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Evaluation Synthesis: "Looking Back, Looking Forward"

A summary of Six Population Health Contribution Program Evaluations of the Population and Public Health Branch

Prepared by:

Management and Program Services Directorate
Population and Public Health Branch

and

Departmental Program Evaluation Division
Applied Research and Analysis Directorate
Information, Analysis and Connectivity Branch

Presented to

Health Canada
Departmental Audit and Evaluation Committee

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Canada

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Evaluation Synthesis for Promotion of Population Health
Action Plan

October 2003

Background

This action plan originated from an evaluation synthesis report (October 2003) which summarized what was learned about how programs are designing and implementing program evaluations. The action plan draws on the lessons learned from the synthesis to initiate further discussions on issues of common interest to evaluation practitioners and policy analysts across the branch regarding the role of evaluation in furthering accountability objectives. As such, the action plan is intended to be used as a focal point for training and development activities on program evaluation.

PPHB Performance Management and Evaluation Network

A network of PPHB program officers and evaluators will be convened in early 2004 as a starting point for discussions to develop suggested responses to the areas of improvement cited below. Such a network can provide a common forum for training and continuous learning on program evaluation in PPHB and a mechanism for exploring common issues, tools, approaches, and best practices in evaluation. The network will discuss items in the action plan and establish plans for their implementation. Network activities will link to ongoing performance management related activities that will be implemented as part of the Promotion of Population Health umbrella Results-based Management and Accountability Framework. The creation of this network is in keeping with Health Canada's evaluation policy, which encourages embedding evaluation into the on-going management responsibilities and practices of managers.

The Population Health Evaluators Network (NPHEN) and the National Evaluation Team for Children (NETC) represented by NCR and all seven Health Canada regions, provide existing venues for expanding membership to include program and functional representation across the branch.

Accountability

This action plan reflects an evolution in the branch among promotion of population health grant and contribution programs in placing greater emphasis on the role of evaluation in furthering program accountability. It should be emphasized that no one program is responsible for instituting changes recommended in the action plan. The majority of recommendations involve discussion and exploration, and as such, an accountability structure for implementing improvements will be agreed upon by the network when it convenes.

Evaluation Synthesis for Promotion of Population Health
Action Plan

October 2003

Conclusions	Suggested Improvements	Suggested Response
1. Program Design and Implementation: Planning program evaluations with national scope	◆ Improve linkages of results-based approaches to performance measurement and to evaluation, including the use of logic models in helping to forge that link and clearly define program details, particularly at the beginning of a program. ◆ Establish evaluation as an integral component of program design, through, for example, evaluation strategies contained in Results-based Management and Accountability Frameworks. ◆ Strengthen linkages of project and regional evaluations to inform national program evaluations. ◆ Place greater emphasis on examining the individual effects of funded projects on target populations. ◆ Place greater emphasis on examining cause-effect relationships to arrive at outcome-oriented information	▲ Convene a branch-wide network of program officers and evaluators to develop responses to all suggested improvements in the action plan. ▲ Program-level Results-based Management and Accountability Frameworks (RMAFs) to address definition of program details. ▲ RMAF ▲ RMAF ▲ RMAF ▲ Component RMAF logic models to illustrate linkages of activities to outcomes

Conclusions	Suggested Improvements	Suggested Response
2. Approaches to program evaluation: Data quality, methodology, and the application of best practices in evaluation.	◆ Establish pre-program baseline measures or reliable points of comparison for assessing program impacts. ◆ Develop performance expectations (including stated connections between program activities and objectives) early in the program life-cycle and apply continuously to direct program activities ◆ Present methodological details (e.g. data collection tools/process and analytic plans) necessary to undertake successful evaluations in evaluation reports.	▲ Convene a one-day learning forum/workshop for all branch staff involved in evaluation and effectiveness of intervention research to address these common issues. Each program will also develop a component Results-based Management and Accountability Framework, including the development of program logic models, to address items in the action plan.. ▲ Component RMAFs ▲ Component RMAFs
	◆ Improve focus and relevance of program evaluations in the Branch by examining single evaluation issues in depth, as opposed to examining several issues at once ◆ Improve linkages of evaluation to departmental planning, policy and program decision-making activities ◆ Test pilot approaches to program implementation to guide community-level program interventions and their evaluation where appropriate. ◆ Explore the challenges of attribution in health promotion programming (e.g. attributing program activities to the achievement of long-term (i.e. health) outcomes)	▲ Encourage the Departmental Program Evaluation Division and PPHB Audit and Evaluation Committee to address branch-wide resource requirements (training, human and financial resources) to enhance evaluation capacity. ▲ Link to effectiveness of interventions project currently underway.

Conclusions	Suggested Improvements	Suggested Response
3. Current evaluation environment: Capacity requirements do not meet shifts in expectations for results-based	◆ Shift to 'results-based' environment implies use of information derived from several sources (e.g. using quantitative and qualitative data) over an extended period of time for evaluation. ◆ Learning and training on evaluation necessary for developing a strong 'community of practice' in evaluation. ◆ Insufficient capacity to conduct evaluations, reflected by the need for additional human and financial resources and common understandings of evaluation concepts and their application. ◆ Lack of time and capacity to conduct evaluations leading to heavier reliance on sources of information that may be deemed biassed, as well as reliance on external consultants to evaluation programs. ◆ Absence of a sound data and information platform consisting of a wide range of sources to be able to undertake the evaluation, with an eye to methodological rigour. ◆ Insufficient performance measurement systems capable of housing data and enabling a planning framework well in advance of evaluations.	▲ Component RMAF's ▲ Performance management system ▲ Build branch capacity through common learning activities among evaluators and policy analysts. ▲ Component RMAF's ▲ Performance management system for Promotion of Population Health

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PREFACE

The objectives of the research team in undertaking this report are to:

- improve understanding of program impacts;
- improve understanding of the types of evaluation activities being undertaken within Health Canada's Population and Public Health Branch and provide guidance on common approaches for future evaluations;
- inform the Results-based Management and Accountability Framework for the Promotion of Population Health; and
- satisfy the Treasury Board Secretariat's requirements to renew the Terms and Conditions for Promotion of Population Health.

Six programs were selected to be included in the synthesis: the Canada Prenatal Nutrition Program; the Canadian Strategy on HIV/AIDS; the Falls Prevention Initiative; the Hepatitis C Prevention, Support and Research Program; the Population Health Fund; and the Rural and Remote Care Component of the Innovations in Rural and Community Health Initiative.

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EXECUTIVE SUMMARY

Between April and September 2003, Health Canada's Management and Program Services Directorate of the Population and Public Health Branch, in collaboration with the Departmental Program Evaluation Division of the Information Analysis and Connectivity Branch, performed a systematic review of six Promotion of Population Health program evaluations.

This report communicates what we learned about how programs are designing and implementing evaluations and summarizes what has been reported in those evaluations. In addition to reporting on conclusions reached in the individual evaluation reports, reviewers also present their own conclusions about program outcomes and implementation practices. Particular attention is paid to methodological rigour and the methodological challenges that may be encountered in the planning and execution of program evaluations. This report will be of most interest to those who may wish to draw on the lessons learned in planning program evaluations with national scope.

Results of the Review: Summary of the Integrated Analysis

The six programs included in this evaluation synthesis have reported making progress toward achieving their immediate outcomes of increased partnership and collaboration, capacity building, and knowledge development and dissemination. All programs have been able to respond in some measure to the needs of their target groups. Their ability to engage target populations and stakeholders in program implementation and to develop new knowledge and information are notable successes.

Several common challenges are identified with regard to system-wide (e.g. relating to all programs) and program-specific challenges faced in undertaking evaluations. A 'Summary of Lessons Learned' table (p.v) presents reviewers' conclusions about what worked well in the evaluations and what might be improved upon for future evaluations to ensure rigour in approach, a sound planning framework well in advance of undertaking the evaluation, and a clear articulation of relationships of program activities and outputs to health outcomes.

Based on the lessons learned, the project team identified three key issues that could be examined further to improve program implementation practices and our understanding of their impacts. The areas highlighted as requiring improvement stem from several challenges and gaps that were identified as common to all programs undertaking program evaluations, both through conclusions reached by the review team and through consultation with program officers. These areas relate to *program design and implementation, approaches commonly used to evaluate Health Canada programs and projects, and the current evaluation environment.* The challenges are summarized below and are discussed at length in the Integrated Analysis (Part B) and Future Directions (Part C) sections of this report.

Program design and implementation

- Improve linkages of results-based approaches to performance measurement and to evaluation, including the use of logic models in helping to forge that link and clearly define program details, particularly at the beginning of a program.
- Establish evaluation as an integral piece in program design, through, for example, evaluation strategies contained in Results-based Management and Accountability Frameworks.
- Strengthen linkages of project and regional evaluations to inform national program evaluations
- Place greater emphasis on examining the effects of funded projects on individuals in target populations;
- Place greater emphasis on examining cause-effect relationships to arrive at outcome-oriented information

Approaches to program evaluation

- Establish pre-program baseline measures or reliable points of comparison for assessing program impacts.
- Improve focus and relevance of program evaluations in the Branch by examining single evaluation issues in depth, as opposed to examining several issues at once
- Improve linkages of evaluation to departmental planning, policy and program decision-making activities
- Develop performance expectations (including stated connections between program activities and objectives) early in the program life-cycle and apply continuously to direct program activities
- Present methodological details (e.g. data collection tools/process and analytic plans) necessary to undertake successful evaluations in evaluation reports.
- Test pilot approaches to program implementation to guide community-level program interventions and their evaluation.
- Explore the challenges of attribution in health promotion programming (e.g. attributing the achievement of long-term (i.e. health) outcomes to program activities).

The current evaluation environment

- Shift to ‘results-based’ environment (Central Agencies, TBS) implies use of information derived from several sources (e.g. using quantitative and qualitative data) over an extended period of time for evaluation.
- Insufficient capacity to conduct evaluations, reflected by the need for additional human and financial resources, training, and common understandings of evaluation concepts and their application.
- Lack of time and capacity to conduct evaluations leading to heavier reliance on sources of information that may be deemed biassed, as well as reliance on external consultants to evaluate programs.

- Absence of a sound data and information platform consisting of a wide range of sources to be able to undertake the evaluation, with an eye to methodological rigour.
- Insufficient individual (program-specific) and common (horizontal) performance measurement systems capable of housing data, enabling a planning framework well in advance of evaluations, and enabling project and regional evaluations to inform national evaluations.
- Learning and training on evaluation necessary for developing a strong 'community of practice' in evaluation

To maintain the dialogue on these issues and to identify potential areas of improvement for future evaluation efforts, the Project Team recommends that a network of PPHB program officers and evaluators be convened. An action plan devoted to addressing these common issues can be used as a starting point for discussion. Such a network could provide a forum where a culture of evaluation can be developed and sustained within the Branch. This critical mass will also serve as a focal point for training and continuous learning on program evaluation. The existing PPHB Audit and Evaluation Committee, which consists of senior program staff and management, will link to the evaluation network and the Departmental Audit and Evaluation Committee. These fora will together provide an opportunity to explore the issues identified above in greater depth.

SUMMARY OF LESSONS LEARNED FOR FUTURE EVALUATIONS

Lessons Learned	Page
Program Evaluation Methodologies	
Evaluation planning needs to occur early in the program development process: • Results-based Management and Accountability Frameworks should continue to be developed early in the program life cycle, including implementation of ongoing data collection activities, storage mechanisms and how the information collected will be analyzed. • Baseline data should be established as part of the program planning and development exercise, both to support the rationale for the program and to support the evaluation function. • Detailed information should be provided on the methodology used for the evaluation study (e.g., descriptions of processes used to collect and analyze data) and the results of this work (e.g., a list of the literature reviewed) to allow for validation. Guidelines — such as *Health Canada's Evaluation Report Assessment Guide* — could be used to ensure quantitatively and qualitatively consistent, thorough presentation of evaluation methodologies, findings, and recommendations.	P. 17
Ensuring systematic data collection practices which encompass several data sources (including reliable interview and survey samples) will enable the collection and analysis of data that can be used to effectively measure program impacts and effects.	P. 18
Program Relevance	
Whenever possible, quantitative evidence, in addition to qualitative evidence, should be used by evaluators to substantiate program relevance and effectiveness: • The economic burden of the health issue being addressed (to society, to Canada's economy and to the health system), as well as the potential cost of not taking action, should be considered when assessing program relevance. • Broader departmental and government policy priorities should be considered to support arguments for continued relevance (e.g. SFT, Budget, Parliamentary Reports and other health reports) and to situate the importance of the health issue being addressed.	P. 19
Impact and Effect: Outcomes for Partnerships and Collaborations	
Consistency is needed across Promotion of Population Health programs in defining key concepts such as partnership, stakeholders and client (target) groups. The roles, responsibilities and expected activities of program partners, the role of provincial/territorial governments in program delivery, and the relationship between provinces/territories and Health Canada's regional offices should be clearly illustrated.	P. 21

Impact and Effect: Outcomes for Partnerships and Collaborations (Continued)	
Dynamic and strategic partnerships, based on good communication, should be fostered as an effective means of reaching at-risk target groups, avoiding overlap and duplication of effort, building complementary programs and ensuring optimal use of program dollars (through the sharing of resources).	P. 23
Co-management forums (e.g., funding and monitoring opportunities with other governments) could serve as a means to leverage resources, improve program delivery efficiencies and enhance the impact of Promotion of Population Health programs.	P. 24
Target groups should be engaged at appropriate times, and in appropriate ways, on issues of direct concern to them.	P. 24
Impact and Effect: Outcomes for Capacity Building to Take Action on the Determinants of Health	
Common definitions for capacity building and improved methods for measuring changes in community capacity should be developed.	P. 28
Impact and Effect: Outcomes for Knowledge Development and Dissemination	
Prior to widespread implementation, key Promotion of Population Health messages need to be geared toward target populations and tested through focus groups to ensure that they are culturally appropriate, presented at a suitable literacy level and available in the target group's language of choice.	P. 29
Information management strategies should be developed to facilitate communication and the exchange of information between projects, across program components, across regions and between stakeholders at the national, regional and local levels. Such strategies could include creation of a central repository to coordinate information dissemination on behalf of all stakeholders and partners.	P. 30
To improve the focus of program implementation and evaluation activities, Promotion of Population Health programs should better define key concepts and terminology related to program design and delivery. Logic models are helpful when trying to understand program concepts and their relationships. Evaluation reports should therefore include the program's logic model to provide necessary context and assist the reader in understanding linkages between program activities/outputs and outcomes.	P. 31
The process for setting project priorities and reviewing project applications should be strengthened and streamlined. A key goal should be to encourage the development of concrete project goals with specific measures and process targets.	P. 32
Cost-Effectiveness	
Program effects must be understood before a cost-effectiveness or cost-benefit analysis can be conducted (without accurate effectiveness or cost data, cost-effectiveness ratios cannot be developed).	P. 34

PART A: INTRODUCTION

Management improvement initiatives are being implemented across the federal government, with increased attention to results, responsible spending, and accountability. "Building the Accountability Canadians Deserve" was a core theme of the February 2003 federal budget, which included several new initiatives to improve expenditure management and accountability. Individual departments and agencies have been taking action to implement these directives on their own. Health Canada, for example, has increased its focus on program results and public accountability through the development and implementation of a Departmental Performance Management Framework, which outlines results-based accountability requirements across departmental programs.

