so that you are able to build up evidence under each of them.

You can do this classification in a number of ways. It could be a simple cut and paste, where material is physically cut out of the transcribed data and pasted onto large sheets, with each sheet being used to group information or quotes on one of the themes. You could do this electronically as a cut and paste in any word processing software or you could simply go through your transcribed data using a series of different coloured highlighter pens to indicate material related to each theme. Of course, there are also sophisticated software, such as *In Vivo*, which allows you to do a more sophisticated analysis of the data than simple cut and paste methods.

Hawe et al. (1990) provide a good discussion about how to analyse qualitative data. In addition, the NT Department of Health and Community Services provides guidance on how to analyse both qualitative and quantitative health promotion data: http://www.nt.gov.au/health/healthdev/health_promotion/bushbook/volume1/analyse.html#howto

Quantitative data analysis

Quantitative data is generally analysed and presented as frequencies, measurements or percentages, and involves relatively simple statistical calculations of averages (means, medians) or differences over time or between groups. In most cases, these can be presented in tables, histograms, pie charts or other summary ways. However, where program impacts are being measured, it may be necessary to use relatively sophisticated statistical tests to prove that any difference observed is in fact ‘significant’. In these situations, you may need to enlist the help of a statistician or a colleague with some training in statistics.

There are many guides providing information about statistical methods. An excellent book which covers the basics in simple terms is *Statistics for the utterly confused* (Jaisingh 2000).

Microsoft Excel is a readily available, useful program for analysing quantitative data. It allows you to count, calculate averages, find minimum and maximum values and compare groups using graphs and tables. It also assists you to use more sophisticated statistics including standard deviations. Below is an example of some data that you might collect if you were measuring changes in fitness of participants in an exercise program. Before and after the program, cardiac fitness was measured with a bike test, where participants were asked to ride for as long as possible. Heart rates were measured before (HR1) and after the program (HR2), together with their weight and the time they could keep riding. Once this data was collected, Excel was used to find the averages and median values. Generally you will use simple descriptive statistics, such as frequencies, averages, medians (the middle value) and modes (the most common value).

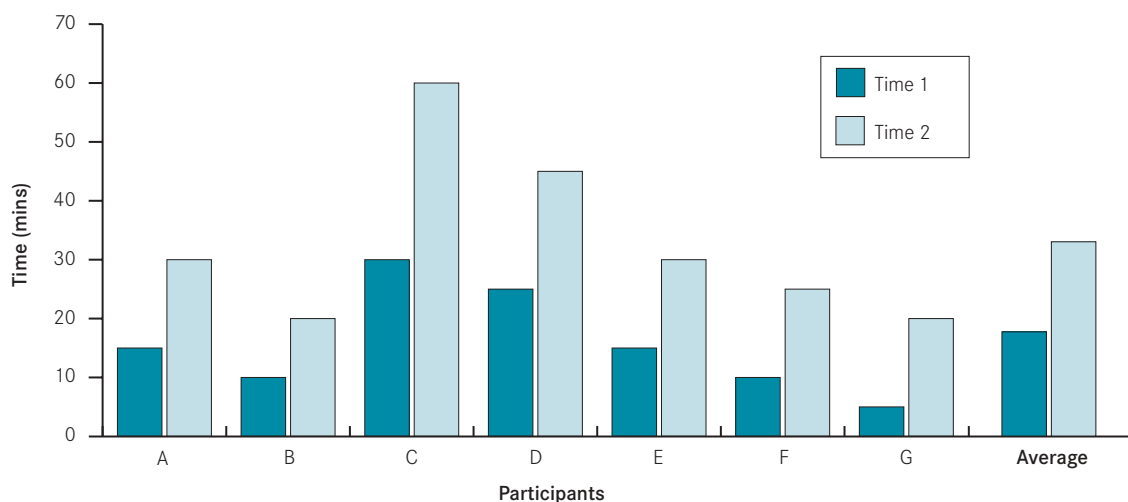
Figure 5: Measurements of participants in a cardiac fitness program

	A	B	C	D	E	F	G	H
1	Participant	HR 1	Time 1	Weight 1	HR 2	Time 2	Weight	
2	A	80	15	90	75	30	85	
3	B	90	10	110	80	20	100	
4	C	65	30	85	65	60	80	
5	D	70	25	87	68	45	85	
6	E	85	15	90	80	30	85	
7	F	85	10	98	80	25	95	
8	G	90	5	95	85	20	89	
9								
10	Average	80.71	15.71	93.57	76.14	32.86	88.43	
11								
12	Difference (pre-test post-test)							
13		-4.57	17.14	-5.14				
14								

Excel also provides a range of tests that would be relevant in evaluation, particularly if you are comparing pre- and post-tests, or intervention and control groups. The ‘Help’ menu in Excel gives you guidance in how to access these functions – just type ‘statistics’ into the help window. You can also use Excel to generate charts and graphs.

Figure 6 shows the time participants could ride their bikes before and after participating in the program. This graph was created by highlighting the relevant columns in the Excel spreadsheet and then selecting the graph function. This allows you to label the axes and format the graph. There are a range of graphs and tables you can produce in Excel including bar charts, pie charts and line graphs; use the ‘Help’ menu for more information.

Figure 6: Comparison of pre- and post-program bike riding times.



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.

We have already identified that evaluation should have a clear purpose and should consider the potential audience. The nature of evaluation reports and other forms of dissemination will vary depending on this audience. Reports to funding bodies and committees of management may differ in detail and presentation format from reports for project staff or for client groups and the wider community. It is, therefore, important that you develop a dissemination strategy. This strategy needs to be consistent with the resources allocated to evaluation.

Some questions that will shape your reporting and dissemination strategy include:

- Who should have access to the results of the evaluation and what is an ideal format for ensuring adequate and accessible information for these groups?
- How will evaluation data be used and stored within the agency to ensure that future programs are able to build on the knowledge base achieved during the evaluation?
- How could or should results be distributed more widely so that other health promotion practitioners are able to know about your work?

Avenues for wider dissemination of program details and evaluation results include organisational and regional newsletters, articles in professional journals, network meetings, workshops, presenting at conferences and other website products such as QIPPS.

Wider dissemination is a critical but often forgotten aspect of health promotion practice – it is often very hard to find information on what others have done, how it worked and, most importantly, why. And if this is true in general, it is particularly true if we are trying to find out what hasn't worked. No matter what results come out of an evaluation, it is important that we make this information available to others to guide their work.

Dissemination strategies can include:

- training
 - communication through print
 - communication through new information technologies
 - personal face-to-face contacts
 - consultancy
 - policies, administrative arrangements and funding incentives
 - committee and other decision making structures
 - collaborative applied research programs
- (King et al 1996 as cited in NSW Health and Australian Health Promotion Australia)

Factors supporting successful dissemination include:

- involvement of key stakeholders
- dissemination expected, planned for and funded
- active supportive dissemination and uptake
- ongoing access to resources
- publicity
- strategies for dissemination and skill development
- political agenda

(Oldenburg et al 1997 as cited in NSW Health and Australian Health Promotion Australia)

It is also important to consider dissemination of evaluation findings within your organisation. You may do this through newsletters, team meetings or message boards. Ensuring that this dissemination remains accessible is also important and is sometimes referred to as 'organisational memory'. To be effective, strategies to develop organisational memory need to be uncomplicated and quick. Some appropriate strategies may include files (electronic and hard-copy), Intranet (through internal computer network) and other products such as the QIPPS website.

You can also use mailing lists external to your organisation to disseminate your findings. This may include health promotion email list servers such as AHPA Vic Branch, click4HP and SDOH.

Evaluation planning summary

The decisions and outcomes of the detailed evaluation planning processes that have just been covered will need to be summarised and presented in a manner that can be used as a basis for day-to-day evaluation decision making and action in agencies. The grid in Figure 7 is suggested as a method of summarising the evaluation planning process. For each program objective, with its associated impacts, the grid asks for a clear statement of the key questions that will be the focus of the evaluation, the information needed to answer these questions, the ways in which this information will be collected, and the budget necessary to undertake this data collection. It also has space for key questions related to the overall project, as distinct from questions relating to individual program objectives, and planning space for the preparation and dissemination of the report. This grid is used in the following section to summarise the evaluation plans for two case study programs.

Figure 7: Evaluation planning process grid

HP priority goal				
Population target group/s				
Objective:	Key questions (what do we need to know to decide if we have achieved this objective?)	What information do we need to answer these questions?	How will this information be collected, by whom and by when?	Budget
Impact:	Process evaluation Impact evaluation			
Overall aspects of the project				
Preparation of evaluation report				
Dissemination				

Case studies

The following two case studies illustrate the six-step evaluation planning framework described in the previous pages. While the case studies are fictionalised examples of programs they have drawn on a number of formal programs that have been funded in Victoria during the past two years.

The first case study is of a mental health promotion program in a rural area, where a number of agencies have worked in partnership to address the needs of same-sex attracted youth. In this case study, the evaluation is relatively straightforward, since it is essentially the evaluation of a single program.

