

Evaluation of the Healthy Canadians and Communities Fund, 2019-2020 to 2024-2025

FINAL REPORT – OCTOBER 2025

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List of acronyms

2SLGBTQIA+	two-spirit, lesbian, gay, bisexual, transgender, queer, intersex, plus
CIHR	Canadian Institutes for Health Research
CSEP	Canadian Society for Exercise Physiology
D2I	Design-to-Implement
EBP	Employee Benefit Plan
FTE	full-time equivalent
FPT	federal, provincial, and territorial
G&Cs	grants and contributions
HCCF	Healthy Canadians and Communities Fund
HCIS	Healthy City Implementation Science
MRAP	Management Response and Action Plan
MSP	Healthy Living and Chronic Disease Prevention – Multi-Sectoral Partnerships
NWA	Northern Wellness Agreement
O&M	operations and maintenance
PHAC	Public Health Agency of Canada
PMEC	Performance Measurement and Evaluation Committee
PT	provincial or territorial
SGBA Plus	sex- and gender-based analysis plus
T&Cs	terms and conditions

Executive summary

Background and evaluation scope

Chronic diseases, such as diabetes, cardiovascular disease, and cancer, are leading causes of death and illness in Canada. Addressing common risk factors, including tobacco use, unhealthy eating, and physical inactivity, can lower the likelihood of developing these diseases.

The Healthy Canadians and Communities Fund (HCCF) is a Public Health Agency of Canada (PHAC) funding program that seeks to prevent chronic disease among people living in Canada. Before the program's renewal in 2020, it was known as the Healthy Living and Chronic Disease Prevention – Multi-Sectoral Partnerships (MSP) program. The program provides grants and contributions (G&Cs) to a variety of projects to address behavioural risk factors for chronic disease and to promote physical and social environments that support good health. Since its renewal, the HCCF has taken a health equity approach by focusing on priority populations that have been shown to face higher risks of acquiring chronic diseases. These include Indigenous Peoples, newcomers to Canada, people with disabilities, 2SLGBTQIA+ communities, people living on low incomes, and racialized communities. The program has an ongoing annual budget of approximately \$25 million, including \$22 million for G&Cs. Funding is provided to interventions based on three phases of project maturity:

- the Design Phase, intended for initial intervention design;
- the Implement Phase, intended for the delivery and evaluation of interventions; and
- the Scale Phase, intended for expanding successful interventions to achieve greater impact.

The purpose of the evaluation was to examine the program's relevance, its effectiveness, and the strengths and challenges related to its design and delivery. It covered activities from fiscal years 2019-2020 to 2024-2025. The evaluation placed less emphasis on the performance of projects addressing tobacco use, as these were examined in a concurrent evaluation of the Health Portfolio's Tobacco and Vaping Activities.

Key findings

The HCCF is highly relevant and responsive to PHAC's mandate and priorities. However, its flexible policy and financial authorities have also led to competing demands that create challenges in resource allocation.

As PHAC's only continuous funding program for chronic disease prevention, the HCCF plays a significant role in meeting PHAC's core responsibility for health promotion and chronic disease prevention. Its focus on priority populations also aligns with the Agency's commitments to addressing health inequalities.

The HCCF is highly responsive to changing needs for chronic disease prevention, thanks to the broad policy and financial authorities that govern its spending. It is the largest health promotion funding program at PHAC that runs regular and open solicitations. At the same time, competing funding demands that make it difficult for the program to allocate its limited resources. In the past 6 years, approximately 12% of the program's funding has been earmarked for, or redirected to emerging Agency priorities, some of which fall outside of the program's objectives. The evaluation did not examine the performance of these projects. Internal G&Cs Modernization activities present opportunities to solidify the HCCF's role in the broader portfolio of PHAC's health promotion funding programs.

The HCCF complements other federal programs and policies, though there are opportunities for further linkages to gain efficiency and multiply impacts.

The HCCF's activities complement policies and programs led by other federal departments by filling in funding gaps, targeting under-served populations, and supporting the testing and evaluation of promising approaches. The program explored collaborations across the federal government, including launching a joint solicitation with the Canadian Institutes for Health Research in 2021. Program partners highlighted how joint funding opportunities reduce administrative burden for applicants and funding recipients and mitigate potential duplication of effort. Further cross-departmental coordination could also allow the HCCF to leverage different ministerial mandates to address social or structural determinants of health that are outside of PHAC's mandate, but which impact chronic disease prevention.

Recent program changes have increased the HCCF's ability to address the needs of priority populations, though it has also decreased the program's reach, as anticipated.

From 2019-2020 to 2024-2025, the HCCF reached 635,645 participants, nearly all from MSP projects. As program staff expected, HCCF Design Phase projects reported fewer participants than MSP projects as they targeted priority populations, which are harder to reach, and focused on testing and refining intervention designs rather than maximizing participation. Since the program's renewal, the HCCF has introduced various measures to address the needs of priority populations, including increasing the focus of funding solicitations on addressing upstream factors of chronic disease and diversifying the types of projects and organizations that receive funding to better reach underserved populations.

Based on available data, the program met expectations for most medium- and long-term outcomes to improve participant health.

In the past 6 years, the program has generally met its targets to improve participant capacity to support healthy behaviours and prevent chronic diseases. However, results for improving participant knowledge have declined over time, falling outside the acceptable range in 2024-2025. The program has maintained consistent and satisfactory performance in improving participant health behaviours and their health status, in line with other regional or national programs. Results were mixed for improving participants' environments to support ongoing healthy behaviours, though there was early evidence of improvements since program renewal. According to funding recipients, engaging priority populations, and forming multisectoral partnerships are the two most important facilitators of success.

HCCF program staff and funded projects collected and shared evidence of promising approaches for chronic disease prevention. Uptake of program-level knowledge mobilization products could be enhanced.

Most funded projects documented lessons learned and produced a considerable number of knowledge products. The HCCF also supported funding recipients by providing evaluation and knowledge mobilization resources and hosting peer knowledge-sharing sessions. At the program level, PHAC staff conducted and funded research studies, rolled up findings from funded projects, and produced and disseminated knowledge products, such as an interactive online map and lessons learned reports. Despite stakeholders expressing a desire for these kinds of products and activities, the evaluation found limited uptake, suggesting an opportunity to improve dissemination.

The HCCF has improved various aspects of its design and delivery as part of its renewal and in response to previous program reviews.

The transition from the MSP to the HCCF has led to many changes in how the program is managed. For example, the introduction of a phased funding model has allowed the program to target project funding at different stages of maturity. Meanwhile, the implementation of time-limited solicitations and an enhanced and continuous improvement process have enabled the program to adjust and improve itself between solicitation periods more effectively. The program has also amended aspects of its operations and governance in response to past evaluations and audits. Still, there remain areas for improvement in communicating feedback to funding applicants and the accessibility of application and reporting processes. The program's ability to make changes is constrained by corporate requirements, although an internal G&Cs modernization initiative at PHAC presents some opportunities to address these challenges.

Matched funding requirements promoted sustainability and fostered multi-sectoral collaboration.