At the Branch level, the Population and Public Health Branch (PPHB) of Health Canada has undertaken to support the drive toward results-based management through initiatives such as the Effectiveness of Community Interventions Project, the recent formation of the PPHB Audit and Evaluation Committee, and the continuing efforts of PPHB programs to improve and strengthen their ongoing performance monitoring and evaluation efforts. Another element of this process, the renewal of Terms and Conditions for grants and contributions for PPHB's Promotion of Population Health programs, gave rise to this evaluation synthesis exercise.

Within this environment of continuous improvement for federally funded programs, PPHB's Management and Program Services Directorate, in conjunction with the Departmental Program Evaluation Division (DPED) of the Information Analysis and Connectivity Branch, set out to systematically review six Promotion of Population Health program evaluations. This synthesis presents a summary of results reported in those evaluations. Throughout the report, lessons learned are highlighted to provide direction for future evaluation work. Lessons learned are also summarized at the outset of the report for ease of reference. An integrated analysis of program evaluation results – based on three selected themes of partnership building, capacity building, and knowledge development, is presented in Part B.

1.1 Definition of Key Terms and Concepts

Evaluation Synthesis

An evaluation synthesis is "a systematic procedure for organizing findings from several disparate evaluation studies."[1] It is a way of examining a particular topic or subject and identifying, reviewing, analyzing and appraising the existing knowledge base on the topic/subject. Although an evaluation synthesis is a reflection of the information upon which it is based and does not endeavour to collect new information, syntheses do represent an effective and efficient process for summarizing knowledge about a particular issue. As a result, evaluation syntheses offer great

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[1] *The Evaluation Synthesis* (Revised 1992). Program Evaluation and Methodology Division, United States General Accounting Office.

potential for applying lessons learned to future policy development, program management, and program implementation practices. The title of this report — *Looking Back, Looking Forward* — clearly reflects the intent to apply lessons learned from this synthesis to future evaluation and synthesis reporting activities in the department.

Terms and Conditions for the Population Health Contribution Programs

In 1998, the terms and conditions for Promotion of Population Health grants and contributions became the technical operating principles for several PPHB programs. These terms and conditions were intended to provide a basis for federal action in areas that aim to "promote health, prevent disease and injuries throughout the life-cycle," with the overall objective of increasing the capacity of individuals and communities to maintain and improve their health. They are the mechanism PPHB uses to provide funding, through grants and contributions,[2] to national and community-based organizations to support and enhance program delivery, with the objective of achieving the outcomes identified in Table 1.

> Over the five years since the Terms and Conditions for Promotion of Population Health were established, almost $1 billion have been allocated across 15 PPHB programs (the six programs captured in this evaluation synthesis account for approximately one-third of that amount.

The terms and conditions for Promotion of Population Health are valid for a period of five years, after which they must be renewed. As part of the renewal process, the Treasury Board Secretariat (TBS) requires that a synthesis be developed summarizing program evaluations and results. This evaluation synthesis will, in turn, provide input for a Treasury Board submission that will propose revised terms and conditions, a Results-based Management and Accountability Framework (RMAF) and a Risk-Based Audit Framework (RBAF).

[2] *Grants* are unconditional transfer payments made to individuals and organizations. *Contributions* are conditional transfer payments made when there is a need to ensure that payments have been used in accordance with legislative or program requirements. Contributions reimburse a recipient for specific expenditures according to terms and conditions set out in a contribution agreement signed by the respective parties.

Table 1: Common Promotion Population Health Contribution Program Outcomes[3]

Outcomes	Broad Program Goals	Definition
Building community capacity	• Encouraging and supporting citizen participation in maintaining and improving their own health. • Increasing community capacity for action on, or across, determinants of health.	Facilitating the development of community knowledge and skills to enhance community development, citizen participation and organizational viability.
Stimulating knowledge development and dissemination	• Generating awareness and understanding of the determinants of health with the public and with policy makers. • Increasing the knowledge base for future program and policy development (evidence-based decision making).	Supporting learning in health promotion at the organizational and community level, as well as providing resources and information to the public on promotion of population health issues.
Partnership building/ intersectoral collaboration	• Encouraging intersectoral (governmental, non-governmental, non-profit organizations) collaboration in health.	Establishing linkages and partnerships intrasectorally (within and between orders of government) and intersectorally (within and between public and private institutions) and across sectors, with professional associations, academic/business/ labour institutions and non-governmental organizations involved in health promotion and population health.

1.2 Evaluation Synthesis Objectives and Methodology

Objectives of the Review

This document presents the results of an internal review of six program evaluations operating under the Terms and Conditions for Promotion of Population Health. It provides a thematic overview of results achieved by the programs in the areas of partnership building, capacity building, and knowledge development, as well as an analytic overview of the evaluation methodologies used to assess these results. The objectives of the synthesis are to:

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[3] These outcomes, goals and definitions are derived from the 1998 Terms and Conditions for Promotion of Population Health.

- improve understanding of program impacts;
- improve understanding of the types of evaluation activities being undertaken within Health Canada's Population and Public Health Branch and document lessons learned to provide guidance on common approaches for future evaluations;
- inform the Results-based Management and Accountability Framework for the Promotion of Population Health; and
- satisfy the Treasury Board Secretariat's requirements to renew the Terms and Conditions for Promotion of Population Health.

The findings of this report will also inform a more in-depth study of best practices in evaluating the effectiveness of Promotion of Population Health interventions.[4]

Methodology for Undertaking the Review

To develop and implement the project, an Evaluation Synthesis Project Team was formed, comprising representatives from PPHB and DPED. Five steps were undertaken to complete the evaluation synthesis:

- Step 1 developed criteria for selecting program evaluations to be included in the synthesis.
- Step 2 defined the project's research components (activities and outcomes) and indicators through the development of an evaluation framework and finalized the synthesis report work plan.
- Step 3 initiated the process of summarizing program evaluation/performance information through data collection.
- Step 4 analyzed collectively and interpreted the data collected into a thematic and integrated analysis of results. This included identification of lessons learned for future program evaluation, and program design and delivery improvements.
- Step 5 summarized the results of the analysis.

Step 1: Selecting Program Evaluations

The study began with the selection of program evaluations based on an established set of criteria and through ongoing consultations with TBS (the screening criteria used to select the program evaluations are described in the Evaluation Framework for Promotion of Population Health). The programs included in the synthesis tend to be mature, address diverse population health issues, and are of significant dollar value. Of particular importance, the programs have adequate evaluation frameworks and data to make a meaningful contribution to the synthesis. As illustrated in Table 2, the synthesis is based on four formative (mid-term) and two summative

[4] The Effectiveness of Community Interventions Project. Further information can be obtained from the Strategic Policy Directorate, Population and Public Health Branch.

(final) evaluations.[5]

The six programs reviewed for the synthesis are:

- the Canada Prenatal Nutrition Program (CPNP);
- the Canadian Strategy on HIV/AIDS (CSHA);
- the Falls Prevention Initiative (a joint program with Veterans Affairs Canada);
- the Hepatitis C Prevention, Support and Research Program;
- the Population Health Fund (PHF); and
- the Rural and Remote Care Component (RRCC) of the Innovations in Rural and Community Health Initiative.

These programs address a wide range of issues impacting the health of children, seniors, marginalized populations and Canadians in general. Some of the programs are focussed on specific diseases and their risk factors (e.g., Hepatitis C, HIV/AIDS), while others are geographically centred (rural and remote areas), concentrate on a single health issue (falls prevention and prenatal nutrition) or are targeted to specific life stages with broad objectives to maintain and improve population health and reduce inequities in health status among population groups (PHF). With the exception of the Canada Prenatal Nutrition and HIV/AIDS Programs, all of the programs have come into being over the last three to five years.

Annual program budgets range from $2.5 million for the Falls Prevention Initiative to $42.2 million for the CSHA, with varying amounts of these budgets allocated for grants and contributions (see Table 2). All of the programs have a regional component. The Falls Prevention Initiative was piloted in three regions (Ontario/Nunavut, Atlantic Canada and British Columbia/Yukon), while the other five programs delivered grants and contributions from each of Health Canada's seven regional offices. A more detailed description of each of the six programs can be found in Appendix A.

[5] A formative evaluation primarily addresses questions about program implementation or process and planning and is usually conducted while a program is under way. Findings of formative evaluations can be useful for improving program management practices. A formative evaluation also presents an opportunity to collect baseline data for future summative evaluations. Summative evaluations also collect baseline data; however, unlike formative evaluations, information is also collected after the program has been completely implemented in order to be able to assess program outcomes or impacts. A summative evaluation is primarily intended to provide evidence about cause-effect relationships and assesses the longer term impacts programs may have on a given health or disease issue.

Table 2: Program Details

Program	Start Date	Annual Funding*	Annual Allocation for Grants and Contributions*	Type and Time Frame of the Evaluation
Canada Prenatal Nutrition Program	1995	$27M	$21M	Summative/Final 1995-2003
Canadian Strategy on HIV/AIDS	1998	$42.2M	$29.9M	Formative/Mid-term 1998-2001
Falls Prevention Initiative	2000	$2.8M°	$2.2M	Formative/Mid-term 2000-2002
Hepatitis C Prevention, Support and Research Program	1999	$9.3M	$2.9M	Formative/Mid-term 1999-2002
Population Health Fund	1997	$15.2M	$14.8M	Formative/Mid-term 1997-2002
Rural and Remote Care Component	1999	$16.7M	$5.5M†	Summative/Final 1999-2001
Total:		**$97.5M**	**$64.6M**	

* Where program funding levels varied from year to year, average annual figures are provided for the evaluation time frame.
° Funding for this program is provided by Veterans Affairs Canada, with the funds administered by Health Canada.
† The RRCC provided grants and contributions totalling $11M over two years.

Step 2: The Evaluation Framework for Promotion of Population Health

Following the selection of program evaluations, an Evaluation Framework for Promotion of Population Health was developed in consultation with TBS and Health Canada colleagues. The framework poses a series of evaluation questions and offers a corresponding set of indicators to summarize program achievements, their impact, program delivery and design, and cost-effectiveness. These questions and indicators are detailed in Table 3 and have been designed to easily link lessons learned about past program management practices and impacts to the forward-looking Results-based Management and Accountability Framework (RMAF).

Table 3: Summary of Evaluation Questions and Indicators

Evaluation Questions	Indicators
Program Relevance: Is there a continued need for federal involvement in this area?	• Evidence of nature and magnitude of the problem (costs to Canadians, health system), evidence in literature of potential impact of programming. • Government/political priorities and stakeholder perception on identified need.
Impact and Effect: *Partnerships*: To what extent have effective partnerships and collaborations been developed?	• Nature, quality and degree/range of involvement and commitment of partners.
Capacity Building: To what extent has capacity to address health promotion issues increased?	• Number and types of outreach activities/projects funded and resources developed. • Statements/evidence of improved capacity to take action on the determinants of health.
Knowledge Development and Dissemination: To what extent have programs been successful in knowledge development and dissemination?	• Quality of knowledge and availability of products. • Evidence of increased awareness and uptake by target groups.
Design and Delivery: How have programs approached the design and delivery of programs?	• Number and types of partners and sectors participating in health promotion activities. • Best practices and recommendations for program change and improvement.
Cost-Effectiveness: To what extent have programs demonstrated leveraging of additional resources to become sustainable without federal funding?	• Amount and proportion of program/project resources leveraged and their sources. • Evidence in literature of alternative delivery mechanisms used by other initiatives/other Canadian jurisdictions and internationally, and available evidence on their cost-effectiveness.