The second case study concerns the evaluation of initiatives to increase participation in physical activity in the catchment area of a PCP. In this case study, the evaluation involves bringing together information on a number of collaborative and individual programs that together contribute to achieving the goal and objectives of the PCP's Integrated Health Promotion Plan.

For each case study, there is a detailed overview of the six steps in the evaluation-planning grid. This is followed by a summary of the evaluation plan, which draws together information on the key aspects of the evaluation. The essential aspect of this summary plan is that it asks staff to be selective in identifying the key questions that their evaluation must answer – clearly it is not feasible or sensible to evaluate every detail of every program, and quality evaluation planning will involve strategic choices in the questions to be answered and the methods selected to do this.

The evaluation summary plans include a column for the associated budget. This is broken down into consumables and the hours required for individual tasks. It is not expected that agencies would report to the Department in this detail, but the breakdown of hours will be useful in developing an EFT equivalent for staff time required for the evaluation.

Case study 1: Happy Valley Community Health Centre

Due to the remote locality of the Shire of Happy Valley, young people often feel isolated and have limited access to services and facilities. Evidence suggests that young people, particularly same sex attracted young people, experience higher rates of depression and attempted suicide, particularly in rural areas. The consequences of sexual orientation and gender identity discrimination on the health and wellbeing of Gay, Lesbian, Bisexual and Transgender and Intersex (GBLTI) adolescents also include:

- increased rates of homelessness, due to rejection by family and friends
- increased and multiple risk-taking behaviours, including substance abuse and unsafe sex
- earlier initiation into risk-taking behaviours
- feelings of guilt and self-denial and, in some instances, internalised homophobia.

The agency has identified that young same sex attracted people are experiencing discrimination and there is a need to increase awareness around stigma and violence (physical and verbal abuse) issues affecting same sex attracted youth (SSAY). The research also identified that SSAY are more likely to feel disempowered and not access services for support (Ministerial Advisory Committee on Gay and Lesbian Health 2002). Young people are an important asset to Happy Valley and the integrated health promotion plan will support SSAY to feel valued and connected to their community. The agency was successful in getting a \$20,000 grant from VicHealth to undertake work in relation to these issues.

Step 1: Describe the program

Describe the goal, objectives, target population, interventions, impact and reach indicators. You may need to re-visit this section once you begin to undertake evaluation to ensure that the program/s was/is to be implemented as documented.

<p>Priority: Mental wellbeing and social connectedness</p> <p>Target Population: Same sex attracted youth</p> <p>Goal: To create a social climate where rural same sex attracted young people are accepted and supported and can live without fear of discrimination.</p>		
<p>Objective 1: To have 50% of schools in Happy Valley area utilise the Health Promoting Schools framework to develop a comprehensive 'Affirming Diversity' policy by July year 2.</p> <p>Impact: 50% of schools in the Happy Valley area will have developed an 'Affirming Diversity' policy by July year 2.</p>		
Health promotion interventions and capacity building strategies	Estimated reach	Timelines and by whom
<p>Settings and supportive environments</p> <p>1. Establish steering committee: local government (LG), school focused youth service (SFYS), Happy Valley Community Health Centre (CHC), Division of General Practice (DGP), Happy Valley Community Mental Health (HVCMH), Regional Office Department of Education and Training.</p>	7 agencies	July year 1 CHC
<p>2. Organise a workshop for key representatives (for example welfare coordinators) from each school to attend. Specific topics covered:</p> <ul style="list-style-type: none"> • What is your school already doing? • Why the need for 'Affirming Diversity'? • review of the Health Promoting Schools Framework • how to develop a policy • guidelines and strategies (these will be supplied to teachers). <p>Plan workshop Send invites to schools</p> <p>3. Provide advice, support and follow up to schools developing a policy.</p>	13 primary and secondary schools Key teachers in the policy development process.	September year 2 LG, SFYS July–September year 1 CHC Year 1 and 2 CHC

<p>Objective 2: To increase the knowledge and expertise of 30 health/welfare professionals in Happy Valley Shire on the health and social issues facing rural SSAY by December year 2.</p> <p>Impact: At least 30 health/welfare professionals attend professional development activities and increase their knowledge of issues affecting same sex attracted youth and how to address these issues within the school context.</p>		
Health promotion interventions and capacity building strategies	Estimated reach	Timelines and by whom
<p>Health education and skill development</p> <ol style="list-style-type: none"> Provide a two-hour workshop to health/welfare professionals and parents. The title of this workshop is ‘Working with and Helping Young People with Same Sex Attraction.’ <ul style="list-style-type: none"> planning of workshop send out invites/advertise A one-day training program will follow the previous workshop for professionals. This aims to provide them with an understanding of experiences and needs of SSAY. <ul style="list-style-type: none"> planning send out invites/advertise 	<p>80% health/welfare workers in youth-related services in Happy Valley. 10 parents</p> <p>80% health/welfare workers in Happy Valley</p>	<p>August year 2</p> <p>July–August year 2 Steering committee</p> <p>Middle of October year 2 CHC with steering committee</p>
<p>Objective 3: To empower same sex attracted young people, their parents and friends to be connected to community and support networks by December year two.</p> <p>Impacts:</p> <ul style="list-style-type: none"> 100% of parents and friends who attend program activities are able to identify and link into community services available to provide support. 100% of young rural people who have same sex attraction have information on how to access service providers and to explore opportunities for addressing their needs. 		
Health promotion interventions and capacity building strategies	Estimated reach	Timelines and by whom
<p>Health education and skill development</p> <ol style="list-style-type: none"> The needs of parents and friends of SSAY will be identified at the workshop mentioned above, by means of a needs assessment. An information session to be conducted for parents and friends of rural SSAY providing information on helping young people with same sex attraction. Develop and distribute information on confidential support services available to SSAY in Happy Valley. 	<p>20 parents and friends of SSAY</p> <p>All students in the secondary schools in Happy Valley area and relevant health and welfare agencies</p>	<p>Middle of August year 2 (at information session)</p> <p>Regional Parenting Resource Service. CHC staff with input from Steering Committee</p> <p>October year 2</p>
<p>Community action</p> <ol style="list-style-type: none"> Explore the possibility of future group meetings specifically for parents and friends of SSAY. Liaise with service providers who work with youth where there may be disclosure of sexual identity. Explore opportunities for SSAY to meet in a supported and confidential environment: <ul style="list-style-type: none"> meet with professionals as a group to discuss options for targeting same sex attracted young people. hold a discussion group with same sex attracted young people. 	<p>10 service providers</p> <p>10 service providers</p> <p>5–8 SSAY</p>	<p>School welfare coordinators July year 2 HVCMH</p> <p>End October year 2</p> <p>Beginning December year 2</p>

Step 2: Evaluation preview

Step 2 involves:

- *engaging stakeholders*
- *clarifying the purpose of the evaluation*
- *identifying the key questions to be answered through the evaluation*
- *identifying evaluation resources.*

A steering committee has been established to facilitate the program plan and will also inform the evaluation plan. The committee consists of representatives from LG, DGP, primary and secondary schools, Regional Parenting Resource Service, HVCMH, SFYS, representatives from the same sex attracted community, that is, parents/carers, young people, friends, CHC, Happy Valley PCP.

The steering committee has identified the following purpose and key questions for the evaluation:

Purpose

- To assess whether the program goal and objectives have been achieved and the extent to which they have contributed towards achieving the health outcome the plan aims to achieve.
- To assess the level of collaboration the partnership has developed.
- To document critical success factors and barriers to implementation of the plan.
- To meet department and Vichealth reporting requirements

Key questions

- Has the program achieved its planned reach?
- Have program participants (staff and community organisations and community members) been satisfied with the program?
- Have the program objectives and impacts been achieved?
- Have all strategies been appropriate and effective in achieving the objectives and impacts?
- What have been the critical success factors and barriers to achieving the objectives and impacts?
- Have levels of partnership and collaboration increased?
- What have been the critical success factors and barriers to partnerships and collaboration within this project?
- Should the program be continued or developed further? Where to from here?

Resources

Plan budget is \$20,000. The evaluation budget at 10% of plan budget, that is \$2,000.

Staff input: Steering committee will consider the data and help shape the report

Step 3: Focus the evaluation design

Evaluation design

The evaluation design should:

- *be the most rigorous, practical design to meet the evaluation purpose and key questions.*
- *involve use of existing measurement instruments or new ones developed for this evaluation*
- *involve careful consideration of who should contribute information and data to the evaluation to ensure that the view of all key stakeholders has been included.*

A mix of qualitative and quantitative data will be used to undertake process and impact evaluation.

Progress report: July year 1

Final evaluation report: July year 2

Sources of information: Key informant interviews at mid-point and end-of-project: school staff; school focussed youth service; CHC staff; local government; steering committee

Focus groups: SSAY; parents of SSAY

Documents: school policies; attendance records of meetings and training sessions; outcomes of meetings and workshops

Surveys: pre- and post-survey of youth-related health and welfare services and their staff members attending workshops; pre- and post-survey of school personnel attending meetings in relation to supporting diversity and whole-school approaches to protecting the welfare of SSAY

Step 4: Collect data

Step 4 involves collection of the information needed to answer the key evaluation questions. This requires a clear vision about what information will be collected, what tasks need to be undertaken, by whom, and by when.