The HCCF program expects funding recipients to secure cash or in-kind funding from other sources equal to the amount received from PHAC. This matched funding requirement has encouraged funding recipients to form multisectoral partnerships and to sustain and amplify their project impact. Moreover, the program's matched funding ratio and the average number of matched funding partners per funded project has improved over time thanks to new flexibilities introduced during the program's renewal. The HCCF has not implemented other measures to promote project sustainability, although the evaluation identified multiple examples of projects that have continued their interventions after PHAC funding ended.

The program faced high demand for its G&Cs funding.

From 2019-2020 to 2024-2025, the HCCF had a budget of \$149 million, including nearly \$134 million in G&Cs funding. In this time, the program's G&Cs funding envelope faced high demand. In the last two open solicitations, the HCCF funded 14% to 22% of eligible project applications. Moreover, in the last 6 fiscal years, approximately 12% of the program's G&Cs funding was reallocated to other health promotion priorities at PHAC. After reallocations, the program spent within 3% of its remaining G&Cs budget each year. The remaining variance was due to administrative delays in approving funding dispersal and pandemic-related interruptions that hindered activities for certain projects.

Recommendations

Recommendation 1: Explore further collaborative funding opportunities with complementary federal programs.

The HCCF faces growing demands that make it difficult to allocate its existing resources to meet program objectives. At the same time, based on evidence of what works in chronic disease prevention, the program has expanded its activities to better address some of the underlying causes of chronic disease, such as healthy built environments and food security. Furthermore, other federal departments currently support the infrastructure costs required to effectively deliver program interventions in these spaces, which are not eligible expenditures under the HCCF's current terms and conditions. There is an opportunity to better coordinate funding with other departments to maximize impact, achieve efficiency, reduce potential overlaps, and simplify the application process.

Recommendation 2: Identify strategies for improving knowledge dissemination and uptake.

Benefits of the program's various knowledge mobilization efforts are not fully realized. Despite keen interest among stakeholders to access program evidence, there is limited awareness and uptake of current products and activities. It should be noted that the PHAC's G&Cs Modernization initiative identifies a need for the development of a G&Cs knowledge mobilization strategy that is aligned with related PHAC initiatives. As such, any actions to improve HCCF's knowledge mobilization will need to align with the PHAC-wide strategy.

Management Response and Action Plan

Recommendation 1

Explore further collaborative funding opportunities with complementary federal programs.

Management response

We agree with the recommendation.

Action Plan	Deliverables	Expected Completion Date	Accountability	Resources
PHAC will conduct a scan of Gs&Cs programs in the GoC to identify programs with complementary mandates and the potential for collaboration.	Detailed table of programs	May 2026	Executive Director, Centre for Chronic Disease Prevention and Health Equity	Internal human resources from the Programs and Performance division (PPD)
Based on scan results and emerging opportunities, PHAC will convene meetings with relevant departments to identify areas for potential collaboration including joint solicitations and reporting.	Departmental meeting schedules and agendas	December 2026	Executive Director, Centre for Chronic Disease Prevention and Health Equity	Internal human resources from the Programs and Performance division (PPD)

Recommendation 2

Identify strategies for improving knowledge dissemination and uptake.

Management response

We agree with the recommendation.

Action Plan	Deliverables	Expected Completion Date	Accountability	Resources
PHAC will conduct an environmental scan to identify best practices for knowledge dissemination and measurement of uptake.	Findings report	August 2026	Executive Director, Centre for Chronic Disease Prevention and Health Equity	Internal human resources from the Programs and Performance division (PPD)
Based on the review, PHAC will develop a knowledge mobilization plan for the HCCF to strengthen uptake of knowledge products	Knowledge Mobilization Plan	December 2026	Executive Director, Centre for Chronic Disease Prevention and Health Equity	Internal human resources from the Programs and Performance division (PPD)

Program description

Chronic diseases, such as diabetes, cardiovascular disease, and cancer, are a leading cause of death and illness in Canada. Addressing behavioural risk factors can lower the likelihood of developing these diseases. The Healthy Canadians and Communities Fund (HCCF) is a Public Health Agency of Canada (PHAC) program that provides grants and contributions (G&Cs) for interventions that address common behavioural risk factors, including tobacco use, unhealthy eating, and physical inactivity. The program also aims to create physical and social environments that are known to support better health. In addition, the program seeks to encourage multi-sectoral partnerships and to uncover new ways to address risk factors. See [Appendix B](#) for the program's expected outcomes. The HCCF was introduced in 2020-2021, replacing the Healthy Living and Chronic Disease Prevention – Multi-Sectoral Partnerships (MSP) program.

Spotlight: The importance of supportive environments for good health

Healthy and supportive environments are critical for enabling healthy behaviours and mitigating risk factors for chronic diseases. Social environments that foster community connections, cultural safety, and social support can lower stress and increase motivation to engage in healthy behaviours, such as physical activity, and reduce the uptake of unhealthy ones, such as smoking cigarettes or drinking alcohol. Physical environments, such as safe and walkable neighborhoods, accessible green spaces, and barrier-free recreational facilities, make it easier for people to be active and reduce sedentary behaviours. Meanwhile, supportive food environments, where nutritious, affordable, and culturally appropriate foods are readily available, help individuals make healthier dietary choices, thereby reducing the risk of cardiovascular diseases.¹

The HCCF focuses on six priority populations identified through research and expert consultations as being at elevated risk of chronic disease and facing greater health inequalities. These are the following:

- Indigenous Peoples;
- newcomers to Canada;
- people with disabilities;
- 2SLGBTQIA+ communities;
- people living on low incomes; and
- racialized communities.

The program has an ongoing annual budget of approximately \$25 million. This includes \$22 million for G&Cs that are mostly distributed through contributions, with a small proportion as grants. G&Cs are provided to organizations across Canada to deliver local, regional, and national interventions. The program supports interventions at three distinct phases of project maturity, as summarized in Table 1.

Table 1. Overview of the HCCF phased funding model

Phase	Focus	Project Duration	Funding	Solicitations Launched
Design	Initial design of an intervention with a priority population and development of multi-sectoral partnerships.	1-2 years	\$50,000 to \$1 million	March 2021
Implement	Project delivery with partners and evaluation of the intervention.	2-4 years	\$200,000 to \$3 million	November 2022 and April 2024 ⁱ
Scale	Expand an intervention that has been evaluated and shown to work in order to impact greater numbers, alter cultural norms, or change policies.	3-5 years	\$1 million to \$5 million	Not yet launched

From 2019-2020 to 2024-2025, the HCCF provided full or partial funding to 114 projects. Of these, 93 were funded through regular solicitation cycles, which included continuous application intake under the MSP and 3 time-limited application periods under the HCCF. The program also funded projects outside of regular solicitation cycles to address opportunities or specific needs for chronic disease prevention. Examples included the development of national physical activity guidelines that align with global partners or support for northern communities that have particularly limited resources. Among these, 4 were non-HCCF projects that belonged to other initiatives, but which required additional funding. These were projects for ParticipACTION's *Let's Get Moving* initiative, Canadian Men's Health Foundation's *Don't Change Much* initiative, and the Framework for Diabetes in Canada. Finally, the HCCF jointly funded 3 projects with the Canadian Institutes for

ⁱ The 2022 solicitation was open while the 2024 solicitation targeted Design Phase recipients.

Health Research (CIHR). The evaluation reviewed all projects listed in Table 2, except for the 4 non-HCCF projects.