Step 3: The Evaluation Synthesis Review Protocol

An "Evaluation Synthesis Review Protocol" was developed to guide the synthesis review process (see Appendix E). The Review Protocol was designed so as to capture a variety of evaluation and outcome information and produce a single set of conclusions and recommendations from the six evaluations. It was largely based on the Evaluation Framework for Promotion of Population Health Contribution Programs and included a scan of existing instruments used for evaluating

reports on health promotion interventions.[6] The review identified a considerable amount of literature for assessing whether evaluation criteria have been satisfied for undertaking a program evaluation. Considerably less information was found on assessing outcome-related evidence.[7]

As part of the Review Protocol's design, criteria were developed for determining whether the principles of the population health and determinants of health approaches guided and/or informed program implementation and evaluation practices. These criteria are based on the Population Health Template, which identifies areas of action for influencing the determinants of health.[8]

Step 4: Applying the Protocol

The Review Protocol was pilot tested using one of the program evaluations and revisions were made as needed by the Evaluation Synthesis Project Team. In addition to refining the protocol, this pilot process helped the Project Team to develop a common understanding of how the protocol was to be applied consistently across the evaluations being reviewed.

Reviews of all six evaluations were then completed by members of the Project Team using the Review Protocol. A secondary reviewer was assigned to review each report in order to validate the summary and assessment (see Appendix C). This double review process helped to ensure identification of gaps, minimized duplication in the reviews, and ensured overall consistency in the interpretation, analysis and consideration of the reports. As well, each of the detailed summary reports was provided to the Project Team for general review and discussion of findings.

Step 5: Developing the Thematic Summary (Knowledge Development, Capacity Building, and Partnership Building)

The review process undertaken in Step 4 resulted in a summary of findings for each evaluation report. These summaries identified the characteristics of each program, the context for the evaluation study, the data collection methods used and findings for each of the four evaluation questions. The Synthesis Evaluation Project Team met several times to discuss the key findings of these summaries and their relevance for future evaluation-related work. These discussions resulted in the development of a first draft of the evaluation synthesis report, which was reviewed

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[6] Health Canada's *Evaluation Report Assessment Guide* and DPED's evaluation peer and expert review protocols were also used to develop the synthesis protocol, as was the *TBS Guide to Developing Result-based Management and Accountability Frameworks*.

[7] Two useful tools used in the field for assessing outcome-related evidence were *A Schema for Evaluating Evidence on Public Health Interventions* (Version 4, June 2002) and *An Assessment of the Methods and Concepts Used to Synthesize the Evidence of Effectiveness in Health Promotion: A Review of 17 Initiatives* (2001). The latter proposes an ideal framework for synthesizing health promotion effectiveness evidence.

[8] See the Population Health Template: http://www.population-health.com.

and discussed by the Project Team. The six programs were asked to review a draft of the text to ensure its completeness and accuracy in relation to their program. The Project Authority overseeing the process for the renewal of the Terms and Conditions for Promotion of Population Health also reviewed and approved the final synthesis, providing content expertise on key issues.[9]

[9] The Project Authority is chaired by Dr. Sylvie Stachenko, Director General, Centre for Chronic Disease Prevention and Control, and comprises Directors General from throughout the Population and Public Health Branch. It acts as an oversight mechanism to ensure that the appropriate level of engagement takes place throughout the department. The management team for the terms and conditions renewal project, consisting of chairs of the designated task groups assigned to lead each renewal activity (RMAF, RBAF), was also consulted on the final draft of the synthesis.

PART B: INTEGRATED ANALYSIS OF EVALUATIONS

Four common evaluation questions were developed to provide a framework for the evaluation synthesis, relating to program relevance, impacts and effects, design and delivery, and cost-effectiveness. This section of the document reports on general findings and themes identified under each of those questions. It begins with an analysis of the methodologies used to conduct each of the six evaluations.

2.1 Review of Program Evaluation Methodologies

Common Characteristics

The Project Team's review of the six evaluation reports revealed a number of commonalities in the approaches used:

- Evaluation consultants external to Health Canada were engaged to some extent in all six evaluations;
- Five of the six evaluation studies were conducted ex-post (i.e., the evaluation designs were developed and implemented after the programs were under way).
- Four of the studies were formative/mid-term program evaluations,
- Two of the studies were final/summative evaluations (RRCC and CPNP);
- Five of the six evaluations were based on non-experimental designs (i.e., there was no use of control groups or repeated measures in time, which might have been useful in assessing cause and effect relationships).
- All of the evaluations used both primary and secondary data. Three data-gathering techniques were common to all six evaluations: literature/document reviews, surveys/interviews and focus groups/case studies. The CPNP evaluation also relied heavily on data collected directly from program participants.

Limitations of the Evaluation Methodologies

Information on the methodologies of the program evaluations could have been more detailed in some cases to assist the reader in assessing the conclusions presented in the evaluation reports. The absence of a complete description of the evaluation methodology can raise questions about the comprehensiveness and rigour of the work. A more detailed description could also provide information on the context or circumstances surrounding the methods for the evaluation, which may or may not have an impact on the outcomes reported in the evaluation (e.g. explanation of limitations/challenges in the evaluation based on methods used).

Each program had developed an evaluation framework and four out of the six evaluations had developed a logic model and indicators, but a third core element needed for effective evaluation — a well-defined process for on-going data gathering — was not observed in five of the six programs (the CPNP being the exception). This is evidenced by the lack of baseline data or other on-going data collection techniques. The approaches used to collect project data varied from region to region making it difficult to understand how individual project evaluations related to the national picture, and ultimately how project evaluations informed the program evaluation. Without such information and data-gathering processes in place, it is difficult for evaluators to assess program impacts and effects over time.[10]

Lesson Learned

Evaluation planning needs to occur early in the program development process:

- Results-based Management and Accountability Frameworks should continue to be developed early in the program life cycle and must define ongoing data collection activities, storage mechanisms and how the information collected will be analyzed.
- Baseline data should be established as part of the program planning and development exercise, both to support the rationale for the program and to support the evaluation function.
- Detailed information should be provided in the report on the methodology used for the evaluation (e.g., descriptions of processes used to collect and analyze data) and the results of this work (e.g., a list of the literature reviewed) to allow for validation. Guidelines — such as Health Canada's Evaluation Report Assessment Guide — could be used to ensure consistent, thorough presentation of evaluation methodologies.

The evaluations (with some exception) did not appear to take full advantage of existing information in the form of needs assessments, meeting notes and other program-relevant historical and supporting documentation. A contributing factor to this situation may be that external evaluation consultants, while playing an important and valuable role in evaluations, generally lack context about the program they are asked to evaluate and may overlook existing data sources. As well, they tend to be gathering information at a single point in time, rather than over an extended period of time. Consequently, there is a strong reliance on interview/survey data with program stakeholders. Survey/interview data itself has several limitations. In order to overcome these limitations and reduce bias, the following are needed:

- A representative sample of partners, stakeholder organizations and clients to illustrate multiple perspectives

[10] It should be noted that baseline studies for health promotion programs are costly and require a significant amount of planning and coordination, particularly for national programs.

- large sample sizes that allow for generalisations of results
- interview questions that are neutral and relevant.

Little evidence was found (survey details were not provided in the evaluation reports) to suggest the evaluations took the necessary measures to ensure that the interview/survey data were not biassed. It should be noted that while bias is always a consideration in social science research, biases should be reported as part of the methodology and steps should be taken to minimize them (for example, by ensuring the proper weighting of sources). Where fitting, for example, it may be beneficial for the programs to include those who should be benefiting from these programs as one of the populations in the pool of interviewees. This would add another perspective that would provide information concerning the ultimate or long term outcomes of a program (behaviour change to improve health status).

> ***Lesson Learned***
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> Ensuring systematic data collection practices which encompass several data sources (including reliable interview and survey samples) will enable the collection and analysis of data that can be used to effectively measure program impacts and effects.

2.2 Program Relevance

Evaluation Question: "To what extent do Promotion of Population Health Programs remain relevant to government priorities and the needs of target populations?"

The intention of reviewing relevance arguments was not to develop relevance arguments for the programs, but to highlight the findings presented in the reports.

All six evaluation reports stated a continuing need for federal involvement in their respective areas of Promotion of Population Health, often noting the importance of the federal role in creating and facilitating national strategies to address these issues. Three of the six evaluations (the CSHA, the Hepatitis C Prevention, Support and Research Program and the CPNP) provided epidemiological and surveillance data to illustrate the breadth and impact of their respective health issues. For example, the evaluation reports provided information on the extent of the problem in Canada (e.g., the number of infected individuals, incidence rates), as well as information on risk factors and risk groups associated with the disease or health issue. The evaluation report for the CPNP compares birth weight rates in Canada to those in other countries, as well as to provincial rates and rates among certain groups. Birth weight is the most widely used measure of infant health — low birth weight is associated with many risk factors, according to the literature (CPNP cites a number of documents to provide evidence for its statements about

birth weight). Both CPNP and CSHA evaluations also included some discussion of the economic burden of the disease/health issue to Canadians, including potential future costs if action is not taken to address the problem.

However, in three other evaluations the relevance argument were based in large part on the views of funding recipients, key informants, partners and other stakeholders, who may have a vested interest in continuance of the program. In these three evaluations, few other types of evidence were used to support assertions that the federal government needs to continue to be involved in these areas. This does not imply that these programs are not relevant, but rather points to the fact that evaluations should use multiple sources of data to support their relevance statements. It also points to the fact that numerous key informant interviews were conducted and that appropriate quantitative research methods were sometimes overlooked.

Resources and expertise exist within Health Canada that could provide the types of information and analysis recommended above (e.g., both internal and external to Health Canada). Other resources that could be used to support relevance arguments include national survey data (e.g., the National Population Health Survey and the Canada Community Health Survey) and policy documents (e.g., the federal budget and federal/provincial/territorial reports on health and the health system) that help position the health or disease issue within a broader socio-political context. This includes documenting supportive health promotion literature about the success of interventions in other, similar contexts. In short, relevance arguments could be further supported by multiple lines and types of evidence.

Lesson Learned

Whenever possible, quantitative evidence, in addition to qualitative evidence, should be used by evaluators to substantiate program relevance:

- The economic burden of the health issue being addressed (to society, to Canada's economy and to the health care system), as well as the potential cost of not taking action, should be considered when assessing program relevance.
- Evaluators should scrutinize a program within the broader context of other health issues and departmental and government priorities when developing relevance arguments.

2.3 Impact and Effect: Contribution to Achievement of Identified Outcomes

Evaluation Question: "To what extent have programs contributed to the achievement of identified outcomes?"

This section of the evaluation synthesis reports on progress toward the following outcomes:

- partnerships and collaboration;
- capacity building; and
- knowledge development and dissemination.

Through the achievement of these outcomes, it is theorized that progress is also made toward the achievement of longer term outcomes, such as increased access to health promotion information and services, increased awareness and improved health practices. Ultimately, this is intended to lead to achievement of the health outcomes identified by the individual programs.

A) Outcomes for Partnerships and Collaborations

Who Are the Branch's Program Partners?

The evaluations determined that a wide range of suitable partners have been engaged in the six programs addressed in this evaluation synthesis. From a strictly numerical standpoint, participation of partners varied widely from one program to another. The evaluation for the Falls Prevention Initiative, for example, identified only two formal partners — the Branch itself and Veterans Affairs Canada — but also noted that numerous other organizations played a role in program development and implementation. The Hepatitis C Prevention, Support and Research Program, on the other hand, claimed some 474 partners, including dozens of community-based organizations.

Partnership development is an underlying theme (and often a stated objective) of all six programs. Although five of the six initiatives deal with distinct health issues, and the target groups and program strategies are often disparate, the types of partners engaged tend to be similar across the programs. For example, provincial/territorial governments and non-government organizations (NGOs) are identified as partners by most programs. Similarly, other programs within Health Canada, other federal departments and agencies, research institutes and universities are commonly named as partners. Depending on the nature of the program, the private sector, community-based organizations and municipalities may also be identified as partners (e.g., the Hepatitis C Prevention, Support and Research Program and the RRCC).

As for the nature of partners' involvement in evaluations, results indicate that key partners were directly involved in the design, development and delivery of the six programs and, in some cases, in program monitoring and evaluation. By participating in the actual planning of programs and in priority-setting exercises, partners were able to influence not only what gets done, but how and when. In the case of the Hepatitis C Prevention, Support and Research Program, for example, the direct involvement of the Canadian Institutes of Health Research (CIHR) as a partner has resulted in a singular focus on biomedical and clinical research. CSHA partners were consulted extensively on the goals and funding allocations for the Strategy, and continue to be engaged in developing strategic directions for this initiative. Provincial/territorial departments and agencies are also influencing program activities and projects under the RRCC. These relationships illustrate that "who" we partner with, and "how," may directly affect program objectives and

outcomes.

Partnerships under these six programs generally take the form of financial or in-kind contributions, although in some cases the Branch's partners may simply share information or offer advice. A driving force for many partnerships appears to be to improve prospects and expand opportunities for reaching specific target groups, especially marginalized populations.

Defining Relationships: Partners, Stakeholders or Clients?

Use of the term "partnership" varied among programs. For example, some programs apply a rigid, almost legalistic meaning to the word, using it only in reference to an organization that has entered into a formal agreement related to program development and delivery (e.g., the Memorandum of Understanding between Health Canada and Veterans Affairs Canada for the Falls Prevention Initiative). The RRCC characterized partners as organizations with a defined role in the program; key partners thus include Health Canada, its regional offices and the CIHR. Others use the term with more flexibility — virtually any organization that interacts with the program would be considered a "partner." Often, Health Canada branches, programs and divisions partner with each other to improve the delivery of programs.