The CHC is to be responsible for maintaining accurate records of attendance and issues covered at all meetings, workshops and forums throughout the life of the project. In addition, the following tasks will be undertaken.

For objective 1:

- The steering committee is to develop a questionnaire/evaluation form for use at the September workshop. To be administered by LG representative.
- SFYS to collect 'Affirming Diversity' policies and conduct interviews in project schools, April–May year 1.

For objective 2:

- CHC responsible for gathering data on how the workshop was advertised and participants recruited.
- Steering committee to develop end-of-workshop evaluation forms for August and October workshops; data to be collated by CHC staff.
- Pre/post surveys to be developed by HVCMMH representative and steering committee; administered and data collated by HVCMMH.

For objective 3:

- Pre/post survey of agencies and schools to be developed by the CHC, HVCMMH, Regional Parenting Resource Centre and steering committee. Administered by HVCMMH in July and October year 1.
- Evaluation form for the workshops for parents and friends of SSAY to be developed, administered and collated by Regional Parenting Resource Centre – August year 2.
- Interviews with young people who attended a discussion group (if it occurred).
- Case studies to be developed by health promotion officer in conjunction with HVCMMH, Parenting Resource Centre, school welfare coordinators – October to December year 1.

Overall aspects of the project:

- Health promotion officer from CHC to conduct interviews with key stakeholders and one focus group interview with the steering committee.

Step 5: Analyse and interpret data

Step 5 involves identifying and summarising the key findings, themes and information contained in the raw data and interpreting these in relation to the purpose and key questions of the evaluation.

Analyse data

Use Microsoft Word to analyse qualitative data: identifying main themes and trends.

Use Excel quantitative data: frequency data for school policy development and implementation.

Interpret what the findings mean

Qualitative data: The agency will identify key themes and report findings based on these themes.

Key questions to include:

- Has the program had the desired impacts? Why? Why not?
- What key lessons have been learned?
- What are the critical success factors?
- What are the barriers?
- What should be done differently in the future?

Quantitative data: use graphs, tables and descriptive statistics to report findings.

Step 6: Disseminate the lessons learnt

Stage 6 involves responses to the following questions:

- *What reports will be produced?*
- *What formats will be used?*
- *How will the lessons learned be disseminated?*

The agency health promotion officer will be responsible for collating evaluation findings and developing an evaluation report. This report will be distributed to all stakeholders and the Department of Human Services regional office. Findings to be reported at Regional Health Promotion Conference. Journal article to be written; case study will be disseminated on QIPPS website.

Using linkages developed through the bi-monthly Happy Valley and District Youth Networking Health Forum issues can be further discussed and personal development activities can be planned and information continually disseminated.

Integrated health promotion evaluation plan

This is an example of an integrated health promotion evaluation plan. It summarises the elements of the six steps above that were used in the planning and implementation of the evaluation of Happy Valley’s Community Health health promotion plan in relation to mental wellbeing and social connectedness.

<p>HP priority goal</p>	<p>To create a social climate where rural same sex attracted young people are accepted and supported and can live without fear of discrimination.</p>			
<p>Target Population</p>	<p>Same sex attracted youth.</p>			
<p>Objective 1:</p> <p>To encourage 50% of schools in Happy Valley to use the Health Promoting Schools framework to develop a comprehensive ‘Affirming Diversity’ policy by July year 2.</p> <p>Impact:</p> <p>50% of schools in Happy Valley area will have developed Affirming Diversity’ policy by July year 2.</p>	<p>Key questions (what do we need to know to decide if we have achieved this objective?)</p> <p>Process evaluation</p> <p>Reach: Did the program achieve its planned reach: 13 schools in the Happy Valley area and 7 agencies?</p> <p>Quality and appropriateness: Were participants satisfied with our work with them?</p>	<p>What information do we need to answer these questions?</p> <p>Membership of the steering committee.</p> <p>Number of key teachers involved.</p> <p>Number of schools involved.</p> <p>Did school members think that the workshops and other support were appropriate to the needs and of high quality?</p>	<p>How will this information be collected, by whom and by when?</p> <p>Minutes of meetings</p> <p>Questionnaire for steering committee and for teachers attending the workshops.</p> <p>Steering committee to develop.</p> <p>SFYS rep to deliver and collect.</p>	<p>Budget/resources</p> <p>1 hour = \$55 (This is an indicative cost which may vary)</p> <p>No cost</p> <p>1 hr for development</p> <p>Printing: \$5</p>
<p>Impact evaluation</p> <p>Did the program achieve its target of having a policy developed and implemented in 50% of schools?</p>	<p>How many schools have developed and implemented ‘Affirming Diversity’ policies?</p> <p>What have been the opportunities and barriers to developing and implanting these policies?</p>	<p>Copies of policies collected from schools – LG to do.</p> <p>Key informant interviews with 6 schools (3 primary schools, 3 secondary schools). Interviews to focus on the impacts of the workshop and the level of support provided for policy development.</p> <p>Telephone or face-to-face.</p> <p>Interview schedule to be developed by the SFYS with assistance from project steering committee.</p> <p>SFYS to conduct key informant interviews with key teachers.</p>	<p>1 hour</p> <p>Mail = \$5</p> <p>6 x 45 mins = 4.5 hours</p>	

Objective 2:	Key questions (what do we need to know to decide if we have achieved this objective?)	What information do we need to answer these questions?	How will this information be collected, by whom and by when?	Budget/resources
<p>To increase the knowledge and expertise of 30 health/welfare professionals in Happy Valley on the health and social issues facing rural SSAY by December year 2</p> <p>Impact: At least 30 health/welfare professionals attend professional development activities and increase their knowledge of issues affecting SSAY.</p>	<p>Process evaluation How many health and welfare professionals and parents attended the workshop and further professional development? Did they find the professional development activities suited their needs and expectations?</p> <p>Impact evaluation Did participants increase their knowledge and expertise in relation to SSAY issues?</p>	<p>Attendance figures and spread of agencies/organisations. Did participants think that the workshops and other training were appropriate to their needs and of high quality? Pre/post test survey to assess knowledge change to be mailed three months after the workshop.</p>	<p>Registration and attendance lists Open-ended question on the end of day evaluation sheet. Pre/post test survey to be developed by HVCMH. Distribution, analysis and dissemination to be the responsibility of HVCMH</p>	<p>No cost Development = 2 hours = Mail = \$35 Admin time to manage mail = 1 hour</p>
<p>Objective 3:</p> <p>To empower SSAY, their parents and friends to be connected to community and support networks</p> <p>Impacts</p> <ul style="list-style-type: none"> • 100% of parents and friends attending workshops are able to identify and link into community services available to provide support. • 100% of young rural people who have same sex attraction have information on how to access service providers and to explore opportunities for addressing their needs 	<p>Process evaluation How many parents and friends attended meetings? Did they feel comfortable in attending? How many SSAY or their friends have been reached through meetings or agency contacts?</p> <p>Impact evaluation Did parents and friends attending the workshop report that they had gained new knowledge and understanding? Was information on services designed to support SSAY available in all schools and relevant health/welfare agencies?</p>	<p>Attendance records of meetings. How did people learn of the meetings? What did they think of the meetings? Views of parents and friends attending the workshop. End pre-and post-project survey of schools and relevant agencies. Key informant interviews (with parents, young people and service providers) to examine level of empowerment. Select several case studies and develop narrative story about empowerment.</p>	<p>Evaluation form at the end of the meeting. Regional Parenting Resource Centre and HVCMH to develop end of workshop evaluation and a pre/post test survey of agencies. HVCMH to disseminate surveys and collate findings. School welfare coordinators to develop key informant interview schedule in collaboration with HVCMH. HVCMH to work with CHC to identify case studies and develop narrative.</p>	<p>Budget/resources</p> <p>1 hour 4 hours Mail out of survey = \$30 Five key informant interviews = \$275 + Travel = \$75.</p>