Table 2. Summary of HCCF-funded projects, 2019-2020 to 2024-2025

Funding opportunity	# of projects
Projects funded through regular solicitations (HCCF & MSP)	93
Projects funded outside regular solicitations	14
Non-HCCF projects receiving full or partial HCCF funds	4
Projects jointly funded with CIHR	3

Evaluation scope and approach

The evaluation assessed the program’s relevance, its effectiveness, and the strengths and challenges of its design and delivery. See [Appendix A](#) for a full list of evaluation questions.

The evaluation examined projects funded between 2019-2020 to 2024-2025, including projects funded before the program renewal in 2020. The evaluation placed less emphasis on the performance of projects addressing tobacco use, as these are being examined in the ongoing evaluation of the Health Portfolio’s Tobacco and Vaping Activities. It did not examine the performance of projects rolled out under HCCF authorities, but funded primarily through other sources, like ParticipACTION’s *Let’s Get Moving* initiative and projects funded under the National Framework on Diabetes.

The evaluation used a mix of qualitative and quantitative methods, including internal and external interviews, program file review, a survey of funding recipients and applicants, performance data analysis, financial data analysis, a literature review, and a comparative analysis. See [Appendix A](#) for the full methodology and limitations.

Findings

Relevance

Key takeaway: The HCCF advances PHAC’s core responsibility for health promotion and chronic disease prevention and aligns with the Agency’s commitments to address health inequalities. The program’s flexible policy authorities and funding envelope makes it suitable for addressing emerging priorities, although these priorities can fall outside of the

program's objectives and reduce resources for project funding within the program's mandate. The HCCF complements other federal programs and policies, though there are opportunities for further linkages to achieve efficiency and reduce overlaps.

Advancing core PHAC responsibilities and commitments

The HCCF is PHAC's only continuous funding program addressing chronic disease prevention, making it relevant for advancing PHAC's Core Responsibility for health promotion and chronic disease prevention.² Stakeholders, particularly those from other federal departments, perceived the HCCF as playing a relevant and significant role in developing evidence on the effectiveness of novel public health interventions in Canada. These efforts align with PHAC's commitments to scientific excellence, creating a culture of innovation, and ensuring evidence-based decision making.

Since the program renewal in 2020-2021, the HCCF has designated addressing health inequalities as a core program principle. Previously, under the MSP, the program did not explicitly consider health equity and social determinants of health in its design and implementation. In contrast, HCCF projects must target at least one of the program's priority populations. This approach is relevant to meeting the health equity priorities outlined by Canada's Chief Public Health Officer for 2022 to 2025.³ This approach is also in line with the 2020 Evaluation of the MSP Program, which recommended a stronger integration of sex- and gender-based analysis plus (SGBA Plus) into project design.⁴

Despite this shift in focus, internal and external stakeholders have continued to suggest that the program increase its focus on addressing the social determinants of health that are essential for tackling the root causes of chronic diseases. However, some of these activities go beyond the program's capacity and mandate. For example, the program's terms and conditions (T&Cs) do not permit certain expenditures like capital costs for projects addressing healthy built environments.

Allocation of funding to PHAC-wide priorities

The HCCF is governed by PHAC's T&Cs for the Promotion of Population Health, which are broad enough to provide the necessary coverage and flexibility for current and future activities. Meanwhile, the HCCF is the largest health promotion funding program at PHAC that runs open solicitations and does not have funding earmarked for pre-determined organizations. While these factors enable the HCCF to adapt to changing needs for chronic disease prevention, they also result in the reallocation of program funding to emerging priorities beyond its core objectives.

As shown in Table 1 in the [Program description](#) section, between 2019-2020 and 2024-2025, the HCCF funded 18 projects outside of regular solicitation cycles, based on emerging priorities. These included a project to conduct Indigenous engagement activities, as part of the Framework for Diabetes in Canada and a project to develop Canadian concussion recovery guidelines, as part of the Concussion Harmonization Project. The HCCF also financially supported the Canadian Task Force on Preventive Health Care. While these reallocations are in line with the program's financial and policy authorities, staff described operational challenges from having to reassign funding intended for HCCF solicitations to other Agency priorities.

Meanwhile, the HCCF funded a relatively small portion of project applicants. In the last two open solicitations in March 2021 and November 2022, the HCCF funded 22% and 14%, respectively, of eligible project applicants. The report discusses resource allocations in greater depth in its [Design and delivery](#) section.

Collaboration and complementarity across the federal government

The HCCF is informed by various stakeholder engagement activities. These include seeking input on priorities from federal, provincial, and territorial (FPT) tables and taking part in ad hoc and formal working groups, such as the FPT Tobacco Control Liaison Committee and the interdepartmental Knowledge Exchange Working Group.

Interviewed federal partners and funding recipients described complementarity between the HCCF and other FPT activities, although there are some instances of perceived and actual overlap. The HCCF's mandate aligns closely with the objectives of federal policies and programs led by other departments, such as the National Active Transportation Strategy, the Food Policy for Canada, and Canada's Tobacco Strategy. The HCCF fills gaps in the work of other federal departments by funding areas not covered by their G&Cs programs, targeting underserved populations, and supporting the testing and evaluation of promising approaches. The HCCF also complements efforts at the provincial or territorial (PT) level. Even though most PT governments offer grants for chronic disease prevention activities, their scopes differ from that of the HCCF, as most PT grants focus solely on physical activity promotion rather than multiple risk factors, do not target underprivileged populations, and provide significantly lower funding (i.e., under \$40,000 per project).

The program continues to explore joint funding initiatives with other federal departments. For example, the HCCF and the Healthy Cities Research Initiative at the Canadian Institutes for Health Research (CIHR) partnered in launching the [Healthy City Implementation Science \(HCIS\) Team Grants](#).

Spotlight: Interdepartmental collaboration on the HCIS

The HCIS Team Grants “support interdisciplinary teams to implement and evaluate interventions in diverse urban contexts with the goal of improving health and health equity.”⁵ CIHR and PHAC are investing up to \$27 million, including up to \$9 million from PHAC, toward the HCIS. The co-funding allows CIHR and PHAC to pool resources to address shared priorities.

To date, PHAC’s HCCF program has provided supplementary funding to three HCIS Team Grants that focus on primary prevention activities aimed at reducing risk factors for chronic diseases. Two of the three projects also received supplementary funding from the National Health and Medical Research Council of Australia, illustrating the widespread impact and relevance of these projects.

According to midterm reports, projects’ research designs, implementation, data collection, and results interpretation benefited from collaboration with a range of stakeholders, including study participants, researchers, and community and municipal organizations. Projects also produced a variety of products, including journal articles and presentations, to share early findings with stakeholders.

Interviewees emphasized opportunities to further integrate the HCCF with other federal programs to achieve efficiency and multiply impacts. Several partners highlighted how joint funding opportunities save applicants the effort of navigating multiple government applications and reporting requirements. They could also leverage different departmental mandates to address social or structural determinants of health that are outside of PHAC’s mandate, but which have an impact on chronic disease. These could include collaborating with programs that address healthy lifestyle factors such as building infrastructure for active transportation or improving food systems to enhance access to healthier foods.