The evaluations also revealed that some programs use the terms "partner" and "stakeholder" interchangeably. All of the programs appear to adopt a broad definition of their stakeholders, sometimes going so far as to encompass "Canadians in general." While this practice ensures that the program is seen as being inclusive, it can also make it difficult, from an evaluation perspective, to ascertain the degree to which stakeholders are being engaged or impacted by the program. Moreover, certain programs (e.g., the Falls Prevention Initiative) refer to their target groups as "clients," while these groups may consider themselves to be partners. Definitions in the evaluation reports would have assisted the reader in understanding how each program perceived their relationships with others — as clients, stakeholders, partners or a combination of the above — and how that perception compared to reality.

> ***Lesson Learned***
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> Consistency is needed across Promotion of Population Health programs in defining key concepts such as partnership, stakeholders and client (target) groups. The roles, responsibilities and expected activities of program partners, the role of provincial/territorial governments in program delivery and the relationship between provinces/territories and Health Canada's regional offices should be clearly illustrated.

Implications for Accountability

The degree of partner engagement in these six programs, although recognized as being both

necessary and beneficial, raises a number of questions around program management issues. Specifically:

- Are all partners deemed to be equal or is Health Canada, as the program sponsor and main funder, seen to be in the position of "senior partner"? How is the responsibility divided, what are the accountability provisions, and are these issues clearly articulated?
- Does the ability of partners to influence programs from the outset strengthen these initiatives, or could it potentially undermine the integrity of the program objectives, as initially defined by Health Canada policy makers?

Developing and Sustaining Partnerships

A number of common themes emerged from the evaluations in relation to the challenge of developing and sustaining partnerships.

While partnerships enable programs to broaden their engagement, extend their reach and leverage additional funding (including from the private sector), they also require a significant investment of time and resources. Some evaluations (e.g., the Falls Prevention Initiative, the RRCC, the CSHA and the Hepatitis C Prevention, Support and Research Program) noted particular difficulty in establishing and maintaining partnerships at the community level. Engaging partners outside the health sector was also identified as an ongoing challenge (although the PHF reported that other sectors were represented in about two-thirds of the funded projects). Frequent changes in staff and program cuts at partner organizations, particularly community-based organizations, were also cited as impediments to maintaining effective partnerships. Nonetheless, all evaluations report attaching a high value to the partnerships formed, as referenced by, among other indicators, leveraging of resources and sustainability of actions at the local level.

Most of the evaluations reported that partnership building and maintenance is a time consuming endeavour. Consideration of the challenges of partnership building should be taken into account during the design and delivery phases of the program. The Falls Prevention Initiative, for example, devoted the first phase of its program delivery solely to partnership building.

Frustration in partnership relations may also result when roles and responsibilities are not clearly defined or when several organizations bring fundamentally different approaches to the table. For example, some initial difficulties were encountered by PPHB and Veterans Affairs Canada in implementing the Memorandum of Understanding to co-manage the Falls Prevention Initiative. The evaluation determined that these problems, since resolved, were due to differences in approach — Veterans Affairs Canada has traditionally focussed on direct health service delivery (e.g. provision of health care service), while PPHB's approach is one of promoting population health (e.g. advancing the principles of population health in program design and delivery).

The ability to effectively form partnerships appears to be related to the urgency or maturity of the issue. The initial phase of partnership building involves increasing awareness of the

issue/problem and creating ‘buy-in’ from potential partners. However, depending on the urgency of the issue and the extent of public attention to the issue (e.g. media attention), this increasing awareness phase is minimized. For example, hundreds of organizations now exist across Canada to support and deliver services to people living with or at risk of HIV/AIDS, which was first identified as a significant public health issue in Canada more than 20 years ago. Conversely, public awareness of how falls can affect the health of seniors and veterans, and the extent of the problem in Canada, is much weaker. The latter issue may be viewed as being less urgent than HIV/AIDS, and can therefore make it more challenging to garner support and attract partners.

The Year Three evaluation of the CSHA also noted that the engagement of new or multiple partners (or funding recipients) in a program can increase the “competition” for limited funds. As the available money is distributed more thinly among participants, partners may be forced to curtail planned activities or cut corners, thus affecting service/project delivery and the overall effectiveness of the program.

Despite these challenges, the evaluations concluded that the impacts of partnerships on achieving program outcomes were overwhelmingly positive.

Lesson Learned

Dynamic and strategic partnerships, based on good communication, should be fostered as an effective means of reaching at-risk target groups, avoiding overlap and duplication of effort, building complementary programs and ensuring optimum use of program dollars (through the sharing of resources).

A Federal Leadership Role

Given its national mandate for promoting population health, the federal government (Health Canada) is seen as having both the capacity and the responsibility to play a leadership role in facilitating program partnerships. For example, the evaluation of the RRCC determined that the federal government is best able to exploit synergies across provincial/territorial boundaries due to its national positioning and federal mandate. The evaluation concludes that, without federal leadership, most projects under this initiative would not have otherwise occurred.

This federal leadership role is especially important in the context of the Social Union Framework Agreement (SUFA). In the post-SUFA environment, buy-in from provincial/territorial partners is essential, and must occur before the program is implemented (preferably in the design stage). Federal/provincial/territorial partnerships strengthen the focus on common opportunities and lead to the development of shared goals and national strategies that can be supported by all provinces and territories. The federal government is seen by many as being in the best position to garner national consensus on specific health care issues, to provide large, one-time capital contributions often required for health projects, and to create and nurture partnerships.

The evaluation results as a whole suggest that opportunities exist to create greater efficiencies in delivering the Branch's Promotion of Population Health programs through the development of more integrative partnership processes. One possible approach is to establish co-funding forums, where partners would come together to agree on program priorities, goals and objectives, share information on projects (to avoid overlap and duplication), and possibly co-manage programs. Such forums could also provide for program co-monitoring and co-evaluation. This could reduce the administrative workload (e.g., by consolidating proposal writing and reporting) for a number of organizations and project leaders who receive funding from multiple sources for the same project. Elements of this approach are already happening in the CPNP. However, a more comprehensive approach could be explored.

> ***Lesson Learned***
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> Co-management forums (e.g., funding and monitoring opportunities with other governments) could serve to leverage resources, improve program delivery efficiencies and enhance the impact of Promotion of Population Health programs.

Engaging Target Populations

All six programs reviewed in this evaluation synthesis promoted the involvement of target populations either in the design, development and delivery of their funded initiative. These efforts met with varying degrees of success. For example, partners in the Hepatitis C Prevention, Support and Research Program felt that their own needs were well-represented on the program's joint advisory committee, but that the target population itself was not well-represented. Similarly, the evaluation of the Falls Prevention Initiative determined that seniors and veterans were effectively engaged in program development and delivery, but that engagement of a third important target group — caregivers — fell short.

> ***Lesson Learned***
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> Target groups should be engaged at appropriate times, and in appropriate ways, on issues of direct concern to them.

Certain at-risk populations are particularly difficult to reach and are subsequently much less effectively involved in program development and delivery. These include injection drug users, street-involved youth and inmates. Although some individuals may be engaged in specific project delivery, their involvement in broader program planning and priority-setting is negligible. Problems were also noted in engaging target groups in rural areas, due at least in part to geographic limitations (there are fewer potential partners in smaller or remote communities, and thus fewer mechanisms for reaching target groups.) Another challenge identified in some

program evaluations (the CSHA and the Falls Prevention Initiative) was engaging volunteers, evidenced by the decreasing volunteer base noted in a number of evaluations.

B) Outcomes for Capacity Building to Take Action on the Determinants of Health

Community Capacity Building: An Elusive Concept

The Terms and Conditions for Promotion of Population Health define community capacity building as "... facilitating the development of community knowledge and skills to enhance community development, citizen participation, and organizational viability." Although this definition was not articulated by any of the program evaluations, the evaluation reports did focus on at least one of these key elements of capacity building.

Analysis of the six evaluation reports reveals that clearer explanation of the concept of "community capacity building" and the federal role in achieving this outcome would assist in forging clearer linkages of program inputs and activities to health related outcomes.

Only one of the six program evaluations (the PHF) endeavoured to define or conceptualize community capacity building, explain how it is operationalized in the context of the program, or explore how it impacts health status and health system performance (in terms of access, equity, quality and efficiency). Understanding capacity in the context of the other five programs required a review of each program's logic model for a breakdown of outputs, activities and outcomes. Moreover, the evaluation reports did not clearly differentiate between types of capacity and the indicators used to measure them. For the most part, activities appeared to revolve around developing capacity at one or more of the following levels:

- the system level (integrating population health approaches into programming - e.g. PHF);
- the organizational level (building inter-organizational and intra-organizational capacities to address the health promotion issue - All programs);
- the health service provider level (e.g., training health professionals - All programs, except PHF); and
- the client level (reaching target communities directly through capacity-building programming - All programs).

A number of questions emerge from this analysis:

- What does PPHB mean when it refers to building capacity?
- What infrastructure/critical elements are required to build capacity?
- Is building capacity a federal and/or Health Canada role? If so, when and how should this outcome be pursued? At which capacity levels does the department and its branches exert influence? How is the impact measured?
- What is the federal role in building capacity when multiple parties are involved in a program or project?

Engagement Is A Key Pillar for Community Development

All six programs worked with voluntary community-based organizations and engaged citizens in implementing their activities and objectives. The evaluations indicate that this approach helped the programs to identify local issues and needs and to better understand the capacity of organizations and individuals to continue to address the relevant health issue beyond the life of the program. The RRCC, for example, engaged citizens by inviting rural Canadians to participate in roundtables on health care access and other issues of importance to them.

A key perceived strength as reported in the evaluations for all the programs was the emphasis they placed on networking and community-based partnerships involving multiple stakeholders. This was exemplified through the Hepatitis C Prevention, Support and Research Program, which was designed with community-based support and research as one of three key pillars of prevention efforts.

At the national level, evidence of capacity building was seen in the institutionalization of the response to the HIV/AIDS epidemic through the creation of a "pan-Canadian" alliance of governments and others, as well as in the evolution of specific services (e.g., the Canadian HIV/AIDS Clearinghouse) and institutions (the Canadian AIDS Society and other NGOs). CSHA partners and stakeholders indicated that building community capacity was one of the program's greatest strengths, particularly in helping organizations better address the epidemic, improving capacity for prevention and strengthening the local capacity of communities generally.

Advancing the Population Health Approach

All of the programs advanced the population health approach[11] in their capacity-building efforts. For the RRCC, this meant improving awareness and capacity within the government for a rural perspective in policy and program development through an increase in the number of working groups on rural health. In the Hepatitis 'C' program, training was provided to 35 000 physicians and was offered to 12 000 individuals infected with, affected by or at risk of contracting the virus in order to improve knowledge and capacity to respond to the hepatitis C virus.

The majority of key informants involved in the evaluation of the Falls Prevention Initiative reported that greater understanding of the population health approach had been achieved. However, this did not necessarily translate into increased capacity to address falls prevention. Key informants involved in the evaluation of the RRCC offered mixed views on whether program funding had, in fact, increased community capacity to address local health issues. As there was not enough data available on access and treatment, the evaluation for the Hepatitis C Prevention, Support and Research Program could not determine whether the increase in capacity

[11] See Evaluation Framework for Promotion of Population Health which describes this approach. See also the Population Health Template, www.population-health.com.

noted resulted in improved access and care for primary clients. In any case, all programs identified a need for continued federal involvement in community capacity building.

Challenges in Measuring Progress in Building Community Capacity

All of the evaluations attempted to assess improvements in capacity, but it was often unclear which aspects of capacity were being considered. While not explicitly stated, it appears that most programs treat capacity building as both a determinant of health and a means to achieve positive health outcomes (i.e., both a means to an end and an end in itself).[12] An additional observation of the reviewers was that the lack of clarity in evaluating capacity building outcomes may be due to the formative nature of four of the six evaluations and the subsequent lack of available data to measure such outcomes. As such, it may not realistic to expect discernible changes in health outcomes as a result of capacity building efforts, particularly for programs whose life-cycle has not even begun to influence - let alone evaluate, capacity building successes (e.g. Falls mid-term evaluation clearly undertook to assess two years of the five year Initiative, and does not yet address capacity building).

The evaluations acknowledged the difficulty in measuring overall success in capacity building (it is important to note that common data sources and methods were used to measure capacity — the evaluations relied on key informant interviews, surveys and document reviews). This is not surprising, considering that indicators for measuring community capacity are not well developed. A project in PPHB Alberta funded by the Office of the Chief Scientist is developing performance indicators for community health promotion/population health programs, which may be of use in informing future program evaluations. It is hoped that this project will help to advance the understanding of capacity building — and how it is measured — as it relates to Health Canada programs. A recent report exploring the concept of community capacity and its relationship to community health also provides insight on how the concept can be applied to measuring the impacts of health promotion interventions at the community level.[13]

Another challenge to measuring progress in this area is fact that only the immediate-term effects of building capacity are discernable at the early stages of program development (both the CSHA and

> ***Lesson Learned***
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> Common definitions for capacity building and improved methods for measuring changes in community capacity should be developed.

[12] Labonte & Laverack note this unresolved distinction (2001a).