	<p>Impact evaluation (cont.)</p> <p>Were SSAY aware of the support services available within the community?</p> <p>Were they willing to use these services?</p> <p>Did any networks of SSAY and/or parents develop as a result of the project?</p> <p>Have service providers identified any change in requests from SSAY, their parents or their friends?</p> <p>Have any new initiatives been developed by services in response to the needs of SSAY and their parents and friends?</p>			
<p>Overall aspects of the project</p>	<p>Key questions (what do we need to know to decide if we have achieved this objective?)</p>	<p>What information do we need to answer these questions?</p>	<p>How will this information be collected, by whom and by when?</p>	<p>Budget/resources</p>
<p>Working relationships</p>	<p>Was it beneficial for the project and for the CHC to actively involve other agencies as part of the project?</p>	<p>Records of involvement of agencies in different aspects of the project</p> <p>Interviews with project staff and agency staff</p> <p>Focus group</p>	<p>Copies of meeting and workshop attendance</p> <p>Health promotion officer will arrange interviews with key individuals, and conduct one focus group of the steering committee</p>	<p>No cost</p> <p>4 hours</p>
<p>Partnerships and networks</p>	<p>Have levels of partnership and collaboration increased during the project?</p> <p>What have been the critical success factors and barriers to increase partnerships and networking?</p>	<p>Records of involvement of agencies in different aspects of the project</p> <p>Interviews with project staff and agency staff</p> <p>Focus group</p>	<p>Copies of meeting and workshop attendance</p> <p>Health promotion officer will arrange interviews with key individuals, and conduct one focus group of the steering committee</p>	<p>No cost</p> <p>4 hours</p>

<p>Critical factors in undertaking the project</p>	<p>What have been the critical success factors and barriers to achieving the objectives and impacts? Was the community ready for this project? Where to from here?</p>	<p>Records of involvement of agencies in different aspects of the project Interviews with project staff and agency staff</p>	<p>Copies of meeting and workshop attendance Health promotion officer will arrange interviews with key individuals, and conduct one focus group of the steering committee</p>	<p>As above (same meetings and interviews)</p>
<p>Preparation of evaluation report</p>	<p>CHC responsible for collating evaluation findings and analysis and developing evaluation report</p>			<p>10 hours</p>
<p>Dissemination</p>	<p>1. This report will be distributed to all stakeholders and Department of Human Services regional office. 2. Findings to be reported at Regional Health Promotion forum. Journal article to be written by CHC and interested key stakeholders. 3. Project report – planning and evaluation – loaded onto QIPPS.</p>			<p>Printing 30 copies of report = \$45 Journal article 5 hours</p>

Case study 2: Sunnyside Hill Primary Care Partnership

Sunnyside Hill PCP consists of 20 member agencies from a range of sectors. It covers a geographic area with three local governments and a population of approximately 350,000 people.

There is compelling evidence that physical inactivity is responsible for a large proportion of coronary heart disease and type 2 diabetes (as well as some cancers, overweight and obesity, osteoporosis, falls in the elderly and mental health problems). Taking this into consideration with other local data sources, such as the Municipal Public Health Plans and Division of General Practice (DGP) plans, the PCP has identified increasing physical activity participation for its older adult population as a key priority for its catchment.

The evidence suggests the greatest public health gains are to be achieved by encouraging even small increases in physical activity among the least active Australians – that is those who are sedentary and engaging in low levels of activity. Current recommendations state that individuals can gain health benefits from accumulating, on most days of the week, 30 minutes or more of moderate intensity physical activity in minimum bouts of around 10 minutes. Middle aged and older male and female adults have been identified as a target group that are most inactive (Garrard 2004).

Evidence around individual focused interventions (such as information, education and behaviour change programs) identify that these programs are successful in getting people more active but they reach only a small proportion of the population and do not produce change that is sustainable in the long term. Physical activity is more likely to be maintained with concurrent community-wide action to create supportive environments (such as policy to support walking and cycling in local communities) (Garrard 2004). In particular, reviews of interventions targeting older adults indicate that in the long term sustainability has been better in group programs that are based at community centres or health care settings and that include self-monitoring (King et al. 1998).

Sunnyside Hill PCP member agencies have considered this evidence and have planned an integrated approach, using a mix of health promotion interventions to address this priority area of increasing physical activity participation of its older adult population. To facilitate work to promote physical activity, agencies in the PCP have formed a Physical Activity Consortium (PAC) which aims to facilitate partnerships and evidence-based practice approaches. The Consortium has representatives from community health services, local councils (LG), Regional Sports Assembly (RSA), YMCA, Women's Health Service, DGP, Community and Learning Centre, Department of Education and community representatives.

Step 1: Describe the program

The Integrated Health Promotion Catchment Plan below gives a clear description of the PCP's work in promoting physical activity. However, it may be necessary to re-visit this to see if the PCP's work is being undertaken as planned.

IHP Catchment Plan

<p>Priority: Physical activity</p> <p>Target populations: Older adults (55+ years)</p> <p>Goal: To improve the health and wellbeing of older adults in Sunnyside Hill PCP through increasing participation in physical activity over the two year plan.</p>			
<p>Objective 1: To enhance partnerships between government, non-government and private sector organisations to address barriers to older adults' participation in physical activity (PA).</p> <p>Impacts:</p> <ul style="list-style-type: none"> • 100% of agencies in the Physical Activity Consortium (PAC) review their PA programs and strategies to identify and address barriers to participation by older adults • Increase in the number and quality of PA-related partnerships between agencies represented on the PAC. • 80% of participants in workforce training programs report improved knowledge and skills in evidence-based PA strategies. 			
Stakeholders	Health promoting interventions and capacity building strategies	Timelines	Estimated reach
PAC	Investigate and define barriers to participation for specific target groups	August–September year 1	
	Develop and deliver workforce training/skill development program addressing evidence-based PA practice	October–December year 1 and year 2	15–20 agencies
	Develop two PA partnerships between PAC members and where appropriate, external organisations to address identified barriers to participation	Ongoing over year 1 and year 2.	3–5 PAC members 1–3 external organisations
	Develop communication and social marketing plan to inform general community of the project, the PA consortium and the benefits of PA	February year 1	
Sporting clubs Leisure service providers Local businesses Community and Learning Centre	Review access to affordable exercise options Put forward recommendations for action by key providers of PA programs	February–March year 1 April – May year 1	3-5 key PA providers
RSA LG	Develop PA brochure highlighting the various PA opportunities and programs in Sunnyside Hill	June year 1 and updated at June year 2	10,000 brochures to be distributed through PAC member agencies

Objective 2: To improve the built environment in Sunnyside Hill PCP catchment to support increased participation in physical activity (PA) over the two year plan.

Impacts:

- Each council has a published framework for assessing the quality of parks and paths in relation to PA.
- 10 community parks upgraded to be safe and useable for PA for people 55+
- 12 bike paths upgraded to be safe and useable for PA
- Increased links between local council and other key stakeholders.

Stakeholders	Health promoting interventions and capacity building strategies	Timelines	Estimated reach
Consumer groups LG Community health services Sporting groups	Develop and publish a framework that identifies a public environment that is safe and useable in terms of seating, sun protection, public toilets and spaces that encourage social interaction. To be linked to local government based on the Heart Foundation's SEPA (Supportive Environments for PA) guidelines.	Feb year 1	3 LGAs
LG Community groups	Design and implement quality infrastructure (parks, bicycle paths, roads, pathways, community facilities, public art)	Feb-June year 1	10 parks 12 bike paths
Leisure service providers Sporting groups LG	Provide and maintain a range of recreation facilities and open space (parks, playgrounds, sporting grounds, aquatic, leisure and community centres)	June year 2	10 leisure service providers 20 sporting groups
LG Bicycle Victoria Walking groups	Design and develop a code of use for the safe and harmonious sharing of roads, walkways and bicycle paths for various types of users and their pets. Distribute to all households.	Sept year 2	100,000 households

Objective 3: To develop a sustainable referral pathway for the Active Script Program (ASP) in Sunnyside Hill to support GPs in supporting their patients to be more active.

Impacts:

- A clearly articulated referral pathway established with agreed roles for GPs, enablers and PA providers
- 80% of participating GPs reporting regularly discussing PA with patients
- 75% of GPs reporting use of Active Script via the referral pathway
- 350 referrals per year through the referral pathway
- Increased links between health and sport and recreation sectors

Stakeholders	Health promoting interventions and capacity building strategies	Timelines	Estimated reach
PAC	Develop and coordinate project steering committee with key stakeholders	June year 1	12 members 12 meetings/year
Project Steering Committee including DGPs, community health services, RSA, LG	Referral pathway development based on evidence and agreed roles of GPs and Community health service (enablers)	July–September year 1	6 partners
Sunnyside Hill DGPs and local GPs	Recruit GPs to participate in pilot project and determine training needs regarding PA promotion and ASP	October–November year 1	10 GPs
	Provide required training to GPs and establish ongoing communication mechanisms with project steering committee	November year 1	10 GPs
Training provider, enablers from community health service	Provide training for enablers regarding ASP, barriers to participation in PA and relevant medical conditions	December year 1	3 enablers plus 3 additional participants
Local sporting groups, leisure centres gyms, local government sporting facilities, Sunnyside Hill Community Health Service	Liaise with local PA providers (including local government) through information sessions regarding the referral pathway and opportunities for providing PA options for older persons aiming to increase activity levels after receiving an Active Script	December year 1	30 physical activity providers 10 relevant physical activity options provided for target group
PAC	Collation of appropriate resources for GPs, patients, activity providers and general community	January year 1	6 partners
GPs, enablers, local PA providers, patients, LG	Implement agreed referral pathway, providing regular feedback to all project stakeholders	February year 1 February year 2	75% of GPs using the referral pathway 350 patient referrals per year

Step 2: Evaluation preview

Step 2 involves:

- *engaging stakeholders*
- *clarifying the purpose of the evaluation*
- *identifying the key questions to be answered through the evaluation*
- *identifying evaluation resources*

The PAC is the mechanism through which stakeholders are engaged in developing the evaluation plan for the PCP's physical activity programs. The PAC Evaluation Working Group has been established with representatives from each program to consider the collective achievements these activities have made towards the goal and objectives of the PCP IHP Catchment Plan. The working group membership consists of: PCP staff, community health services, RSA, LG, Women's Health Service, YMCA and DGP.