Additionally, coordinating with other programs could mitigate fragmentation or duplication of efforts. For example, the same branch in PHAC delivers the HCCF and the Intersectoral Action Fund, both funding programs seek to reduce health inequities and promote multisectoral partnerships, though the HCCF has a narrower focus on behavioural risk factors for chronic diseases. Similarly, PHAC’s HCCF program, Health Canada’s Substance Use and Addictions Program, and Indigenous Services Canada’s Healthy Living Program all fund tobacco cessation interventions. Finally, Sport Canada’s Community Sports for All Initiative and Sport for Social Development in Indigenous Communities support the participation of underserved populations in recreational activities. HCCF similarly supports this population, though it targets physical activities in general, rather than specifically sports.

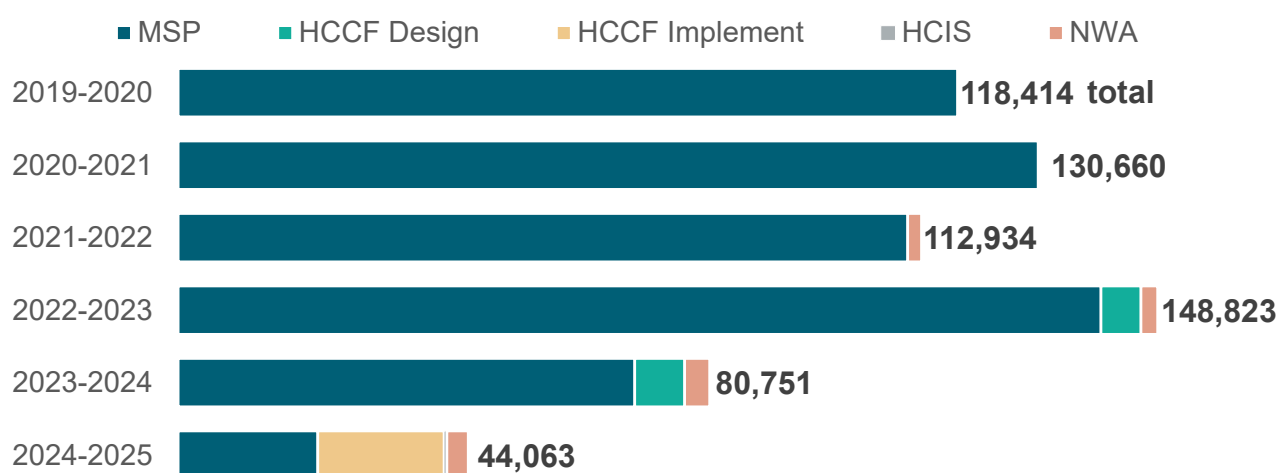
Effectiveness – Achievement of outcomes

Key takeaway: Recent program changes increased the HCCF’s ability to address the needs of priority populations. While these changes have, as anticipated, lowered the number of people reached annually, stakeholders see this shift in focus as beneficial for prioritizing populations with the greatest needs. Based on available data, the program met expectations for improving participant skills, health behaviours, and health status for most years, though improving participant knowledge has declined over time. Earlier results for improving environments to support healthy behaviours were mixed, though there is emerging evidence of improvements since program renewal. Long-term outcomes were measured immediately or up to several months post-intervention, so it was not possible to evaluate whether outcomes have been sustained.

Short-term outcome: Reaching priority populations

From 2019-2020 to 2024-2025, projects included in this evaluation reached 635,645 participants, nearly all from MSP projects (see Figure 1). The annual participation rate declined with the transition from MSP to HCCF, despite more active projects per year (see [Table 9 in Appendix B](#)). Program staff said they anticipated the decrease, as HCCF projects target priority populations, which are harder to reach, and Design Phase projects focused on testing and refining intervention designs rather than maximizing participation.

Figure 1. Number of participants reached by year and by funding opportunity



As of March 31, 2025, HCCF Design and Implement phase projects reported reaching 32,857 individuals, of which the vast majority (82% or 27,005 individuals) were marked as being from priority populations. Based on the available demographic information, a quarter of HCCF project participants are people living on low incomes (see Table 3). It should be

noted that the evaluation was unable to confirm that all these participants are from priority populations and to which populations they belonged. This is because not all projects systematically collected demographic data. For certain projects, participants raised ethical and privacy concerns, while others chose to provide estimates based on assumptions from participant enrollment criteria.

Table 3. Participants from priority populations, 2022-2023 to 2024-2025 (HCCF Design and Implement Phase projects only)ⁱⁱ

Priority population	# of projects (%)	# of participants
People living on low income	17 (40%)	8,027
Individuals with disabilities	8 (19%)	3,219
Racialized communities	21 (49%)	3,112
2SLGBTQIA+ communities	10 (23%)	1,862
Newcomers to Canada	12 (28%)	1,211
Indigenous Peoples	18 (42%)	1,042

The HCCF introduced measures to address the needs of priority populations, such as:

- Increasing the focus of solicitations on projects creating healthy social, food, or built environments to address upstream factors for chronic disease prevention;
- Adding the requirement that projects consult or work with priority populations to ensure cultural relevance in their design and implementation;
- Updating the project selection criteria to diversify the types of projects and funding recipients selected to better reach populations facing health inequalities; and
- Supporting applicants from smaller, equity-focused organizations, including an application coaching service and developing application resources and webinars.

A comparative analysis showed that the HCCF is unique in this approach as other PHAC funding programs do not provide the same level of support and resources to applicants.

In addition to these program-led actions, project reports described ways funding recipients facilitated participation among target populations. Two effective practices emerged across

ⁱⁱ Figures in the table do not add up to the total number of projects and participants. This is because many projects target more than one priority population, some participants identify with more than one priority population, or some projects did not systematically collect demographic information.

multiple projects: 1) working with partners that having existing connections to priority populations to increase participant enrollment; and 2) recruiting staff, volunteers, or intermediaries who belong to the target population and could thereby offer peer support and build trusted relationships with participants.

Nonetheless, most projects described at least some challenges with recruiting and retaining participants. In addition to socioeconomic barriers to participation, project staff observed how participants may be less motivated or able to join or continue interventions. Reasons include fear of discrimination and stigma, and mistrust of existing institutions due to historical injustices. Some barriers at the community level, such as intergenerational trauma faced by Indigenous communities, or isolation of rural communities limiting access to services, facilities, and resources, also hindered participation. COVID-19 disruptions and challenges with project staff recruitment and turnover further hindered program impacts. To mitigate these barriers and unanticipated challenges, many projects described strategies, such as working with multi-sectoral partners to provide incentives like financial compensation, food, childcare, and transportation, working with intermediaries who already have trusting relationships with their communities, and opting for more direct outreach to recruit and retain participants. They also addressed accessibility factors, such as ensuring the location and timing of activities are appropriate for participants and that the cultural relevance of activities and communications are considered.

This focus on priority populations was seen as an appropriate approach by interviewed internal and external stakeholders, who agreed that these populations needed more funding and support. However, a few program stakeholders noted that highly targeted approaches may result in PHAC missing opportunities to affect system-level changes that could help more people who are facing greater vulnerabilities to chronic disease.

Medium-term outcomes: Improving participant capabilities and supportive environments

In the medium term, the HCCF sought two broad outcomes: 1) increasing participants' capabilities to support health; and 2) improving environments that support health.