[13] Smith, Neale, Lori Baugh Littlejohns and Roy Dimple. *Measuring Community Capacity: State of the Field Review and Recommendations for Future Research*, May 2003. The report also offers recommendations about a future national research agenda for measuring and assessing community capacity. Health Canada's Health Policy Research Program supported this research.

the Hepatitis C Prevention, Support and Research Program cited notable advancements in the area of prevention capacity). The evaluation report for the CSHA suggested that improved methods for measuring community capacity should be a monitoring priority and could be an issue for the upcoming year five evaluation of the Strategy.

C) Outcomes for Knowledge Development and Dissemination

Is the Right Information Being Generated?

Knowledge development and dissemination is a core element of the population health approach and was a key area of activity for all six programs. Programs' efforts were generally targeted at:

- improving public, stakeholder and target group awareness of the disease or health issue being addressed by the program; and
- improving knowledge through research

All of the programs reported success in developing (new) knowledge and a wide range of information resources, such as fact sheets, brochures and pamphlets, media information kits, web sites, and information for patients and health care professionals. The impacts that the knowledge products had on improving decision making or increasing overall awareness were less obvious. It should be noted that some individuals who commented on the RRCC stated that it was too early to draw such a conclusion. The evaluations did not provide detailed information on what types and quantities of information products were produced, how information was distributed and to whom, and what the reportable results may be given the uptake of this information.

Attempts appear to have been made by all six programs to engage target groups in developing information tools and sharing knowledge. Despite these efforts, in some cases (e.g., the RRCC), geographic barriers and issues of marginalization worked against the full engagement of certain target groups.

> **_Lesson Learned_**
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> Prior to widespread implementation, key Promotion of Population Health messages need to be geared toward target populations and tested through focus groups to ensure that they are culturally appropriate, presented at a suitable literacy level and available in the target group's language of choice.

Certain evaluations (the CSHA and the Hepatitis C Prevention, Support and Research Program) noted that information created was not always relevant to the target group. The most common problems were that the literacy level of the information was too high for the intended audience (e.g., inmates), the content was not culturally appropriate (e.g., for Aboriginal people), or the literature was not available in the target audience's language of

choice.

Some stakeholders involved in the Falls Prevention Initiative noted that too many educational tools had been developed for the number of projects supported by this program. This evaluation recommended a shift in focus from education to direct, hands-on service delivery. However, other program evaluations stressed the need for continued development of knowledge and information. For example, less than one-third of respondents to the Hepatitis C Prevention, Support and Research Program's secondary client interview felt there was enough information about hepatitis C in Canada. Similarly, more than 50 percent of stakeholders involved in the CSHA evaluation indicated that improvements were needed in information about the Strategy, and that more and better-targeted information was needed for certain groups (e.g., prison inmates, rural and remote dwellers).

Research capacity about these Promotion of Population Health issues appears to have increased due to project funding. However, gaps in research were also noted by some programs, including the CSHA and the Hepatitis C Prevention, Support and Research Program. The identification of research gaps in these mid-term evaluations suggests that research monitoring may be too sporadic, and that program needs would be better served by a more consistent, ongoing monitoring process.

Information Dissemination and Reach

As noted above, all programs reported progress in the development of new knowledge and information. Program stakeholders acknowledge that information sharing helps reduce overlap and duplication, strengthens the capacity of organizations and individuals, and contributes to the development and maintenance of effective partnerships. Similarly, the dissemination of research findings leads to practical applications at the community level.

Some of the evaluations explicitly stated that information products were not reaching their target audiences. For example, the evaluations for the Falls Prevention Initiative and the RRCC both identified geographic barriers as a key factor impacting information-sharing efforts. In the case of the RRCC, the evaluation determined that project sponsors may share information with health service providers in their own community and region or province, but are less likely to do so at a national level. Information dissemination is a particular challenge in rural and remote areas due to small, widely dispersed populations, lower literacy levels than in urban areas and, in some cases, limited access to the World Wide Web.

Challenges also exist in reaching certain target audiences in urban areas, especially marginalized populations (e.g., injection drug users, street-involved youth and Aboriginal people). Again, these groups may not have ready access to the large quantities of information available through the World Wide Web. Innovative outreach strategies are needed to provide marginalized populations with the information they need to change their behaviours and improve their health status.

> ***Lesson Learned***
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> Information management strategies should be developed to facilitate communication and the exchange of information between projects, across program components, across regions and between stakeholders at the national, regional and local levels. Such strategies could include creation of a central repository to coordinate information dissemination on behalf of all stakeholders and partners, with the Canadian Public Health Association's Canadian HIV/AIDS Clearinghouse serving as a possible model. As well, research activities should be closely monitored in order to identify and address knowledge gaps.

2.4 Design and Delivery

Evaluation Question: To what extent has the design and delivery of Population and Public Health programs been effective and appropriate?

Program Design: Theory and Practice

The evaluation reports clearly demonstrated that significant efforts were made to develop programs that would meet the diverse challenges presented by complex health issues. All six programs developed "goals," "objectives," "strategic priorities," "activities" and "project priorities." They also made reference to expected "outputs" and "outcomes," as well as "program components." While these concepts are key elements of many Health Canada programs, they are generally not well-defined or explained in these evaluations (e.g. clearly articulating relationships of outputs to outcomes). What is the link between a program's goals and its strategic directions? How do its objectives relate to its project priorities? How are these concepts measured?

> ***Lesson Learned***
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> To improve the focus of program implementation and evaluation activities, Promotion of Population Health programs should better define key concepts and terminology related to program design and delivery. Logic models are helpful when trying to understand program concepts and their relationships. Evaluation reports should therefore include the program's logic model to provide necessary context and assist the reader in understanding linkages between program activities/outputs, outcome, and cause-effect linkages.

The inclusion of the program logic

model in one of the six evaluation reports (the Hepatitis C Prevention, Support and Research Program) made it easier for the reader to comprehend the program's purpose and activities. Two other reports referenced the program's logic model in an effort to improve understanding of the program. While inclusion of the logic model in the evaluation report is useful in terms of clarifying and defining a program's key elements, the concepts presented in the model still need to be clearly defined (this will support both program delivery and evaluation).

Common Activities and Outputs

A review of the logic models reveals strong similarities in their expected activities and outputs. In fact, the different programs performed almost identical activities (strategic management/ policy development, coordination/consultation with stakeholders, knowledge development and dissemination and funding projects) to achieve their respective outputs. Although each evaluation report presented a general rationale for intervention, none illustrated how this rationale evolved into focussed, targeted program activities.

Most of the programs also incorporated the same components within their activity areas.[14] For example, the knowledge development activity almost always consists of performing research and developing information products (e.g., pamphlets and discussion papers), and knowledge dissemination usually involves the distribution of information products and participation in various fora to share research findings. Although some unique approaches were identified — for example, in the staging of theatre performances to disseminate information on hepatitis C — the general approach to disseminating information was similar across the six programs. The question arises, is the common approach evident in these programs appropriate for achieving the diversity of health outcomes addressed by PPHB?

Consistency vs. Flexibility:

Each of the programs used consultation processes and multi-disciplinary teams to establish project priorities and to review and approve project applications. Most programs involved the target population (the beneficiaries of the program) in these processes, along with other stakeholders such as representatives of Health Canada and other government departments, the research community, academia and community organizations.

Project priorities and funding criteria, as outlined in the evaluation reports, were very similar from program to program. For example, all programs identified the development and dissemination of knowledge, the development of models using the population health approach and the development of networks as project priorities.

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[14] PPHB's Results-based Management Framework incorporates a results-based logic model that clearly illustrates the activity areas, outcomes and outputs that commonly define Promotion of Population Health programs.

> ### *Lesson Learned*
>
> The process for setting project priorities and reviewing project applications should be strengthened and streamlined. A key goal should be to encourage the development of concrete project goals with specific measures and process targets.

The administration of project funding was essentially the same for all six initiatives — program staff in Health Canada's regional offices were responsible for implementing the project solicitation process. This approach, combined with the open-ended funding criteria that were common across the programs, makes it difficult to measure results because program priorities are so general and open to individual interpretation. According to the evaluation reports, variations in project funding procedures resulted in differences from region to region, not only in the types of projects that received funding but also in the implementation of other program activities.

Many program staff and stakeholders saw differences in approach from region to region as a positive indication that the program was flexible and adaptable - an essential component for project success, particularly where the diversity and varying needs of communities can be addressed. The types of projects that tend to be successful in the Northwest Territories, for example, would often fail in Toronto. Others attributed the variations to an inability to properly communicate the program's vision and goals. The question remains: do variations in program implementation from one region to another compromise or enhance the approved policy direction? What is the appropriate balance between flexibility to meet local needs and maintaining national program priorities?

Generally, with increased variation of projects within a program, there needs to be a subsequent increase in coordination to reduce duplication and increase productivity . A thorough illustration of the program's strategy and goals will show how projects are able to feed into the bigger program picture. Throughout the evaluations, improved coordination — including coordination from region to region, across federal departments and across governments — was routinely identified as an area needing improvement.

2.5 Cost-Effectiveness

Evaluation Question: "To what extent have programs demonstrated leveraging of additional funds/resources to become sustainable without federal funding?[15]

What the Evaluations Reported

[15] This is not the traditional or recommended approach to assessing program cost-effectivness, however the question is reflected by the availability of information in each program evaluation.

The evaluation reports addressed the issue of cost-effectiveness in the following ways:

- as an assessment of stakeholder opinions/perceptions of cost-effectiveness. When this approach was used, programs were generally considered to be cost-effective (e.g., in the evaluations of the CSHA and the RRCC).
- by identifying other sources of funds leveraged by projects. Although this approach is not considered to be a traditional cost-effectiveness analysis, the amount of funding leveraged is an important factor to be taken into consideration in program analysis;
- by citing data on the costs of certain health issues, with implied comparisons to the federal investment in addressing those issues. This comparison, which was done for both the Hepatitis C Prevention, Support and Research Program and the CSHA, is usually presented in the relevance section of evaluation reports. While this information is interesting, it does not constitute a complete cost-effectiveness/cost-benefit analysis.

Of the six programs, only the CPNP evaluation undertook a comparative assessment in order to draw conclusions about costs and benefits relating to program impacts. It should be noted that undertaking a cost-effectiveness study was not the focus of two of the six evaluations reviewed (PHF and Falls), due to the formative nature of the evaluations.

In the case of the CPNP evaluation, it found that assessing cost-effectiveness from an intervention-specific focus, rather than from a national perspective, may provide a clearer indication of what worked — and what did not work. This may provide more meaningful evidence not only about program management practices, but also about the effectiveness of the intervention.

It is important to note that the methods used to evaluate cost-effectiveness varied across programs, and were not always consistent with the Treasury Board Secretariat approach to assessing program costs and benefits (see discussion below). As acknowledged elsewhere in this report, the evaluations were not designed to provide the comprehensive impact data needed to support such an analysis. Although the evaluation reports implied that observed effects can be attributed to these programs (see the section on *Methodology*), accepted attribution methodologies were not applied.

> ***Lesson Learned***
>
> Program effects must be understood before a cost-effectiveness or cost-benefit analysis can be conducted (without accurate effectiveness or cost data, cost-effectiveness ratios cannot be developed).

Understanding Cost-effectiveness in the Context of Promotion of Population Health Evaluations

Cost-effectiveness and cost-benefit analysis are the two most common methods used to assess the

program effectiveness (programs should obviously aim to produce benefits that outweigh their costs). The Evaluation Framework for Promotion of Population Health defines cost-effectiveness and cost-benefit analysis in the following manner: observations on cost-effectiveness, funds and resources leveraged, and related published literature on cost-effectiveness. This is a reflection of the availability of information for each of the evaluations reviewed. Thus, the cost-effectiveness studies undertaken in each of the six evaluations differ from what might be achieved using the TBS definition: "In cost-effectiveness analysis, program results in some non-monetary unit, such as lives saved, are compared with program costs in dollars. In the case of cost-benefit analysis, program benefits are transformed into monetary terms and compared to program costs."[16] This type of cost-effectiveness study whereby program affects are identified in relation to program costs, was not applied to any of the evaluations with the exception of CPNP.

2.6 Summary of the Integrated Analysis

The programs included in this evaluation synthesis appear to have made progress toward achieving their immediate outcomes of increased partnership and collaboration, capacity building and knowledge development and dissemination. This is evidenced by progress reported in developing new partnerships, increasing the capacity of organizations and individuals, and building knowledge on a given health issue to affect behaviour change. One evaluation did undertake to assess population-level outcomes in their target community (CPNP).

All six programs have been able to respond to the needs of their target groups. The ability of programs to engage target populations and stakeholders in program implementation and to develop new knowledge and information are cited as notable successes. Further work is required in other areas, such as increasing the coordination of resources and establishing clearer national program directions and measurement strategies.

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[16] For a detailed discussion of the TBS definition of cost-effectiveness, see *Measurement and Attribution of Program Results*. Chapter 5: Analytical Methods (5.6 Cost-benefit and cost-effectiveness Analysis). Treasury Board of Canada Secretariat. Third Edition, March 1998.

PART C: FUTURE DIRECTIONS

Challenges commonly faced by programs in adequately assessing the impacts of their activities were identified throughout this review.

There is considerable debate inside federal government departments and throughout central agencies about the merits of grants and contributions funding. In order to be able to provide clear answers to questions being raised about the distribution of grants and contributions funds and the impacts funded programs may have on health status, a more rigorous approach to evaluation is needed. It is clear that the current approach to program evaluation (which is common across the federal government) is not providing answers to questions being raised about program impact and effectiveness.