The Evaluation Working Group has identified the following purpose and key questions for the evaluation:

Purpose

- To assess whether the interventions/capacity building strategies have been implemented as planned.
- To assess whether the various programs included in the Community Health Plan have achieved their objectives.
- To examine the extent to which the various objectives have contributed towards achieving the overall goal of the PCP Community Health Plan.
- To assess the level of collaboration the partnership has developed.
- To document critical success factors and barriers to implementation of the plan.
- To meet Department of Human Services reporting requirements.
- To assist future allocation of capacity building resources.

Key questions

- Have the programs achieved their planned reach?
- Have program participants (staff, community organisations and community members) been satisfied with the program?
- Have the program objectives and impacts been achieved?
- Have all strategies been appropriate and effective in achieving the objectives and impacts?
- What have been the critical success factors and barriers to achieving the objectives and impacts?
- Have the various programs within the overall plan come together to contribute towards achieving the goal?
- Have levels of partnership and collaboration increased?
- Which programs should be continued or developed further? Where to from here?
- Which population groups and geographic areas are being reached by the PCP's physical activity work? Which groups or areas are missing out?

Resources

Member agencies of the PAC indicated that 5–15 per cent of their program budgets would be available to support the evaluation.

Local government currently collects a range of data which can be used in the evaluation; for example, all three LGAs receive data from the Victorian Population Health Survey, including data on participation in physical activity.

The PCP will contribute \$5000 to the costs of the evaluation.

Step 3: Focus the evaluation design

The evaluation design should:

- *be the most rigorous, practical design to meet the evaluation purpose and key questions*
- *involve use of existing measurement instruments or new ones developed for this evaluation*
- *involve careful consideration of who should contribute information and data to the evaluation to ensure that the view of all key stakeholders have been included.*

Evaluation design

A mix of qualitative and quantitative data will be used to undertake process and impact evaluation. The evaluation will consist of information from each program as well as an overall picture of the catchment-wide changes that have resulted from the sum of the PCP activities. In other words, the evaluation will have a number of layers:

- Has each program been implemented as planned? What has been the result?
- How has the PCP functioned as an alliance to achieve this goal?

Mid evaluation report: July year 1

Final evaluation report: July year 2

Sources of information

Focus groups:

- with PAC incorporating use of VicHealth Partnership Analysis Tool at project mid point and completion
- with community members engaged in work with councils around parks and bike paths at completion of project
- with key stakeholders involved in development of referral pathway to gauge satisfaction with process pre implementation.

Surveys:

- agencies involved in PAC after workforce development events
- users of council facilities pre- and post-upgrade
- GPs to investigate uptake of ASP referral pathway
- Victorian Population Health Survey.

Audit:

- PA opportunities for older people through development of brochure for community (at yearly intervals)
- observation of community use of council parks and bike paths pre- and post-upgrade.

Documents:

- local council policies and frameworks for built environment
- PAC meeting papers
- participant evaluation of workforce development/training sessions
- quarterly reports from enablers detailing ASP referral statistics
- council maintenance schedules for public open space.

Step 4: Collect data

Step 4 involves collection of the information needed to answer the key evaluation questions. This requires a clear vision about what information will be collected, what tasks need to be undertaken, by whom, and by when.

The PAC Chair is responsible for maintaining accurate records of all meetings, workforce development and other training sessions. The lead agency for each program will provide relevant process and impact evaluation information to PAC Chair at agreed intervals to contribute to the overall PCP evaluation. The following tasks will be undertaken by PAC members:

Objective 1:

- PAC to complete the VicHealth Partnership Analysis tool for use at mid project and project completion as part of a broader focus group to be facilitated by an external consultant.
- PCP staff to develop evaluation and feedback forms to be completed by participants at all workforce development/training opportunities.
- PAC to complete audit of existing PA opportunities in the catchment on yearly basis. Utilise student placement to collate results of audit.

Objective 2:

- Local councils to audit existing policy and other key documents regarding design/maintenance of built environment pre-project implementation and at completion of project.
- Local councils to engage students to observe community use of public spaces such as parks and bike paths pre- and post-upgrade.
- Community health service to facilitate focus groups with consumers involved in project.
- Local councils to develop satisfaction surveys and engage students to administer to users of public space pre- and post-upgrade of parks and bike paths.

Objective 3:

- PCP staff to engage external consultant to run focus group for key stakeholders post-development of referral pathway and pre-implementation.
- DGP to develop survey for GPs regarding uptake of ASP referral pathway and administer at yearly intervals.
- Community health service to develop quarterly reports based on referral rates from enablers.
- PCP staff to develop and administer survey for local activity providers regarding satisfaction with referral pathway and links with health sector (at one year of implementation).

Overall aspects of the Community Health Plan:

- Local government to provide support for increased sampling in all three LGAs for Victorian Population Health Survey at regular intervals. Councils to develop and disseminate report based on PA participation in catchment as identified through survey.

Step 5: Analyse and interpret data

Step 5 involves identifying and summarising the key findings, themes and information contained in the raw data and interpreting these in relation to the purpose and key questions of the evaluation.

Analyse data

Qualitative data – examine documents and transcripts to identify the main themes being raised. Cut and paste transcripts in Microsoft Word to group data according to the main themes and trends.

Quantitative data – use Excel to summarise quantitative data in tables, graphs, charts.

Interpret what the findings mean

The PAC will identify key themes and report findings based on these themes. Key questions to include are as listed in Step 2.

Quantitative data – use appropriate graphical representation and descriptive statistics to report findings. For analysis of sophisticated data, the services of a statistician may be required.

Step 6: Disseminate the lessons learnt

Stage 6 involves responses to the following questions:

- *Who should have access to the results of the evaluation and what is an ideal format for ensuring adequate and accessible information for these groups?*
- *How will evaluation data be used and stored within the agency to ensure that future programs are able to build on the knowledge base achieved during the evaluation?*
- *How could or should results be distributed more widely so that other health promotion practitioners are able to know about your work?*

Dissemination strategies include:

- PAC will be responsible for collating evaluation information as described. PCP staff will then develop evaluation report to be distributed to all PAC members and Department of Human Services regional health promotion officer.
- Key findings will be reported by PCP staff to the department through regular reporting mechanisms.
- Findings to be shared with other PCPs through regional health promotion meetings and appropriate workforce development opportunities in the region/state.
- Report added to QIPPS website and 'Go For Your Life' professionals website.
- Journal article to be written by subgroup of PAC and abstracts to be submitted for national physical activity and health promotion conferences.
- Findings reported to PCP member agencies and other interested stakeholders through PCP and Regional Health Promotion newsletters, Department of Human Services *Health Promotion Strategies Bulletin* and statewide PCP website.
- PAC to develop and facilitate local forum for member agencies and other interested stakeholders to outline PCP approach to PA promotion and report on evaluation findings.
- Member agencies of PAC to distribute outline of key findings through own networks to broaden reach of information distribution.

Integrated health promotion evaluation plan

This is an example of an integrated health promotion evaluation plan. It summarises the elements of the six steps above that were used in the planning and implementation of the evaluation of Sunnyside PCP's IHP Catchment Plan in relation to physical activity (PA).