Each outcome was made up of detailed indicators that match the specific health issue a project is trying to address. Projects only reported on indicators that relate to their work. Because of this, the yearly results for indicators and outcomes did not include all projects and fluctuated from year to year, depending on which projects were reporting. The program result for each outcome was made up of the average of the results from all reporting projects. Each year, the program sets a range of acceptable performance targets

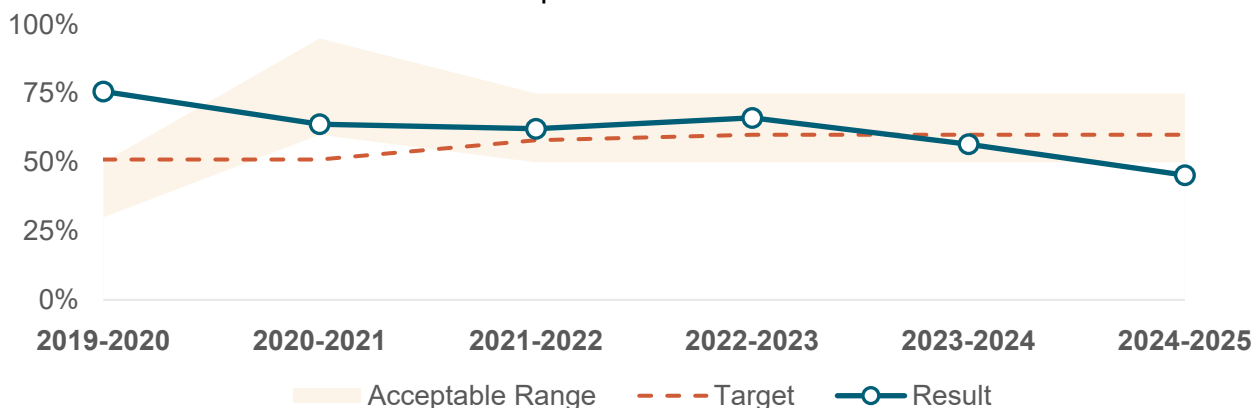
and ranges based on baseline measures recorded in earlier years. Targets and target ranges are only set at the outcome level and not for individual indicators. See Table 10 in [Appendix B](#) for a full summary of HCCF results by indicator.

Results in this section include available data from MSP, HCCF Implement Phase, and HCIS projects that were active during the period covered by the evaluation, from 2019-2020 to 2024-2025. As the HCCF Design Phase did not seek to change medium- and long-term outcomes, those projects are not represented in the quantitative data, although relevant qualitative information have been included. Finally, as summarized in the [Program description](#), the HCCF funded 18 additional projects outside of regular solicitation cycles. Given the unique nature of these projects, only 2 projects fit into the program's performance measurement framework and could be included in the analysis.

Participant capabilities

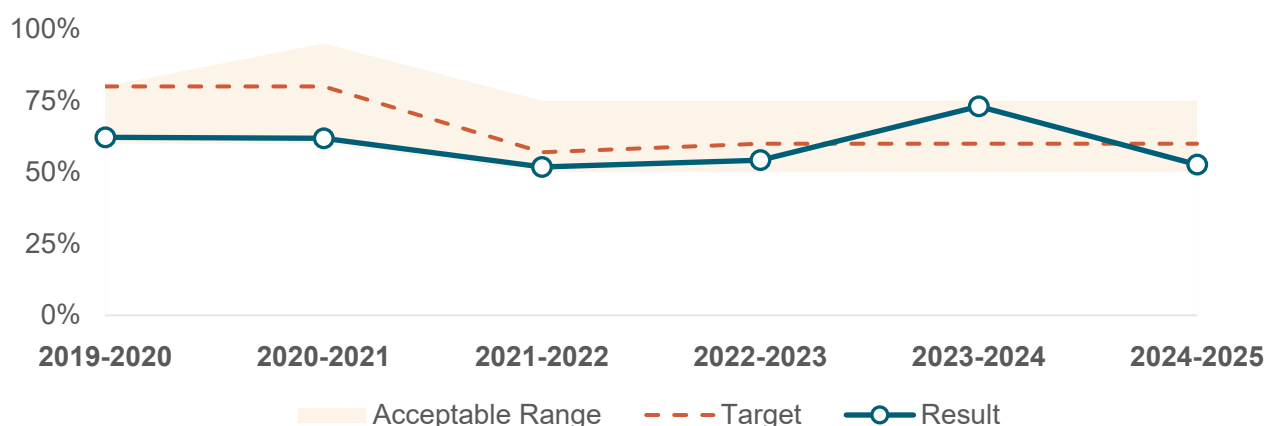
The HCCF largely performed within expectations for its outcomes to improve participant knowledge of chronic disease and their skills and abilities to support healthy behaviours. The program surpassed its targets to improve participant knowledge in 4 out of the past 6 years but results have declined over time. Plus, in the most recent year, the results fell outside of the acceptable range (see Figure 2). Results for each year were based on data from 3 to 9 projects, representing an annual total of 515 to 3,918 participants. [Appendix B](#) provides a detailed summary of results and denominators for each indicator by year.

Figure 2. Project participants demonstrating **increased knowledge** of chronic disease risk/protective factors



Meanwhile, the program's results for improving participants skills or abilities were within the acceptable range for all 6 years examined, although results were slightly below target in the first 4 years (see Figure 3). These results represented data from an annual total of 706 to 10,860 participants per year, collected from 2 to 9 projects.

Figure 3. Project participants demonstrating **improved skills/abilities** to support healthy behaviours



These results are modest when compared with national chronic disease prevention program in other countries. For example, between 2019-2020 and 2022-2023, the *Life!* Program, an Australian lifestyle modification program for the prevention of diabetes and cardiovascular disease, saw between 70% to 98% of participants with increased knowledge of chronic disease risk factors.⁶ In comparison, the HCCF reported a 6-year average of 62% of participants demonstrating increased knowledge of chronic disease risk or protective factors. In sum, while the program generally met expectations for improving participant capabilities, there may be a need to investigate and address the declining results for improving participant knowledge, should the trend continue.

Spotlight: Improving healthy lifestyle habits among underprivileged youth

Project name: Power Up!

Organization: Tremplin Santé

This project worked with summer day camps to promote physical activity and healthy eating by training camp workers in that area and delivering related programming to children and youth. Many of the participants came from socioeconomically disadvantaged backgrounds.