Use of Terminology and Process Issues

Common terminology and approaches for conducting evaluations are not well articulated by a range of actors that participated in these evaluations, including the evaluators themselves. Future evaluation activities in the branch could seek to ensure that evaluation concepts are properly explained and applied. This will help avoid unrealistic expectations as to the level of analysis that will be provided in evaluations.

Program personnel (those responsible for developing evaluation frameworks and conducting evaluations) do not require all of the skills to do the work, but they do need to know where to go for help. This implies the need for better linkages between the department's policy development, program management, evaluation and communication functions to ensure a systematic approach, improved quality and an appropriate focus for future evaluations. This will not only strengthen the evaluation function but also contribute to efficient Branch operations and effective decision-making.

PPHB can also strengthen its organizational capacity to be engaged in evaluation processes by relying less on external evaluation consultants. Consultants play a critical role in evaluating Promotion of Population Health programs, but they cannot represent the entire solution to the Branch's evaluation needs. The Branch has a role to play in guiding evaluations to ensure that there is stable evaluation capacity and that programs and evaluators are gathering the information needed to properly evaluate programs, and are analyzing this information appropriately as part of a continuous learning and improvement journey to improve health outcomes for Canadians.

Narrowing the Focus of Evaluations

This synthesis exercise has also made it clear that the Branch's evaluations are examining too many issues. Most studies are centred around the four standard evaluation issues suggested by the TBS (i.e., relevance, implementation, outcome achievement and cost-effectiveness). The examination of any one of these issues can be a huge and significant undertaking; studying all

four at once is extremely challenging and requires evaluation budgets, capacities and methodologies that far exceed those available for or used in these studies.

Evaluations could be made most useful by focussing on single, key issues in order to be more productive and useful. Otherwise, evaluations will continue to generate little knowledge about a lot of issues, rather than a lot of knowledge about a single issue. In other words, the depth of an evaluation is more important than its breadth. This means that the approach for conducting evaluations may have to move beyond the standard mid-term/final review approach currently prescribed by the Treasury Board Secretariat to a new model — a rolling evaluation agenda that examines key programmatic issues, rather than all issues at once.

This raises questions about the continued relevance of conducting "program" evaluations. Is it feasible to assess the effectiveness of a complex program with diverse priorities, activities and outcomes through a single effort, or should the Branch be breaking down the issues, as well as the components of the programs, to do better evaluations? A more productive approach may be to identify and examine issues that cut across programs/components (i.e., horizontal evaluations).

Furthermore, it must be recognized that evaluations are not the panacea to Health Canada's information and decision-making needs. Good evaluation information, while critical, is only one input to the policy-making process. Political issues, departmental priorities and other factors must also be taken into consideration.

Measuring Progress Toward Health Outcomes

As noted earlier, the evaluations focussed on assessing progress toward each program's immediate outcomes but did not examine the connection between immediate outcomes and health outcomes. This gives rise to three questions: Are these programs actually affecting long-term health outcomes; and could PPHB be using different models of program design? Is it realistic to expect that a change in health outcomes could be discernable in as little at 2-5 years?

While the ultimate health outcomes of individual projects funded by Health Canada can be observed within the project's life cycle, at the national level, it is important to acknowledge that the long-term outcomes of the programs examined in the synthesis are best understood in longer time periods (e.g. five-to-eight year periods). It should also be noted that there are several challenges in assessing the results of activities and attributing them exclusively to federally funded programs. There are a number of reasons for this:

- It takes time for reporting and surveillance systems to collect, analyze and report macro-level data (e.g., new national estimates for HIV/AIDS are reported every three or four years). While macro data may be continually updated, it does not reflect the current picture given the time lag (1999 epidemiological data for HIV/AIDS were not published until 2002). This makes it difficult to estimate program effects on macro data.

- Forging causal connections between program actions and health outcomes, given the many other variables at play - particularly when evaluating actions at the community-level, needs to be considered in the social, political, economic and cultural context in which a program is being implemented.

- Because Health Canada funded projects vary greatly, both within and across programs, there are significant challenges when attempting to aggregate individual project results to the national picture. Programs fund a variety of different types of interventions, some of which appear to work well and others less so.

- These challenges are further compounded (as clearly illustrated within five of the six evaluations) by a lack of systemic project data-collection processes and systems. It is therefore difficult to generalize the effects of specific interventions across entire programs.

Health Canada is working to address these issues, for example through national tracking of CSHA-funded projects and by enhancing the department's analytical capacity to examine existing data (a CPNP initiative).

Identifying specific and effective client-focussed interventions could be a key PPHB role in future programming. This could be done through the development of pilot projects whose primary goal would be to determine the effectiveness of certain types of interventions prior to national implementation. Examples currently exist of pilot initiatives that could inform intervention research across Canada.[17]

The application of best practice knowledge for Health Canada programs could lead to the establishment of common monitoring and evaluation practices that allow for shared approaches and processes in evaluation, and ultimately employ effective methods in building the evaluation evidence-base. This can include, for example, the development of evaluation frameworks that link project-level activities and outcomes to program evaluations. Building this evidence-base will improve the Department's ability to understand the overall program contributions to health outcomes.

Assessing the Impact of Individual Projects

The program evaluations reviewed for this synthesis generally did not document or systematically account for the effects of funded projects on target populations. Rather, the evaluations examined population- and organization-level impacts. How many Canadians are accessing projects funded by Health Canada's Promotion of Population Health programs, and who are these individuals?

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[17] The Canadian Heart Health Initiative (CHHI), for example, undertook to develop a process evaluation framework that could be useful for evaluating similar community-based efforts. The framework includes a number of core indicators that were collected by all provincial heart health programs. This framework has also been adapted and used by World Health Organization programs.

The evaluations generally do not provide this information. More information is required on program services provided and accessed in order to better understand the causal connections between immediate outcomes (e.g., partnerships, collaboration, capacity) and intermediate and long term outcomes (e.g., awareness, improved health practices and health status). Future evaluation work needs to explore these connections if we are to better understand the impact of Health Canada programs. This points to the need for stronger program design and improved implementation of the program evaluation function. Ultimately this requires a clear understanding of how (i.e., the the cause and effect) an intervention is expected to bring about the intended outcomes. It also points to the need to strengthen evaluation methodologies and establish pre-program baselines or other reliable points of comparison for assessing program impacts.

The CPNP is a notable exception; according to the evaluation, an estimated 100,000 plus women accessed projects over the 1995-2002 period. The Branch can build on the lessons learned from this example and systematically apply it to other programs. Without reliable access data, the causal connections between partnerships, capacity and knowledge development cannot be reliably linked to increased awareness, improved health practices and health outcomes. Future evaluation work needs to improve understandings and further explore these connections if Health Canada is to better comprehend the impact of its programs.

This points to the need for stronger evaluations of project outcomes. Are Canadians who are accessing CSHA-funded projects practising safe sex or using other harm reduction measures? Are seniors falling less as a result of their participation in projects supported by the Falls Prevention Initiative? Do Canadians in rural areas have access to better health services? Are pregnant women who participate in CPNP projects eating healthier, and what is the impact on newborns? Answering these questions, and others like them, will give Health Canada a better understanding of its contribution to the long-term outcomes identified by Promotion of Population Health programs.

In other words, the department needs to invest in understanding the effectiveness of community interventions supported by federally funded programs, in particular by testing and implementing reliable and valid methods and tools that facilitate assessing such interventions. PPHB has already undertaken to build departmental knowledge in this area through the Effectiveness of Community Interventions Project. Evaluation practices are also being improved through the development of an “umbrella” Results-based Management and Accountability Framework, which links several programs under a single performance management framework.

In the meantime, programs need to be well-equipped for developing strong project evaluations. The areas highlighted in the executive summary of this report target several areas for enhancement and allude to the systemic challenges of effectively undertaking evaluations. A common performance management system - one which facilitates a sound information platform for evaluations and links to a broad program/branch evaluation framework (RMAF) and to promotion of population health objectives, will ensure evaluations are made most informative

and useful from the decision-makers point of view. Without this information, Health Canada is unable to communicate to partners, stakeholders, Parliament and the Canadian public on the impacts of its funded work. This is the challenge before us.

APPENDICES

Appendix A: Program Descriptions

Canada Prenatal Nutrition Program

Program Rationale: The Canada Prenatal Nutrition Program is a comprehensive program designed to provide food supplementation, nutrition counselling, support, referral and lifestyle counselling to pregnant women who are most likely to have unhealthy babies. The Program provides long-term funding to community organizations to enable the provision of such services and supports to pregnant women facing conditions of risk that threaten their health and the health of their newborn babies.

Strategic Objectives: The objectives of this program are to:

- increase the proportion of babies born with healthy birthweights;
- improve the health of both infant and mother; and
- encourage breastfeeding.

Activity Areas:

- One-on-one and group prenatal nutrition counselling.
- Food supplements.
- Collective kitchens.
- Peer counselling on lifestyle issues/social support.
- Education.
- Resource mothers.
- Breastfeeding education and support.
- Referral services.
- Post-partum support.

Target Groups: The CPNP targets those women most likely to have unhealthy babies due to poor health and nutrition and pregnant women and their infants facing conditions of risk (defined as women living in poverty; pregnant teens; women who use alcohol, tobacco or other harmful substances; women living in violent situations; recent immigrants; Aboriginal women; and women living in geographic or social isolation or with limited access to services).

Partners: The CPNP is jointly managed by the federal government and provincial/territorial governments. Administrative protocols, established for the Community Action Program for Children, set out how the program will be managed in each province/territory. Projects are delivered in partnership with community organizations such as Rotary Clubs, food banks, high schools, school boards, aboriginal organizations, physicians, public health departments/Regional Health Authorities, religious groups and professional organizations such as the Canadian Dietetic Association.

Stakeholders: Child and maternal health agencies/institutes; provincial and territorial governments; Aboriginal communities; and other key stakeholders, including families and affected individuals.

Budget: The CPNP was launched in 1994 with a budget of $85M over four years (supplementary estimates and adjustments resulted in additional funding over the four years). As of 2002-03, the budget for the non-reserve portion of the program is $30.8M. Of this amount, $27M goes directly to communities in the form of grants and contributions.

Regional Component: The CPNP is delivered through PPHB's regional offices, which fund community groups to deliver services.

Canadian Strategy on HIV/AIDS

Program Rationale: The Canadian Strategy on HIV/AIDS, which replaced the previous National AIDS Strategies (NAS I and NAS II), represents a shift from a disease-oriented approach to one that looks at the root causes, determinants of health and other dimensions of the HIV epidemic. The CSHA emphasizes a pan-Canadian approach that encourages the engagement of all levels of government and all sectors of society in the effort against HIV/AIDS.

Strategic Objectives: Funds are allocated to the following strategic areas:

- prevention;
- community development and support to national NGOs;
- care, treatment and support;
- research;
- surveillance;
- international collaboration;
- Aboriginal communities;
- legal, ethical and human rights issues;
- HIV/AIDS among inmates in federal penitentiaries; and
- consultation, evaluation, monitoring and reporting.

Activity Areas:

- Developing and disseminating information.
- Developing policies, guidelines, programs and training manuals.
- Funding projects.
- Developing and fostering collaboration and partnerships.
- Delivering services.

Target Groups: Persons living with HIV/AIDS or at risk of HIV infection and program partners/stakeholders.

Key Partners: Health Canada, Correctional Service Canada, CIHR, Canadian International Development Agency and NGOs (Canadian Aboriginal AIDS Network, Canadian AIDS Society, Canadian AIDS Treatment Information Exchange, Canadian Association for HIV Research, Canadian Foundation for AIDS Research, Canadian Public Health Association, Canadian HIV/AIDS Legal Network, Canadian HIV Trials Network, Canadian Treatment Advocates Council, Interagency Coalition on AIDS and Development and International Council of AIDS Service Organizations).

Stakeholders: NGOs; federal departments and agencies; provincial/territorial governments; community-based organizations and networks; academics; researchers; health professionals; Aboriginal groups; and persons living with HIV/AIDS or at risk of HIV infection.

Budget: Funding for the CSHA was set at $42.2M per year for five years (FY 1998-99 to 2002-03), to be administered by Health Canada ($41.6M) and Correctional Service Canada ($0.6M). Grants and contributions account for $29.864M of these funds per year. CIHR was allocated $10,225,000 in 2002-03 under the Strategy, leaving Health Canada to administer $31,375,000.

Regional Component: PPHB's regional offices play a vital role in program delivery and in improving collaboration among all levels of government, communities, NGOs, professional groups, institutions and the private sector.

Falls Prevention Initiative

Program Rationale: The Falls Prevention Initiative is a joint venture of Health Canada and Veterans Affairs Canada. Established in August 2000 to address the health problems of falls among Canadian seniors and veterans, the Falls Prevention Initiative provides time-limited funding to sustainable community-based projects that have the primary objective of promoting the independence and quality of life of veterans and seniors by preventing the number and/or reducing the severity of falls.

Strategic Objectives: The objectives of the Falls Prevention Initiative are to:

- assess the health status impact of funded intervention projects and their potential for improving quality of life and reducing health care utilization and costs;
- gather, synthesize and disseminate evidence regarding falls prevention interventions and their impact on an aging population;
- identify the most promising models of intervention for falls prevention directed at the target population;
- understand the barriers and facilitators to developing sustainable community partnerships for effective falls prevention programs;
- increase the involvement of, and promote new partnerships between, the VAC target group and other seniors in Promotion of Population Health community programs and initiatives; and

- promote the population health approach within the target community of veterans and seniors.