HP priority goal	To improve the health and wellbeing of older adults in Sunnyside Hill PCP through increasing participation in physical activity over the 2 year plan.				
Population target group/s	Older adults (55+ years)				
Objective 1:	Key questions (what do we need to know to decide if we have achieved this objective?)	What information do we need to answer these questions?	How will this information be collected, by whom and by when?	Budget/resources 1 hour = \$55 (This is an indicative cost which may vary)	
Objective To enhance partnerships between government, non-government and private sector organisations to address barriers to older adults' participation in PA	Process evaluation How many organisations and community representatives were members of the PAC? How often did the PAC meet?	Attendance records of PAC meetings	Meeting minutes, PAC chair to collect on an ongoing basis	No cost	
Impacts: <ul style="list-style-type: none"> 100% of agencies in the Physical Activity Consortium (PAC) review their PA programs and strategies to identify and address barriers to participation by older adults Increase in the number and quality of PA-related partnerships between agencies represented on the PAC. 80% of participants in workforce training programs report improved knowledge and skills in evidence-based PA strategies. 	How many people and organisations participated in the training sessions? Were they satisfied with the training? Did it meet their needs? How many PA brochures were distributed in the catchment? In what areas?	Number of participants and types of organisations represented Survey of participants satisfaction How many brochures were distributed through each agency?	Workshop records of attendance End of day evaluation to be developed by PAC Records of the distribution of brochures Survey of numbers used – RSA to be responsible	No cost 1 hour for collation 3 hours	
	Impact evaluation Did 100% of PAC member agencies review and modify PA programs in their core business?	Record of what PA programs each agency offers for people 55+, and changes made to increase access	Survey of all PAC member agencies at start of project and yearly; PAC chair to coordinate	30 mins per agency to complete 2 hours to collate data	

<p>Impact evaluation (cont.)</p> <p>What new knowledge and skills did participants in the training gain?</p> <p>Was this knowledge useful in developing or refining their agency's PA programs?</p>	<p>Views of training participants at the end of the training, and reflections six months later, on the impact of any new knowledge</p>	<p>End of day evaluation and six-month telephone survey to be developed by PAC. Organised by CHS staff.</p>	<p>1 hour development 2 hours collating survey 3 hours in telephone survey at six-month mark</p>
<p>Are there more PA-related partnerships now? Who is involved? What is their purpose?</p> <p>What level of commitment is there to each partnership?</p>	<p>Baseline and one-year data on what partnership activities and programs exist, who is involved, what their purpose is.</p>	<p>Same survey as above - baseline and yearly</p>	<p>As above</p>
<p>What have these partnerships achieved? Have these partnerships added value?</p>	<p>Records of meeting attendance and partnership activities; follow up; views of members</p>	<p>Pro forma developed by CHS, RSA and local government. Completed by the lead agency in each partnership.</p>	<p>2 hours meeting to develop</p>
<p>What have been the barriers and enablers to establishing effective partnerships?</p>	<p>Views of partner agencies on the ease of establishing and maintaining the partnerships</p>	<p>VicHealth Partnership Analysis Tool + open-ended questions. Results and implications explored at a focus group of the PAC.</p>	<p>Mail of tool to all partnership members \$20 2 hours to collate responses 1 hour of meeting time for focus group 3 hours for transcribing notes and analysing data</p>
<p>Are there more affordable and accessible opportunities for PA in the catchment?</p>	<p>Actions taken by PAC member agencies to increase access for all 55+ people</p>	<p>Yearly survey of PAC member agencies. Case studies to be developed by CHS staff of two programs in member agencies.</p>	<p>Survey - as above Case studies - 4 hours of CHS time to develop case studies 1 hour for each agency interviewed</p>
<p>Is the community more aware of PA opportunities in the area? Did the PA brochure make a difference?</p>	<p>Community members' knowledge of the brochure. New participants to PA activities reporting that they heard about it through the brochure. Increase in use of PA opportunities.</p>	<p>Request to all PA programs and groups in the brochure to record how new participants heard of it. Records of changes in participation following distribution of the brochure.</p>	<p>Record of numbers of brochures distributed Survey posted to PA agencies, recording any change in participation. Mail \$20</p>

Objective 2:	Key questions (what do we need to know to decide if we have achieved this objective?)	What information do we need to answer these questions?	How will this information be collected, by whom and by when?	Budget/resources
<p>To improve the built environment in Sunnyside Hill PCP catchment area to support increased participation in PA.</p> <p>Impacts</p> <ul style="list-style-type: none"> Each council has a published framework for assessing the quality of parks and paths in relation to PA. Ten community parks upgraded to be safe and useable for PA for people 55+. Twelve bike paths upgraded to be safe and useable for PA for people 55+. Increased links between local council and other stakeholders. 	<p>Process evaluation</p> <p>How many agencies were involved in developing the framework?</p> <p>Did the Heart Foundation SEPA guidelines meet the needs of all stakeholders?</p> <p>Impact evaluation</p> <p>Was a useable and comprehensive framework for public recreation and leisure areas developed? Has it been used? How useful is it perceived to be?</p> <p>Have improvements been made to 10 parks and 12 bike paths over the period of the plan?</p> <p>Has the framework influenced the types and extent of ongoing maintenance and upgrading schedules in council plans?</p> <p>Is there increased use of the parks and paths following improvements?</p>	<p>Records of attendance at meetings and working groups.</p> <p>Views of working group members on the usefulness and practicability of the SEPA guidelines.</p> <p>Views of stakeholders on the usefulness and breadth of the framework. Implementation plans arising out of the framework.</p> <p>What priorities re parks and paths were identified through the framework? What improvements have been carried out?</p> <p>How has the framework been incorporated into council plans?</p> <p>Data on community use pre and post the improvements. Survey to note the numbers of people using and the types of activity.</p>	<p>Chair of working group to keep records</p> <p>Focus group interview with the group developing the framework – part of a regular meeting. CHS staff member, external to the group, to facilitate.</p> <p>Copy of the framework</p> <p>Record of meetings with stakeholders re implementation</p> <p>Audit pre and post based on the framework</p> <p>Record of council and sporting origination programs for improvement</p> <p>Examination of council schedules and requirements for maintenance and upgrading of paths and parks. Local government reps on PAC to collect and summarise.</p> <p>Observational data on community use of parks and paths pre and post improvements. Local government to undertake survey – three different times during a one-week period.</p>	<p>No cost</p> <p>1 hour of meeting time</p> <p>2 hours of CHC staff members' time to prepare and write up a summary</p> <p>No cost over normal meeting costs</p> <p>Development of audit based on framework – 4 hours</p> <p>Pre and post audit of 10 parks and paths: 20 hours</p> <p>Collation of results: 4 hours</p> <p>1 hour per council</p> <p>80 hours of observation per survey \$1600</p> <p>5 hours to compile and analyse data.</p>

	<p>Impact evaluation (cont.)</p> <p>Have there been improvements in recreation and sporting facilities to make them more accessible to people 55+?</p>	<p>Changes in facilities for each club or organisation during the period of the plan. Views of consumers on these facilities.</p>	<p>Record of works undertaken at each club or agency</p> <p>Member survey of five clubs and organisation for impact of improvements. Sporting and recreation bodies to undertake, supported by the PAC.</p>	<p>3 hours to assemble list of works. 2 hours to prepare survey. 2 hours at each agency to distribute and collect. 10 hours to collate and analyse data.</p>
<p>Is the community aware of the improvements in parks/paths and leisure and recreation facilities?</p>	<p>What community coverage has there been of the improvements? Are people using these facilities aware of change?</p>	<p>Media coverage</p> <p>Face-to-face interviews with 10 people using a sample of parks, paths and facilities</p>	<p>2 hours to maintain media file</p> <p>10 hours for face-to-face interviews</p>	
<p>Was a code of safe use of roads and paths developed and distributed? Is it comprehensive and appropriate for all older people?</p>	<p>How many were distributed? Are people happy with the finished product?</p> <p>Views of key stakeholders on the usefulness of the brochure</p>	<p>Records of distribution</p> <p>Stakeholder views gathered at a PAC meeting</p>	<p>No cost</p> <p>30 minutes of meeting time</p>	
<p>Has there been a decrease in accidents on shared paths and roads?</p>	<p>Accident data</p>	<p>Police and ambulance records</p>	<p>3 hours in collecting data from police and ambulance services</p>	
<p>Are there increased links between the three councils and other stakeholders in relation to PA? What has come out of these increased links?</p>	<p>What links and partnerships are the councils involved in, particularly in relation to parks, paths and facilities? Information on outcomes of partnerships and links.</p>	<p>Mapping of council links with other PA stakeholders. Council reps to supply data to PAC meeting. Pro forma prepared by 1 rep from council, community and sports club.</p>	<p>2 hours for each council</p>	

Objective 3:	Key questions (what do we need to know to decide if we have achieved this objective?)	What information do we need to answer these questions?	How will this information be collected, by whom and by when?	Budget/resources
<p>Objective</p> <p>To develop a sustainable referral pathway for the Active Script Program in Sunnyside Hill to support GPs in supporting their patients to be more active.</p> <p>Impacts</p> <ul style="list-style-type: none"> • A clearly articulated referral pathway with agreed roles for GPs, enablers and PA providers • 80% of participating GPs reporting regularly discussing PA with patients • 75% of GPs reporting use of Active Script via the referral pathway • 350 referrals per year through the referral pathway • Increased links between health and sport and recreation sectors 	<p>Process evaluation</p> <p>Reach: Did the development of the referral pathway engage the key stakeholders (including 10 GPs)?</p> <p>Were the stakeholders satisfied with the development of the referral pathway?</p> <p>How many GPs were aware of the development of the referral pathway?</p> <p>Were GPs' training needs met?</p> <p>Do GPs feel confident about the quality of service provided to their patients by the enablers?</p> <p>What response was there from enablers and PA providers to the opportunity to be involved in the program?</p>	<p>Identification of members of the steering committee involved in development.</p> <p>Number of representative GPs and practices involved in development.</p> <p>Were GPs satisfied that the development of the pathway met their needs?</p> <p>What did enablers and PA providers think of the development of the pathway?</p> <p>Proportion of GPs reporting knowledge of the ASP referral pathway program</p> <p>Perceptions of GPs in the pilot project</p> <p>What feedback have GPs had from patients referred to enablers?</p> <p>How many enablers successfully completed the training course? How many PA providers attended information sessions?</p> <p>Were people clear on their role?</p>	<p>Minutes of meetings</p> <p>PCP project worker on monthly basis</p> <p>Survey of GPs through the DGP: immediately post training and then yearly</p> <p>Feedback from enablers and PA providers at the end of the training and information sessions</p> <p>Survey of GPs through the DGP: immediately post training and then yearly</p> <p>End of training survey + survey of GPs (as above)</p> <p>Survey of GPs through the DGP: immediately post training and then yearly</p> <p>Training and meeting attendance records</p> <p>Feedback from enablers and PA providers at the end of the training and information sessions</p>	<p>Staff time</p> <p>2 hours</p> <p>Survey development - 2 hours</p> <p>Collation and analysis of data - 10 hours/year</p> <p>Mail costs to all GPs \$250</p> <p>Data entry costs - \$200</p> <p>1 hour</p> <p>As above</p> <p>1 hour to develop</p> <p>1 hour to collate results</p> <p>As above</p> <p>No cost</p> <p>1 hour</p>