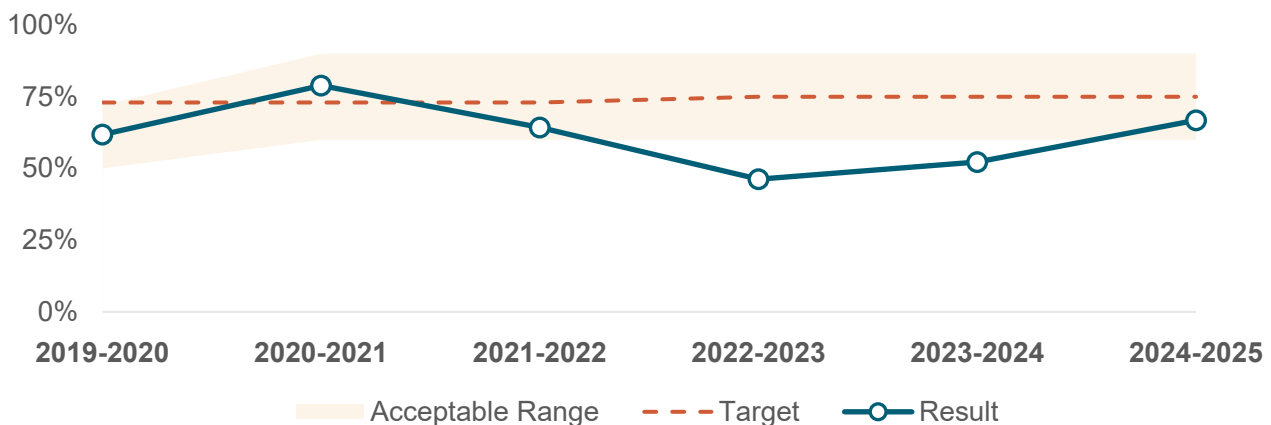
From 2018 to 2023, the project reached 246,000 youth and 16,200 facilitators. According to the most recent report, the project increased the number of campers participating in regular moderate-to-vigorous physical activity from 39% to 53%, decreased the number spending over two hours per day doing sedentary activities from 26% to 25%, and reported 40% of campers consuming at least 5 servings of fruits or vegetables per day, which is above the 25% average for Canadian youth.

Supportive environments

From 2019-2020 to 2024-2025, the program showed mixed results for improving the environments to support ongoing healthy behaviours. Results for 4 of the 6 years examined fell within the acceptable range (see Figure 4). However, annual results fluctuated, given that only 2 to 6 projects contributed to this outcome each year, representing an annual total of between 524 to 10,897 participants. Performance also varied between reporting projects (see [Appendix B](#) for detailed results tables). While some projects showed robust performance, including 7 that had over 75% of participants that reported improved environments each year, others saw much weaker results, including 4 projects that found less than half of participants reported improvements each year. The evaluation could not identify other programs that also measured participant-reported improvements to supportive environments to contextualize these results.

It should be noted that from 2019-2020 to 2022-2023, the program measured improvements to social environments only. From 2023-2024 onwards, the outcome expanded to include social, physical, and food environments. This change reflected the shift in focus for the HCCF Implement Phase solicitation in 2022. However, results available to date do not fully capture the impact of this shift; projects funded under that solicitation only began in 2023-2024, with most still collecting baseline and preliminary data. Presently, only two Implement Phase projects have reported preliminary results. Nevertheless, both were above target and contributed to results for this outcome returning within the acceptable range in 2024-2025. To assess whether the program has successfully addressed lower performance on this outcome in previous years, it would be helpful to observe whether results continue to improve as more Implement Phase data become available in subsequent years.

Figure 4. Project participants that report **social, physical/built or food environments are improved** to support health



Spotlight: Creating a supportive social environment to encourage cycling among newcomers

Project name: National Newcomer Bike Mentor Program

Organization: Immigrant Services Society of BC

The project sought to introduce cycling to newcomers in Ontario, British Columbia, and Nova Scotia. In addition to significantly increasing participants' time spent doing physical activity, the intervention successfully improved participants' social environments through group rides and other social events. Establishing a sense of community encouraged participants to stay in the program and create a support system that encourages them to stay active.

In a retrospective study, most respondents agreed or strongly agreed that they felt more connected to their neighbourhoods and cities after participation. Longitudinal models used to measure change in participants' sense of belonging found that it had increased between the beginning and the end of the 3-month program; it decreased slightly after a year but remained higher than the original level.

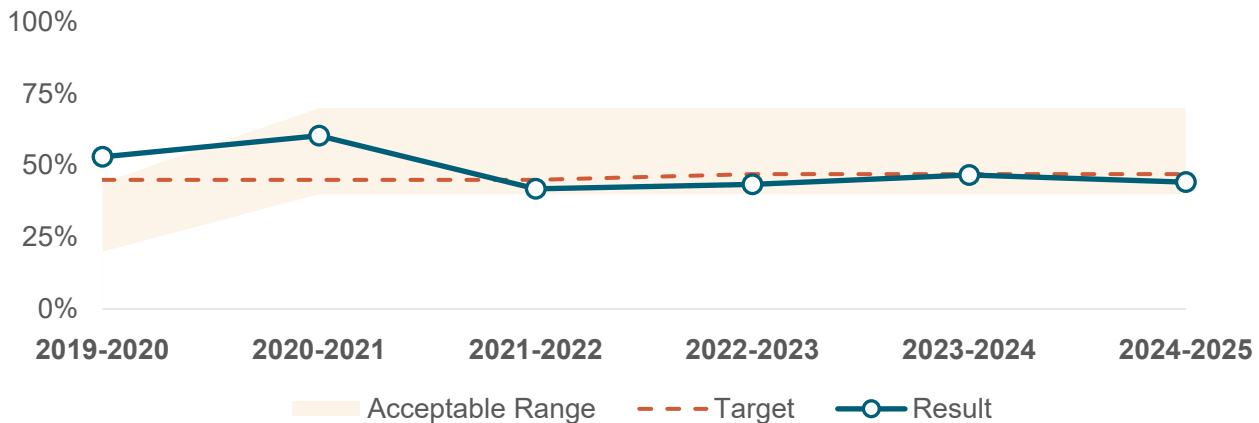
Long-term outcomes: Improving participant health behaviours and health status

The HCCF targeted two broad long-term outcomes: 1) improving participants' health behaviours; and 2) improving participants' health status. As with the medium-term outcomes, there was high variability in the projects reporting composite indicators for long-term outcomes. See Table 11 [Appendix B](#) for results by indicator. Of note, although these are the long-term outcomes identified in program planning, these results are measured immediately or within 3 to 12 months after interventions end. As such, they cannot be used to determine sustained behaviour or health status changes among participants.

Health behaviours

The HCCF maintained consistent and satisfactory performance in improving health behaviours. This outcome was composed of 7 indicators for behavioural changes related to healthy eating practices, increased physical activity, and decreasing cigarette smoking. From 2019-2020 to 2024-2025, the program's results surpassed or were within the acceptable range each year (see Figure 5). These results aggregated the performance data from between 6 to 12 projects each year, representing an annual total of 1,077 to 55,613 participants.

Figure 5. Project participants have improved health behaviours



When compared with the HCCF's 6-year averages for indicators associated with smoking cessation and physical activity, programs in Quebec,⁷ the United States,⁸ and Australia,⁹ reported results in similar ranges. Meanwhile, while the HCCF reported a 5-year average of 65% of participants having increased their fruit and vegetable consumption, this is lower than the results from Australia's *Life!* Program, which reported between 75% to 96% of participants having improved their diet from 2019-2020 to 2021-2022.¹⁰ Although these indicators related to healthy diets are not directly analogous, the HCCF introduced a new, more comparable indicator in 2024-2025 that measured the proportion of project participants "who demonstrate improved diet quality and/or eating practices." The result for this indicator was 62% based on the one year of data, which was still lower than the recent results in the *Life!* Program.