Activity Areas:

- Partnership development.
- Falls prevention projects.

Target Groups: Community-dwelling veterans and seniors and their caregivers; organizations providing services to seniors and veterans.

Partners: Health Canada, Veterans Affairs Canada and their regional offices in Atlantic Canada, Ontario and British Columbia.

Stakeholders: Seniors' and veterans' organizations; Health Canada's Division of Aging Seniors (PPHB); Veterans Affairs Canada; community-based organizations working on falls prevention; and other NGOs interested in the study of falls prevention.

Budget: $10 million over four years (August 2000 to March 31, 2004). Grants and contributions funding breaks down as follows: $2.217M in 2001-02, $2.217M in 2002-03 and $1.801M in 2003-04.

Regional Component: The Falls Prevention Initiative is being piloted in three regions: Atlantic, Ontario and British Columbia.

Hepatitis C Prevention, Support and Research Program

Program Rationale: The Hepatitis C Prevention, Support and Research Program was created following the release of the report of the Krever Commission, which explored the safety of Canada's blood supply. As part of its response to this report, the federal government committed to develop new programs related to hepatitis C and to support research on hepatitis C.

Strategic Objectives: The objectives of this program are to:

- contribute to the prevention of hepatitis C;
- support persons infected with and affected by hepatitis C;
- provide a stronger evidence base for hepatitis C policy and programming decisions and advance prevention, treatment and care options by expanding the body of available research and Canada's research capacity; and
- strengthen the response of the Canadian population to hepatitis C through increased awareness and capacity.

Activity Areas:

- Consultation and liaison with hepatitis C stakeholders.
- Developing strategic directions and priorities.
- Funding projects for prevention, support and research.
- Developing and disseminating information.

Target Groups: Primary target group is those infected with, affected by or at risk of contracting hepatitis C (high-risk groups include injection drug users (IDUs), street youth, Aboriginal people and inmates). A secondary target group is individuals or organizations providing services to these primary clients.

Partners: CIHR, Office of Canada's Drug Strategy, Correctional Service Canada and NGOs (Hepatitis C Society of Canada, Canadian Hemophilia Society, Canadian Liver Foundation, Thalassemia Foundation of Canada, Canadian Public Health Association, Canadian Centre for Substance Abuse and Canadian Association for the Study of the Liver).

Stakeholders: Primary and secondary target groups, as well as the general public.

Budget: $50M over five years (FY 1999-00 to 2003-04). These funds are allocated across five components: Management, Policy and Public Involvement ($4.47M); Prevention ($4.9M); Community-Based Support ($18.06M); Care, Treatment and Support ($8.43M); and Research ($14.13M). Grants and contributions funding was $1.095M in 1999-00, $3.713M in 2000-01, $3.887M in 2001-02, $3.887M in 2002-03 and $3.236M in 2003-04.

Regional Component: The program is administered by PPHB staff in seven regions: British Columbia, Alberta, Manitoba/Saskatchewan, Quebec, Ontario, Atlantic and the Northern Secretariat (Northwest Territories, Yukon and Nunavut).

Population Health Fund

Program Rationale: Health Canada has adopted a population health approach to further its continuing mandate to maintain and improve the health of Canadians. The population health approach integrates action on or across a broad range of determinants that affect the health of all Canadians (e.g., social and economic factors, individual lifestyle choices, availability of health services). To support this approach, the Population Health Fund was created in April 1997 to increase community capacity for action on or across the determinants of health (the Fund replaced a number of grants and contribution programs established under sunsetting strategies).

Strategic Objectives: The objectives of the PHF are to:

- develop community-based models for applying the population health approach;
- increase the knowledge base for program and policy development on population health; and
- increase partnerships across sectors to address the determinants of health.

Activity Areas:

- Promotion of Population Health.
- Disease (and injury) prevention.
- Risk management.
- Policy coordination.
- Medical treatment.
- Rehabilitation.
- Palliative care.

Target Groups: All Canadians.

Partners: Academics and researchers, Canadian Institute for Advanced Research, Canadian Institute for Health Information, Canadian Population Health Initiative, Canadian Consortium for Health Promotion Research and CIHR.

Stakeholders: Lobby groups; national NGOs (e.g., Canadian Cancer Society) and their provincial chapters; provincial/territorial and municipal governments; community, regional, provincial and territorial organizations; project participants; the voluntary sector; Statistics Canada; Human Resources Development Canada; Veterans Affairs Canada; Interdepartmental Reference Group on Population Health; and federal/provincial/territorial advisory committees (e.g., Advisory Committee on Population Health, Advisory Committee on Health Services and Advisory Committee on Health Human Resources).

Budget: From its inception in 1997-98 through to 1999-00, the PHF had an annual budget of $15M, of which $14.6M was allocated to grants and contributions. Since 2000-01, the Fund's annual budget has been $15.375M, of which $14.97M is allocated to grants and contributions.

Regional Component: Provincial/territorial, regional or local projects are administered through PPHB's regional offices. The Population Health Fund Section at Health Canada headquarters is responsible for national projects.

Rural and Remote Care Component, Innovations in Rural and Community Health Initiative

Program Rationale: The Rural and Remote Care Component of the Innovations in Rural and Community Health Initiative was established to contribute to the "building blocks" of a rural health strategy by facilitating and supporting the development of information, resources and models for improving the health of Canadians living in rural and remote communities.

Strategic Objectives: The RRCC was designed to address the complexity surrounding the range of factors or determinants that affect the health of Canadians. Key objectives include:

- better meeting the health needs of Canadians living in rural and remote communities;
- improving the quality and accessibility of home and community care as an integral component of an integrated health system;
- improving Canadians' access to drugs and the affordability and sustainability of drug plans; and
- improving the integration and quality of health services across the entire health system.

Activity Areas:

- Strategic management and coordination.
- Knowledge development.
- Awareness building.

Target Groups: Those most likely to be affected by and/or benefit from the Component's activities and outputs; residents of rural and remote communities; and rural health providers.

Partners: Other federal departments and relevant agencies and Health Canada's regional offices.

Stakeholders: Canadians living in rural and remote communities; policy and program staff of Health Canada and other federal government departments and agencies; provincial/territorial officials; research organizations; rural and remote care providers; and NGO's with an interest in the health of Canadians.

Budget: The RRCC received funding of $16M over three years (FY 1999-00 to 2001-02). Of this amount, $11M was for grants and contributions to fund projects in rural areas. These funds were administered by a national steering committee.

Regional Component: Regional offices provide liaison with provincial/territorial governments.

Appendix B: Evaluation Synthesis Work Plan

Detailed Evaluation Synthesis Activities: March 2003 – July 2003		
Work Plan Step	**Activity**	**Description of Tasks**
April 1 – May 15, 2003: Information Collection and Synthesis		
Steps One and Two	**Information/data collection on programs and information synthesis**: - *Document and select information sources.* - *Complete evidence source summary table (attached).* - *Complete program characteristics table.* **Information synthesis** *Summarize/synthesize the information.*	• Pilot data collection templates with selected evaluation report(s). • Develop evaluation review protocol. • Identify and obtain evidence/research findings (gather program literature, including performance reviews, annual reports, published and unpublished documentation etc.). • Build the body of evidence on supportive literature for potential impact of key health promotion interventions (projected savings etc.). • Accumulate evidence related to past and current practice of proven interventions (across populations, locations, etc.) that takes into account health promotion values, theories, and beliefs. This should include evidence on the relationship between results/outcomes and processes. • Describe the generic evaluation approach used across programs. • Summarize findings and describe achievement of objectives and key results.
May 15 – June 15, 2003: Analysis of Findings		
Steps Three and Four	**Analysis of findings:** - *Analyze the information and generalize to health promotion results.*	• Assess evidence from reviews/syntheses of evidence for outcomes of each program. • Analyze state of the evidence base, data gaps, strengths, deficits, recommendations for future assessments. • Identify factors contributing to program success/failure. • Identify key lessons learned. • Identify tools that exist or need to be developed to obtain/collate/synthesize additional data.

<table>
<tr><th colspan="3">Detailed Evaluation Synthesis Activities: March 2003 – July 2003</th></tr>
<tr><th>Work Plan Step</th><th>Activity</th><th>Description of Tasks</th></tr>
<tr><td colspan="3">June 15 – July 30, 2003: Report Writing and Consultation</td></tr>
<tr><td rowspan="2">Step Five</td><td rowspan="2">Writing of Storyline/Establish Policy Relevance of Findings:

(See Draft Table of Contents below)

- Report on findings.
- Recommendations for future evaluation studies and RMAF evaluation strategy.
- Implications for promotion of population health Terms and Conditions Renewal.
- Health Promotion program and policy recommendations.</td><td>Report Writing
• Introduction.
• Objectives of synthesis evaluation, purpose and scope.
• Accurately reflect relevant findings in recommendations.
• Analysis of data collected.
• Findings and recommendations.
• Best practice decisions according to the literature reviewed.
• Describe learnings relevant to health promotion.
• Reflect concerns of relevant stakeholders.
• Identify new questions that arise out of our evaluation for which we want to seek evidence.</td></tr>
<tr><td>Consultation Process
• Distribute draft report to Project Team July 5.
• Project Team to provide comments
• Re-written draft to be distributed to Evaluation Synthesis Working Group (ESWG) July 20.
• Face-to-face consultation of ESWG July 30.
• Final draft to be distributed to Project Team, Management and Program Services Directorate management and ESWG August 5.
• Final revised draft to be sent to project authority for approval August 15.</td></tr>
</table>

Appendix C: Primary and Secondary Review Teams

Program Evaluation	Primary Reviewer	Secondary Reviewer
Canadian Strategy on HIV/AIDS	Monika Gupta	Nancy Hajal
Hepatitis C Prevention, Support and Research Program	Jennifer Davidson	Fowsia Abdulkadir
Canada Prenatal Nutrition Program	Nancy Hajal	Jennifer Davidson
Health Canada/Veterans Affairs Canada - Falls Prevention Initiative	Fowsia Abdulkadir	Geoff Cole
Population Health Fund	Fowsia Abdulkadir	Geoff Cole
Rural and Remote Care Component of the Innovation in Rural and Community Health Initiative	Nancy Hajal	Geoff Cole

Appendix D: Key Performance Management and Evaluation Terms and Definitions

Most of the definitions provided here are drawn from the TBS lexicon. For definitions of other related performance measurement terms, consult the lexicon at http://www.tbs-sct.gc.ca/eval/pubs/RMAF-CGRR/rmafcgrr05_e.asp.

Accountability: The obligation to demonstrate and take responsibility for performance in light of agreed expectations. There is a difference between responsibility and accountability: responsibility is the obligation to act, whereas accountability is the obligation to answer for an action.

Activity: An operation or work process internal to an organisation, intended to produce specific outputs (e.g. products or services). Activities are the primary link in the chain through which outcomes are achieved.

Attribution: The assertion that certain events or conditions were to some extent, caused or influenced by other events or conditions. This means a reasonable connection can be made between a specific outcome and the actions and outputs of a government policy, program or initiative.

Cost-effectiveness: The extent to which an organization, program, etc. is producing its planned outcomes in relation to expenditure of resources.

Effect: Effect, like *impact*, is a synonym for *outcome*, although impact is somewhat more direct than an effect. Both terms are commonly used, but neither is a technical term. For technical precision, Treasury Board Secretariat recommends that outcome be used instead of effect.

Effectiveness: The extent to which an organization, policy, program or initiative is meeting its planned results.

Efficiency: The extent to which an organization, policy, program or initiative is producing its planned outputs in relation to expenditure of resources.

Evaluation: The systematic collection and analysis of information on the performance of a policy, program or initiative to make judgements about relevance, progress or success and cost-effectiveness and/or to inform future programming decisions about design and implementation.

Final Outcome: These are generally outcomes that take a longer period to be realized, are subject to influences beyond the policy, program or initiative, and can also be at a more strategic level.

Goal: A general statement of desired outcome to be achieved over a specified period of time. The term goal is roughly equivalent to *strategic outcome*. For technical precision, Treasury Board Secretariat recommends that strategic outcome be used instead of goal. (See also *objective*).

Horizontal Result: An outcome that is produced through the contributions of two or more departments or agencies, jurisdictions or non-governmental organizations.

Impact: Impact, like *effect*, is a synonym for *outcome*, although an impact is somewhat more direct than effect. Both terms are commonly used, but neither is a technical term. For technical precision, Treasury Board Secretariat recommends that outcome be used instead of impact.

Indicator: A statistic or parameter that provides information on trends in the condition of a phenomenon and has significance extending beyond that associated with the properties of the statistic itself.

Indicator, comparable: A comparable indicator is an indicator based on common baseline information, definitions and database collection, and a compatible reporting system. This term is expressly used in relation to the Social Union Framework Agreement.

Input: Resources (human, material, financial, etc.) used to carry out activities, produce outputs and/or accomplish results.

Logic model: An illustration of the results chain or how the activities of a policy, program or initiative are expected to lead to the achievement of the final outcomes. The logic model is usually displayed as a flow chart. (Also referred to as Results-based Logic Model.)

Objective: The high-level, enduring benefit towards which effort is directed. The term is roughly equivalent to *strategic outcome*. For technical precision, Treasury Board Secretariat recommends that strategic outcome be used.