	<p>Process evaluation (cont.)</p> <p>Did the program reach its target of 350 referrals over one year?</p> <p>Impact evaluation</p> <p>Did the program achieve its target of having 80% of participating GPs reporting regular discussion of PA with patients?</p> <p>Did the program achieve its target of having 75% of GPs using the ASP referral pathway?</p> <p>Of those people referred by GPs, what proportion made contact with the enabler?</p> <p>Of those people who are referred, what proportion is now active enough to meet PA guidelines?</p> <p>Are there increased links between the health and sports sectors? If so, about what, and with what outcome?</p>	<p>How many people were referred by GPs over a one-year period?</p> <p>Reports from GPs on how often they raise the issue of PA with their patients</p> <p>Self-reports from GPs on use of referral pathway</p> <p>Enabler records of the numbers of GPs making referrals</p> <p>How do GP referral figures compare to records held by enablers?</p> <p>Information from PA providers on number of ASP referrals and on sustained participation by these people</p> <p>What links have developed by enablers and PA providers?</p>	<p>Survey of GPs through the DGP: after one year</p> <p>Survey of GPs through the DGP: immediately post training and then yearly</p> <p>Survey of GPs through the DGP: immediately post training and then yearly</p> <p>Collation of enabler records</p> <p>Comparison of GP survey data with collated enabler records</p> <p>Initial screening surveys by practice staff (GPs or practice nurse). Follow up of patients at six and months by enabler (phone) and written survey at 12 months.</p> <p>Survey of enablers and PA providers at yearly intervals. CHS staff to develop and administer. Follow up focus group to discuss and explore the results of the survey.</p>	<p>As above</p> <p>As above</p> <p>As above</p> <p>1 hour per enabler to collate data from files.</p> <p>3 hours</p> <p>2 hours to develop</p> <p>5 hours to collate data</p> <p>Patient survey: 2 hours to develop</p> <p>Total of 50 hours for telephone interviews across the year (in kind)</p> <p>Mail costs to 350 people \$40</p> <p>Data entry \$400</p> <p>Analysis of results – 5 hours</p> <p>Preparation of survey – 2 hours</p> <p>Mail costs – \$25</p> <p>Focus group – 3 hours</p> <p>Collation and analysis of data – 2 hours</p>
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Overall aspects of the plan	Key questions (what do we need to know to decide if we have achieved this objective?)	What information do we need to answer these questions?	How will this information be collected, by whom and by when?	Budget/resources
Reach	Which population groups are benefiting from the program? Which population groups in the catchment area are missing out on PA initiatives? Which geographic areas within the catchment are being reached/missing out?	Mapping of all PA initiatives across the catchment according to demographics of population groups targeted, and the geographic areas	Pro forma for all PA initiatives contributing to the Community Health Plan. Annual return organised through the PAC representatives. To be a part of all program proposals in all agencies.	Approximately 2 hours per agency (in kind)
Partnerships and networks	Have levels of partnership and collaboration increased during the project? What have been the critical success factors and barriers to increase partnerships and networking?	Records of involvement of agencies in different aspects of the project Interviews with project staff and agency staff. Focus group.	Copies of meeting and workshop attendance PCP Health Promotion Officer will arrange interviews with key individuals, and conduct one focus group of the PAC	No cost 4 hours
Critical factors in undertaking the plan	What have been the critical success factors and barriers to achieving the objectives and impacts? Was the community ready for this project? Where to from here?	Records of involvement of agencies in different aspects of the project Interviews with project staff and agency staff	Copies of meeting and workshop attendance Health promotion officer will arrange interviews with key individuals, and conduct one focus group of the PAC	As above (same meetings and interviews)
Future actions	What changes need to be made to program activities? How should issues of sustainability be dealt with?	Recommendations for modification of the Community Health Plan on an annual basis	PCP Health Promotion Officer will arrange interviews with key individuals, and conduct one focus group of the PAC	As above (same meetings and interviews)
Preparation of evaluation report	PCP staff will be responsible for collation of all data from the evaluation, analysis and preparation of the report. Drafts will be presented to the PAC for input and comment. The PAC will decide on the number of reports and their format.			15 hours
Dissemination	1. This report will be distributed to all stakeholders and Department of Human Services regional office. 2. Findings to be reported at Regional Health Promotion forum. Journal article to be written by CHC and interested key stakeholders. 3. Project report – planning and evaluation – loaded onto QIPPS.			Printing 150 copies of report \$250 Journal article – 5 hours

Additional guides

The following resources may provide additional guidance in completing your evaluation plan.

Software and online

The Department of Human Services – *Integrated health promotion resource kit* describes a range of qualitative evaluation methods. It is available at http://www.health.vic.gov.au/healthpromotion/hp_practice/eval_dissem.htm

Quality Improvement Program Planning System (QIPPS) – this software developed by the Victorian Community Health Association will assist subscribing organisations with planning and evaluation of health promotion programs. Further information can be found at: www.qipps.com

The Planning and Evaluation Wizard – developed by the South Australian Community Health Research Unit (SACRU), this resource assists the user to develop a case for their projects, construct project and evaluation plans and to write project reports. See: <http://www.sachru.sa.gov.au/contactus.htm>

NT Government resources – the Northern Territory Government has developed a guide for planning and evaluating health promotion projects. This comprehensive guide discusses evaluation planning processes and provides tools for planning and evaluation. While it is aimed at practitioners who work with remote Aboriginal communities, many elements are applicable to other contexts. It is available online: www.nt.gov.au/health/healthdev/health_promotion/bushbook/volume1/ch4.html

Information on analysis of quantitative and qualitative data is also provided at: www.nt.gov.au/health/healthdev/health_promotion/bushbook/volume1/analyse.html#howto

US Centre for Disease Control – a number of step-by-step manuals for program evaluation are available for download through the US Centre for Disease Control at: www.cdc.gov/eval/resources.htm

University of Toronto – The Health Communications Unit, Centre for Health Promotion at the University of Toronto has developed an excellent guide to evaluating health promotion programs. Examples and pro formas are included. In addition, a comprehensive list of evaluation references is provided. This guide is available online: <http://www.thcu.ca/infoandresources/evalcasestudies.htm#purple>

Books

A number of books provide useful information on evaluation planning and implementation:

- Greenbaum, TL (1998) *The handbook for focus group research*. 2nd Edition. California: Sage Publications.
- Hawe, P, Degeling, D and Hall, J (1990) *Evaluating health promotion: a health worker's guide* Sydney: MacLennan and Petty.
- Labonte, R and Feather, J (1996) *Handbook on using stories in health promotion practice*. Ottawa: Health Canada.
- Patton, MQ (2002) *Qualitative research and evaluation methods*. 3rd Edition. California: Sage Publications.
- Rice, PL and Ezzy, D (1999) *Qualitative research methods: a health focus*, Melbourne: Oxford University Press.

Tools for planning

Integrated health promotion

Department of Human Services – *Integrated health promotion resource kit* assists agencies/organisations/partnerships to plan for effective integrated health promotion. This kit is available online:

http://www.health.vic.gov.au/healthpromotion/hp_practice/plan_implem.htm

A major strength of the kit is its emphasis on supporting a systematic and evidence based approach to health promotion including the use of a mix of health promotion interventions, which are supported by capacity building strategies.

An information resource has been created to assist you with combining the key elements of the [Integrated Health Promotion Resource Kit](#) with the [Environments for Health](#).