Spotlight: Increasing access to fruits and vegetables for low-income communities

Project name: Market Greens

Organization: Community Food Centres Canada

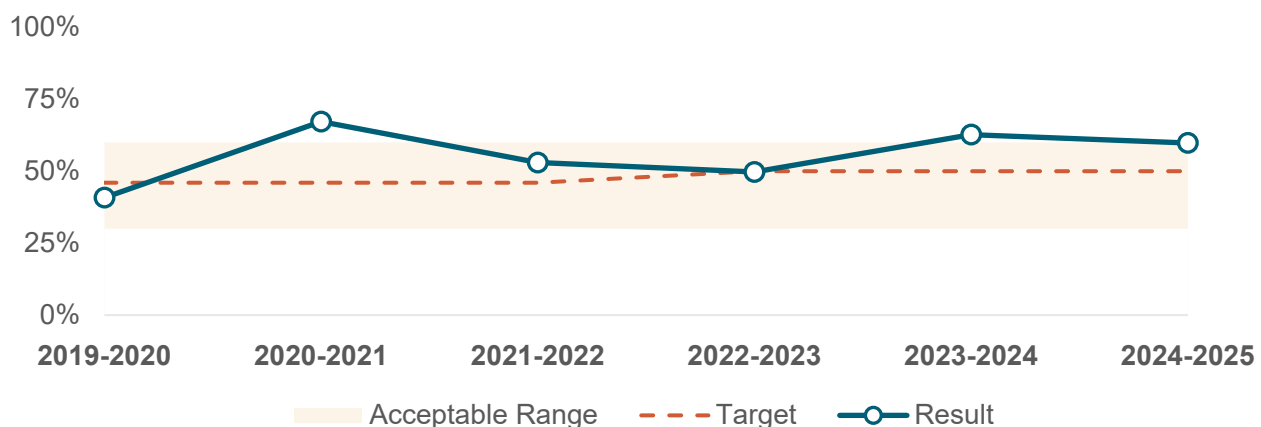
This project piloted several methods to increase access to fresh fruit and vegetables for low-income populations, including establishing affordable produce markets, providing financial incentives for purchasing produce, and implementing a fresh produce prescription program for at-risk community members.

Results showed promising impacts on participants' diets and access to healthy foods. A survey conducted about 3 months after program completion found that 90% of participants in the prescription program and 72% of surveyed market shoppers reported eating more fresh fruits and vegetables.

Health status

The HCCF has consistently achieved its goals of improving the physical and psychological health and well-being of participants, as measured through physiological or health-related quality of life measures. The program has met or significantly surpassed its targets for this outcome for all fiscal years except 2019-2020, although the result was still within the acceptable range (see Figure 6). Each year, 4 to 7 projects reported on this outcome, representing an annual total of 430 to 8,176 participants.

Figure 6. Project participants have improved health status



The evaluation did not identify any other programs that used equivalent indicators of health status. However, three national diabetes prevention programs in the United States, England, and Finland measured weight loss among participants and reported results that were similar or significantly lower than the HCCF's results. These other programs reported 52.5%,¹¹ 37%,¹² and 17.5%¹³ of participants having experienced weight loss, compared with the 5-year average of 58% improvement in body composition among HCCF participants.

Spotlight: Promoting culturally relevant programming to improve wellbeing

Project name: Caring for the Land, Caring for Each Other: Health and Well-being from Indigenous Fire Management Programs

Organization: Gathering Voices Society

Through implementing Indigenous fire management programs in the Yunesit'in and Xeni Gwet'in First Nations, the project aimed to improve participant health by promoting physical activity and reducing psychological distress.

Cultural burning is physically demanding, with some participants recording up to an average of 20 km of walking per day. Participants also expressed how these

fire management programs contributed to their positive mental well-being by decreasing stress and negative thoughts and helping them connect with their land. Research shows that reducing psychological stressors also reduces risky behaviour and chronic disease development and increases feelings of control and agency to adopt or maintain healthy behaviours.

Effectiveness – Supporting and mobilizing knowledge and promising practices

Key takeaway: Most funded projects documented their lessons learned and produced a considerable number of knowledge products. At the program level, PHAC staff also collected evidence on promising approaches for chronic disease prevention and produced various knowledge mobilization products, though uptake of these products could be enhanced.

Identifying promising practices

Uncovering new ways to address risk factors for chronic disease has been a key element of the program. Between 2019-2020 and 2024-2025, 37% to 73% of active MSP and HCCF projects were documenting lessons learned from interventions. This variation was due in part to projects being at different stages of implementation; those that were closer to completion had more to document. As such, years with more projects ending will have higher proportions of projects documenting lessons learned.

The HCCF also funded project to collect evidence on promising practices; Design Phase projects gathered evidence on how to design interventions for specific priority populations, while Implement Phase projects are testing and reporting on promising interventions. To support funding recipients to evaluate their projects and share their findings, the program published a list of [evaluation and knowledge mobilization resources](#) on Health Infobase, PHAC's public portal for health information and health data tools.

In addition, PHAC's collaboration with the Canadian Institutes for Health Research (CIHR) on the Healthy City Implementation Science (HCIS) Team Grants is generating knowledge on evidence-based interventions to promote health and health equity in urban environments. While implementation is still underway, mid-term reports confirm that all 3 projects are successfully meeting this objective. For example, the Small Steps for Big Changes project is using a tracking system to monitor the use and adaptation of implementation strategies to determine which approaches are the most effective.

In addition to funding the development, implementation, and evaluation of promising interventions, the HCCF conducts research or funds external studies to uncover new ways to prevent chronic diseases. These include a report on opportunities to leverage underused outdoor spaces to foster physical activity among children and social connectedness within communities, and a report analyzing promising interventions to address tobacco use in high-risk populations. Several program-led studies have been published in academic journals and program staff confirm that results have been used to inform the design of subsequent solicitations.

Mobilizing knowledge and lessons learned

Knowledge mobilization for the HCCF is led by both funding recipients and PHAC program staff. Between 2019-2020 and 2023-2024, MSP and HCCF projects developed 630 knowledge mobilization products. The majority (68%) of these were produced to raise awareness of the project or communicate its impact, while a fifth (20%) were used to inform project delivery. About a third of products (36%) were various forms of presentations, including presentations to academics, sector conferences, and online webinars. Nearly a quarter (24%) were marketing materials like newsletters, infographics, posters, videos, or media articles. Projects calculated the reach of their knowledge mobilization products in final project reports, but the program does not roll these up. However, this evaluation sampled the information from final project reports submitted in 2022-2023 and 2023-2024. In this sample, 21 completed projects produced over 461 knowledge mobilization products and activities, with a median reach of 5,000 people per project. One project, the Canadian Society for Exercise Physiology's (CSEP's) *24-Hour Movement Guidelines for Adults and Older Adults*, generated particularly high reach. CSEP reported 12 million media impressions associated with its national communications campaign to promote the physical activity guidelines. It should be noted that reach numbers reported by projects likely include duplicates, as individuals may be accessing or multiple products or participating in multiple activities for a given project.

Meanwhile, the HCCF has addressed the recommendation from the last MSP evaluation to implement a systematic process to compile and share program lessons learned. In response, the HCCF expanded its performance team to add knowledge mobilization as one of its main responsibilities. Additionally, program staff developed a knowledge mobilization framework to guide knowledge gathering and sharing. Based on this framework, staff are generating and sharing evidence at the project, program, and organizational levels (see Table 4). The program also learned and improved from each solicitation, as discussed further under the findings on [program design and delivery](#).