Outcome: An external consequence attributed to an organization, policy, program or initiative that is considered significant in relation to its commitments. Outcomes may be described as: immediate, intermediate or final, direct or indirect, intended or unintended. (See also *Result*).

Output: Direct products or services stemming from the activities of a policy, program or initiative, and delivered to a target group or population.

Performance: How well an organization, policy, program or initiative is achieving its planned results measured against targets, standards or criteria. In results-based management, performance is measured and assessed, reported and used as a basis for management decision-making.

Performance measure: An indicator that provides information (either qualitative or quantitative) on the extent to which a policy, program or initiative is achieving its outcomes.

Performance measurement strategy: Selection, development and ongoing use of performance measures to guide corporate decision-making. The range of information in a performance measurement strategy could include: reach; outputs and outcomes; performance indicators; data

sources; methodology and costs.

Performance monitoring: The ongoing process of collecting information in order to assess progress in meeting strategic outcomes, and if necessary, provide warning if progress is not meeting expectations.

Performance reporting: The process of communicating evidence-based performance information. Performance reporting supports decision-making, serves to meet accountability requirements and provides a basis for citizen engagement and a performance dialogue with parliamentarians.

Planned results (targets): Clear and concrete statement of *results* (including outputs and outcomes) to be achieved within the time frame of parliamentary and departmental planning and reporting (one to three years), against which actual results can be compared.

Reach: The individuals and organizations targeted and directly affected by a policy, program or initiative, also defined by the target group being reached.

Result: The consequence attributed to the activities of an organization, policy, program or initiative. Result is a general term that often includes both outputs produced and outcomes achieved by a given organization, policy, program or initiative. In the government's agenda for results-based management and in Results for Canadians, the term result refers exclusively to outcomes.

Results-based management: A comprehensive, life cycle approach to management that integrates business strategy, people, processes and measurements to improve decision-making and drive change. The approach focusses on getting the right design early in a process, implementing performance measurement, learning and changing, and reporting performance.

Results-based Management and Accountability Framework (RMAF): A document that serves as a blueprint for managers to help them focus on measuring and reporting on outcomes throughout the life cycle of a policy, program or initiative.

Strategic outcomes: The long-term and enduring benefits to Canadians that stem from a department's vision and efforts. These outcomes describe the difference a department is mandated to make. In most cases, these outcomes will require the combined resources and sustained effort of several partners over a long period of time. Most importantly, however, progress toward these outcomes will require, and Canadians will expect, the leadership of a federal department or agency.

Promotion of Population Health

Evaluation Synthesis Program Evaluation Review Protocol

Population and Public Health Branch
Health Canada

Background

The aim of this review is to contribute to the synthesis of research findings from six evaluation reports that summarize program impact and effects. Synthesis research is defined as the identification, review, analysis, and appraisal of the best available existing knowledge. Synthesis research should be as comprehensive as possible and should:

- Align with population health concepts (Health Canada, 2001);
- Include published literature, unpublished literature, the practical experience of policy/decision makers and/or the knowledge of multi-disciplinary practitioners and experts in the field; at global, international, national, provincial/territorial levels; and from a variety of discipline-specific perspectives (for example, databases such as Psychlit, ERIC, Soc Sci Cit Index and MEDLINE should be searched).

Objectives of the evaluation synthesis are:

- To identify program accomplishments and common outcomes;
- To demonstrate effectiveness (impact) and efficiency (value for money)
- To assess how the results affect program implementation practices; and
- To identify areas of enhancement to improve the program delivery practices;

Approach

The following evaluation synthesis protocol is based on the above definition of the evaluation synthesis and is consistent with Health Canada's standards and recommended approaches to evaluation in decision-making.[18] The protocol is also based on the *Evaluation Framework for Promotion of Population* Health[19] to guide reviewers in their systematic collection and analysis of data from program evaluations. Recommendations found in the "*Program Evaluation Tool Kit*" among other guidance documents were also used to guide this review.[20]

Review Protocol

The Protocol was informed by existing guides ('checklists' or criteria) for evaluating reports on health promotion interventions. Existing guides addressed core aspects of critically appraising

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[18]See Health Canada's "Evaluation Policy" (2002) and "Criteria Assessment Guide" (2003), Departmental Program Evaluation Division, Information Analysis and Connectivity Branch, Health Canada.

[19] *Evaluation Framework for Promotion of Population Health*, Population and Public Health Branch, Health Canada (March 2003).

[20]*A Schema for Evaluating Evidence on Public Health Interventions*, National Public Health Partnership, School of Public Health, University of Australia (Version 4, April 2002).

evaluations, including the rigour of the evaluation (methods and data collection) as well as the health promotion intervention being evaluated (settings, context, program delivery elements). The issues covered and the information collated will be of interest to those individuals (researchers, planners, policymakers) and organizations (NGO's, other levels of government) working in the area of health promotion engaged in the development, implementation and utilization of evaluation studies.

Validation Process

In addition to reviewing the relevant literature to inform this Protocol, consultations were carried out with Health Canada colleagues in the Departmental Program Evaluation Division. Implementation of the Protocol involved pilot testing the first draft using one of the evaluation reports under review for the Evaluation Synthesis. The research team reviewed those findings and further refined the Protocol, recognizing that as the additional reviews were completed, the Protocol would be considered a "work in progress."

Instructions for Completing the Protocol:

1. Each section of the protocol should be completed.
2. If the information is not contained in the evaluation study, note this gap with 'N/A'.
3. Where information is captured in the evaluation on indicators that were not part of the Evaluation Synthesis Framework, note these information sources with an '*'.
4. Findings should be noted in bullet form.
5. Each evaluation study should be reviewed by two members of the project team to increase assessment validity (see primary and secondary reviewers list).

Program Evaluation (Title):

Health Canada Evaluation Lead:
***Evaluation consigned to**:*
Evaluation Study Initiated:
Evaluation Study Completed:

***Evaluation Report Reviewed By**:*
***Date Review Completed**:*

Reviewers overall assessment of the evaluation, including strengths, limitations, and gaps in the evidence:

Considerations/Criteria used to evaluate evidence (e.g. study design, context)

Weaknesses/Study Limitations:

Strengths:

Recommendations/Suggested Improvements:

***Summary of key findings and lessons learned through the evaluation**:*

Overall Assessment of Methodology
□ Weak □ Fair □ Excellent

Rationale for this assessment:

A. Program Characteristics

Program Start Date:
Program End Date:

Budget

Allocated Funds/Year:
G and C Funds/Year:

Structure

1. **Does the Program have a Regional Component:** ☐ **Yes** ☐ **No**

Describe:

2. **Key Program Partners (including Federal Departments and NGOs):**

3. **Program stakeholders:**

4. **Program target groups**:

Program rationale

1. **What did the program set out to do? (Key outcomes - immediate, intermediate, long-term):**

Purpose of the Program:

Key Objectives:

Activity areas:

Project priorities:

Population/Determinants of Health Approach:

1. Is the application of the key elements of the population health approach incorporated in program design and delivery?

1.b. If so, describe how the population health approach applies/how this is demonstrated through each of the following key elements?

1. **Focus on the health of populations**:
2. **Address the determinants of health and their interactions**:
3. **Base decisions on evidence**
4. **Apply multiple strategies**:
5. **Employ mechanisms for multiple involvement**
6. **Collaborate across sectors and levels**:
7. **Increase upstream investments**
8. **Demonstrate accountability for health outcomes**

B. Evaluation Study Context

1. Why was the evaluation study undertaken?

2. How will the results be used? (Evaluation objectives and issues):

3. What are the key evaluation issues are being examined? (What were the evaluation assessment criteria)?

4. Timing and Costing

4a. What were the key milestones in the evaluation from the date it was initiated?

4b. What was the cost for completing the evaluation?
FTE:
Contract:
Other:

5. Evaluation planning

5.a. Was an evaluation framework completed? ☐ Yes ☐ No
5.b. Did the evaluation framework identify the information necessary to successfully complete the evaluation? (Questions, indicators, data sources) ?
☐ Yes ☐ No
Explain:

C. Evaluation Study Methodology

1. Evaluation Study is:
□ Ex ante (before the fact) □ Ex poste (after the fact)

2. Evaluation Study is:
□ Mid-Term □ Final □ Other (e.g. progress report): _______

3. Evaluation Study is:
□ Formative (descriptive, focus on process) □ Both Formative and Summative
□ Summative (focus on impact, reports on outcomes)

Methods Used

4. Data types used
□ Primary (observations, surveys, interviews, experiments to gather information about demographic/socioeconomic characteristics, attitudes/opinions/interests, awareness/knowledge, intentions, motivation, and behaviour).

□ Secondary (other research, lit. review, epidemiological or administrative data etc.)
□ Both

5. Data sources
Qualitative
□ Descriptive □ Inferential □ Content
Quantitative
□ Bi/Multi-variate (examining relationships between 2 or more variables)

Describe:

6. The methodology design includes:
□ Pre/Post □ Time Series □ Comparisons □ Other □ None

7. Data collection techniques (e.g. literature reviews, surveys, case studies):

8. Qualitative Data Sources (interviews, observation, written documents):

☐ Program files ☐ Key program stakeholders ☐ Program clients
☐ Issue literature ☐ Partner organizations ☐ Case Studies
☐ All ☐ Other

Describe:

9. Quantitative Data Sources

☐ Experiments ☐ Correlational studies using surveys
☐ Simulations ☐ None

10. Data Collection Methods and Description:

Method	Source and description	Method Critique
(e.g,) Key Informant Interviews		
Surveys		
Literature Review, including document and database review		
Case Studies and Focus Groups		

Evaluation Question #1: Relevance - Is there a continuing need for federal involvement?	
Indicator	**Evidence/Finding**
Rationale for the Program Evidence of nature and magnitude of the problem (costs to Canadians, health system), evidence in literature of (potential) impact of programming (Key issues, trends, risk factors).	
Government/political priorities and stakeholder perception on identified need.	

Evaluation Synthesis Question #2a: To what extent have effective partnerships and collaborations been developed? **Impact and Effect**			
Indicator	**Evidence/Finding**	**Conclusion**	**Important Considerations**
nature, quality, and degree of involvement and commitment of partners (examples of working together, within and across departments, jurisdictions, sectors).			

Evaluation Synthesis Question #2b: ***To what extent has capacity to address health promotion issues increased?*** **Impact and Effects of Community Capacity Building**			
Indicator	**Evidence/Finding**	**Conclusion**	**Important Considerations**
Number and types of outreach activities/projects funded and resources developed.			
Statements/evidence of improved capacity to take action on the determinants of health.			

Evaluation Synthesis Question #2c: ***To what extent have programs been successful in knowledge development and dissemination?*** **Impact and Effects of Knowledge Development and Dissemination**			
Indicator	**Evidence/Finding**	**Conclusion**	**Important Context to Consider**
• availability/quality of knowledge products (e.g. reports, papers, innovative models, evaluations, website information).			
• examples of use/uptake (e.g., NGO use of HC reports, needs assessments, etc.).			

Evaluation Synthesis Question #3: ***Have programs been delivered appropriately?*** **Design, Delivery, and Approach: Process and Implementation**			
Indicator	**Key Program Activity/ Output/Outcomes**	**Evidence Implemented/Produced**	**Lessons Learned**
Number and types of activities and associated outputs related to knowledge development and dissemination, community capacity building, and partnership building.			
Number and types of partners and sectors participating in health promotion activities.			
Best practices and recommendations for program change and improvement.			

Key Recommendations

Evaluation Synthesis Question 4: *Have programs been delivered cost-effectively?*		
Indicator	**Key Program Activity/Output**	**Possible Lesson Learned**
Amount/type and proportion of funds/resources leveraged and their sources**.**		
Identified recommendations to support the long- term successes and sustainability of program outcomes.		
What are the general observations on cost-effectiveness?		

BIBLIOGRAPHY

Program Evaluations

Evaluation of Hepatitis C Prevention, Support and Research Program (Health Canada): A Mid-Term Report, March 2003.

Evaluation of the Rural and Remote Care Component of the Innovations in Rural and Community Health Initiative: Final Report. Ekos Research Associates Inc., July 2002.

Health Canada Evaluation of the Canada Prenatal Nutrition Program: Final Report. Prairie Research Associates (PRA) Inc., July 2003.

Mid-Term Review of the Health Canada/Veterans Affairs Canada Falls Prevention Initiative. Ekos Research Associates Inc., 2002.

Population Health Fund Evaluation Interim Report. June 2003

Year Three Evaluation of the Canadian Strategy on HIV/AIDS: Final Report. May 2002.

Additional Sources

An Assessment of the Methods and Concepts Used to Synthesize Evidence of Effectiveness in Health Promotion: A Review of 17 Initiatives. Jackson, Edwards, Kahan, and Goodstadt, September 2001.

A Schema for Evaluating Evidence of Public Health Interventions (Version 4). National Public Health Partnership, April 2002.

Evaluation Assessment Criteria Guide. Departmental Program Evaluation Division, Health Canada, 2003.

Evaluation Policy. Treasury Board Secretariat, April 2001.

Measurement and Attribution of Program Results (Third Edition). Treasury Board Secretariat, March 1998.

Measuring Community Capacity: State of the Field Review and Recommendations for Future Research. Smith, Neale, Littlejohns, Bauch, Dimple, and Roy, May 2003.

The Evaluation Synthesis. Program Evaluation and Methodology Division, United States General Accounting Office, 1992.

The Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe. International Union for Health Promotion and Education, 2000.

Treasury Board Secretariat Management Accountability Framework. Treasury Board Secretariat, 2003.