Available at: http://www.health.vic.gov.au/healthpromotion/downloads/e4h_ihp_inforesource_pch.pdf

Evidence-based health promotion

Department of Human Services – a series of evidence-based health promotion resources relating to particular areas of health promotion activity. Available at: http://www.health.vic.gov.au/healthpromotion/quality/evidence_index.htm

The Cochrane Collaboration Health Promotion and Public Health Field – reviews of evidence-based practice in a range of areas. Available at: www.vichealth.vic.gov.au/cochrane

Environments for Health: Municipal Public Health Planning Framework

<http://www.health.vic.gov.au/localgov/mphpfr/index.htm>

Environments for Health was released in 2001 and is the planning framework that guides the development of Municipal Public Health Plans by local governments. All councils are required by the Health Act to develop Municipal Public Health Plans. The framework was developed by Public Health Group in the Department of Human Services, in partnership with the Municipal Association of Victoria, the Victorian Local Governance Association, local governments, and other stakeholders.

Like the *Integrated health promotion resource kit*, *Environments for Health* includes a focus on partnerships, the determinants of health and the use of a systematic planning framework. While the language is slightly different, the planning steps outlined in *Environments for Health* have the same intent to the integrated health promotion planning framework.

Understanding *Environments for Health* can assist other agencies in:

- understanding the local council's role in the local community.
- engaging councils in integrated health promotion programs.
- considering the broad determinants of health by using the four domains (built, social, natural and economic environment) in their vision setting and problem definition processes.
- adding value to program and evaluation planning stages by using the four domains (built, social, natural and economic environment) when planning strategies and interventions.

An information resource has been created to assist you with combining the key elements of the *Environments for Health* with the *Integrated Health Promotion Resource Kit*.

Available at: http://www.health.vic.gov.au/healthpromotion/downloads/e4h_ihp_inforesource_pch.pdf

Other planning frameworks

Health Communication Unit, Health Promotion Unit, University of Toronto – Health Promotion Planning Framework provides detailed support in all aspects of program planning, including developing goals and objectives. Available at:

<http://www.thcu.ca/infoandresources/planning.htm>

Useful data

Women's Health Victoria – an excellent guide to a range of data sources, often applicable to both genders, rather than women specifically. Available at: http://www.whv.org.au/health_policy/directory.htm#gdd

Department of Human Services – the Population Health Survey collects valuable information about the health of Victorians. You can use this data as a comparison or to identify priorities. Available at:

<http://www.health.vic.gov.au/healthstatus/vphs.htm>

Tools for evaluation

This section has been categorised by integrated health promotion priority areas to enable easy identification of relevant tools.

Physical activity

Centre for Physical Activity and Nutrition Research, Deakin University – physical activity monitoring and evaluation toolkit. Available online: http://www.deakin.edu.au/cpan/PA_assessment__toolkit.pdf.

The US Centres for Disease Control and Prevention – resource guide for nutrition and physical activity interventions. Available online: <http://www.cdc.gov/HealthyLiving>

Food and nutrition

The US Centres for Disease Control and Prevention – resource guide for nutrition and physical activity interventions. Available online: <http://www.cdc.gov/HealthyLiving>

Mental wellbeing and social connectedness

Community strength

Department for Victorian Communities – a set of indicators to measure community strength in Victoria. This document is available online: <http://www.dvc.vic.gov.au/web14/dvc/dvcmain.nsf/headingpagesdisplay/research+and+publicationsindicators+of+community+strength>

Social connectedness

The US National Institute of Health (NIH) – the NIH acknowledges the complexity of social connectedness and organises numerous tools to measure social connectedness into a range of categories including social networks, social cohesion and social capital. This document is available online: <http://trans.nih.gov/CEHP/HBPdemo-socialsupport.htm>

The NSW Health Department – progressive tools to develop and measure capacity building. Two key documents include:

- *Indicators to help with capacity building in health promotion*: <http://www.health.nsw.gov.au/pubs/i/pdf/capbuild.pdf>
- *A framework for building capacity to improve health*: http://www.health.nsw.gov.au/pubs/f/pdf/frwk_improve.pdf

Quality of life

Australian Centre on Quality of Life: <http://acqol.deakin.edu.au/index.htm>

Monash University's Centre for Health Economics – the Assessment of Quality of Life: <http://www.buseco.monash.edu.au/centres/che/pubs/wp76.pdf>

Short Form – 36 (SF36) – can assist in measuring health outcomes: <http://www.sf-36.org/>

Social capital

The Australian Bureau of Statistics – provides a comprehensive range of standardised measures of social capital, including measures of trust, cooperation, acceptance of diversity and inclusiveness, social participation, civic participation, friendship and sense of efficacy.

Their 'Themes' web page (<http://www.abs.gov.au/websitedbs/d3310114.nsf/Home/themes>) provides access to many areas. You will find the social capital measures under the 'People' stream. Follow this link to the next screen and select 'social capital releases'. From this, select 'Information Paper: Measuring Social Capital – An Australian Framework and Indicators'.

Healthy weight

A focus on promoting healthy weight is relatively recent. As such, tools to evaluate interventions are limited. However, the Sentinel Site for Obesity Prevention is working towards tool development. A number of tools have been developed for use in school-based programs. These are available online: <http://www.deakin.edu.au/hmnbs/who-obesity/ssop/ssop.php>

Some tools listed in physical activity and food and nutrition categories may be applicable to healthy weight interventions. Some useful strategies for evaluating the effectiveness of your interventions may include pre/post weight measurements, measurement of knowledge/awareness through surveys or focus groups.

Neighbourhood renewal

Neighbourhood renewal is the integrated health promotion priority setting for 2004–06. A series of documents exploring the tracking of change in neighbourhood renewal projects has been developed by the UK Government Neighbourhood Renewal Unit and is available online: <http://www.renewal.net>

Other useful tools

Built environment

The University of South Carolina – several tools to measure interventions targeting the built environment, including environmental supports for physical activity, recreational facility evaluation tool and sidewalk assessment tool. Available at: <http://prevention.sph.sc.edu/tools/index.htm>

Consumer participation

The National Resource Centre for Consumer Participation in Health – a number of tools to measure consumer and carer participation, including:

- consumer and community participation self-assessment tool for hospitals
- organisational self-assessment and planning tool for consumer and community participation: a tool for organisations involved in health policy and education; useful to determine extent of consumer and carer involvement in the organisation and will assist in identifying areas for improvement
- primary health care self assessment tool: useful to assess levels of consumer and carer participation.

The website also provides access to *Improving health services through consumer participation: a resource guide for organisations*, which includes an evaluation checklist and list of evaluation tools. These documents can be accessed online: www.participateinhealth.org.au/evaluate/practical_tools.htm

Cultural competency

The Ministry for Children and Families, Government of British Columbia (Canada) – a tool to assess cultural competency. It is available online: http://www.mcf.gov.bc.ca/publications/cultural_competency/assessment_tool/tool_index1.htm

Gender

The Prairie Women’s Health Centre of Excellence – a guide, titled *Including gender in health planning: a guide for Regional Health Authorities*, provides an outline of gender-based analysis. The influences of gender on health are explored in two case studies. Checklists for program planning, data analysis and evaluation are provided. This document is available online: <http://www.pwhce.ca/gba.htm>

Injury prevention

Evaluating Injury Prevention Initiatives: Tools for designs and classifications of evaluations of injury prevention: www.nisu.flinders.edu.au/pubs/biblio/biblio-2.html

Partnerships

VicHealth Partnerships Analysis Tool:

http://www.vichealth.vic.gov.au/assets/contentFiles/VHP%20part.%20tool_low%20res.pdf

Labonte, R (1997) *Power, participation and partnerships for health promotion*. This resource is available online:

<http://www.vichealth.vic.gov.au/Content.aspx?topicID=368>

The Division of Public Health, New York Academy of Medicine, Centre for the Advancement of Collaborative Strategies in Health – a web-based partnership assessment tool is available at: <http://www.cacsh.org/psat.html>

Tools for dissemination

Mailing lists

CLICK4HP: This Canada based email list is used by a wide variety of health promotion practitioners to share information on their programs and to seek assistance in planning and evaluating programs. Although much of the content is Canadian, it does provide access to a range of resources, often available via the Internet.

To subscribe to the 'Health Promotion on the Internet' email discussion list (CLICK4HP), send an email message to listserv@yorku.ca with the following message in the text section (leave the subject header blank): subscribe click4hp.

To post a message to all subscribers, send it to click4hp@yorku.ca

To view the archives of CLICK4HP, go to <http://listserv.yorku.ca/archives/click4hp.html>

Social Determinants of Health (SDOH): To subscribe to the SDOH list, send the following message to listserv@yorku.ca in the text section, NOT in the subject header. SUBSCRIBE SDOH yourfirstname yourlastname

To post a message to all 1000+ subscribers, send it to SDOH@yorku.ca Include in the Subject, its content, and location and date, if relevant.

Guidelines for authors contributing to journals

Australian & New Zealand Journal of Public Health: <http://www.phaa.net.au/journalWriting.php>

Australian Journal of Primary Health: <http://www.latrobe.edu.au/aipc/ajph/guide.html>

Health Promotion International: <http://www3.oup.co.uk/jnls/list/heapro/instauth/>

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- Department of Human Services Northern and Western Region (2004) *Writing narrative action evaluation reports in health promotion – guidelines*. Victorian Government Department of Human Services, Melbourne.
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