Table 4. HCCF knowledge mobilization framework and achievements

Pillar	Outcomes	Examples of achievements
Project level	Highlight project descriptions, results, and stories. Enable collective expertise of funded organizations to be shared and used.	An interactive map that displays recent active and completed projects. Quarterly Peer Network meetings to foster knowledge exchange and collaboration among funding recipients.
Program level	Strengthen HCCF program design and use of reporting measures. Demonstrate accountability by communicating HCCF impact.	A “Learnings at a glance” report that compiled lessons learned and best practices from funded projects. Peer-reviewed academic publications. Performance result infographics.
Organization level	Continuously evaluate and adjust the way the program can increase equity, rigor, and impact.	Internal presentations from post-solicitation surveys and reviews. Internal reports from the application support initiative pilot and evaluation.

Despite the program’s many achievements in knowledge mobilization, the benefits of these efforts have not been fully realized. While funding recipients who attended Peer Network sessions found them informative, only 19% (5 out of 26) of evaluation survey respondents indicated that lessons learned from other projects facilitated their own project’s success. This indicates an opportunity to increase engagement in, or relevance of, peer knowledge sharing. There is also limited awareness and uptake of the program’s core knowledge mobilization products. For example, from May 2023 to June 2024, the HCCF’s interactive map of funded projects received 688 unique visitors. In contrast, the webpage listing active projects for the Substance Use Addictions Program at Health Canada received 9,573 unique visitors in this same period. Awareness of HCCF knowledge products appears to be higher among federal partners. For instance, a web analytics report found that nearly half of the traffic on the HCCF interactive map web page came from Government of Canada networks, a significantly higher proportion than for other Health Infobase products. Considering that stakeholders expressed a desire for these kinds of products, the low uptake signals an opportunity to improve dissemination efforts. Some interviewees suggested that the program could share the evidence behind the selection of priority populations to enhance transparency and help other equity-focused programs tailor their interventions.

Design and delivery

Key takeaway: The program's renewal in 2020 led to improvements in the program's design and delivery, such as introducing a phased funding model, implementing systematic continuous improvement and knowledge mobilization processes, and updating the program's performance measurement framework and governance structure. Matched funding requirements promoted sustainability and fostered multi-sectoral collaboration. The program also reported consistent underspending of its G&Cs budget due to reallocations, administrative delays, and pandemic-related interruptions to project delivery.

Impacts of the program renewal

The HCCF program renewal introduced many changes to its design and delivery, as summarized in Table 5. In addition to the changes already discussed on the focus on priority populations and improved knowledge mobilization processes, the HCCF updated its funding and solicitation approach. Under the renewed program, solicitations are designed to identify and support projects at varying stages of maturity, from design, to implementation, to scaling up. This phased funding model aligns with what is used by several other PHAC health promotion funding programs like the Mental Health Promotion Innovation Fund, the Mental Health of Black Canadians Fund, and the Type 2 Diabetes Prevention Challenge. External interviewees highlighted how funding projects at a Design Phase supports the development of strong interventions by enabling learning, evidence collection, and testing new ideas before they get implemented and scaled up.

Another key change is the use of time-limited solicitations instead of continuous application intake. Program staff highlighted that having a defined start and end date for solicitations enhanced project management by improving budget and workload predictability, even though the time constraints increased workloads over a compressed period. A few internal and external interviewees suggested that time-limited solicitations promoted a perceived transparency and fairness in the project selection process. At the same time, some interviewed funding recipients pointed out that having a set period for solicitations was difficult for applicants from smaller organizations and those that needed more time to engage community members in their applications. Of note, HCCF adjusted its deadlines in response to these challenges. While the Design Phase solicitation was 4 weeks long, subsequent solicitations ran for 8 weeks. As well, for the Implement and Design-to-Implement Phase solicitations, the program gave advance notice by emailing external stakeholders to inform them of the launch of the upcoming funding opportunity.

Table 5. Summary of changes from the HCCF program renewal

	MSP 2013-2014 to 2019-2020	HCCF 2020-2021 to Present
Addressing health inequalities	Considered when possible	Program priority
Matched funding	Restricted to non-taxpayer sources (i.e., private sector, foundations)	Expanded to a range of partners (e.g., P/Ts, other federal departments, non-profits)
Application intake	Continuous	Time-limited
Assessment of project maturity	No parameters to identify and assess project maturity	Phased funding parameters to explicitly assess projects maturity Launched phase-specific funding solicitations
Knowledge mobilization	Limited activities (e.g., Peer Network meetings), no strategy	Program Knowledge Mobilization Framework Core knowledge products (e.g., interactive map)
Performance measurement and disaggregated data collection	Inconsistent data collection Limited reporting on sociodemographic factors	Updated performance measurement framework and program logic model Requirements for SGBA Plus data collection and disaggregation
Stakeholder engagement	Ad hoc, no strategy	Strategic stakeholder engagement strategy
Governance	Investment Committee (internal)	Management Committee (internal) Expert Review Committee with internal and external representation Internal Investment Committee removed to streamline governance

Continuous improvements to program management and delivery

Over the period examined, the program introduced various improvements to its management and delivery based on program reviews and on its own continuous improvement processes.

To address recommendations from previous evaluations and audits, the program introduced several operational changes, as summarized below.

- As discussed earlier, the HCCF created Knowledge Mobilization Framework to systematize its approach to sharing program evidence.

- The HCCF updated its performance measurement framework, which introduced new methods of analyses and improved data disaggregation in newer projects.
- The HCCF developed a Program Charter in response to an audit recommendation to improve program governance. The Charter provides a comprehensive program description, establishes a framework for implementation and administration, and outlines roles and responsibilities between program teams.
- The HCCF established six client service standards to track its response rates at various stages of the application process. Data show that the program consistently met the standards for each solicitation except for its notification to successful application in the Design-to-Implement solicitation in 2024.

Moreover, the program embeds continuous improvement processes throughout the life cycle of each funding solicitation to inform future solicitations. Through surveys, discussions, report analyses, and additional research, program staff regularly introduced improvements to program delivery. These included reducing barriers for project data collection, new resources to support funding recipients in meeting SGBA Plus requirements, improved relevance and accessibility of Peer Network meetings, various changes to reduce application barriers and decrease administrative burden for applicants, program staff, and reviewers. Correspondingly, nearly all respondents (96%) to the funding recipient survey were satisfied with their experiences with the program or felt that only minor changes were required.

Despite the recent enhancements to the application process, there remain a few improvement areas. Although the evaluation received limited feedback from unsuccessful applicants, most of those who were interviewed or surveyed said they wished to receive a clearer rationale and feedback for the decision. This is despite program staff offering unsuccessful applicants the option to seek formal feedback on the decision. Additionally, while the program provided more informational sessions and guidance on SGBA Plus, project staff continue to face difficulties in meeting this requirement, based on feedback gathered from funding recipients through the evaluation and program staff. They noted that the language and concepts are not accessible to some community members, and meeting the data disaggregation reporting requirements is very time consuming. Moreover, interviews and surveys found that applicants continued to find the application and reporting processes burdensome, although some external interviewees acknowledged that the detailed forms allow for a rigorous and informed project selection and evaluation process.

However, further changes to the program design and delivery are dependent on corporate requirements and efforts. At the time of this report, PHAC has been working on the

modernization of its G&Cs, the results of which may help the HCCF address some of its ongoing challenges. For example, in October 2024, the Digital Transformation Branch, a shared service of Health Canada and PHAC, launched the Funding Application System to provide a digital, automated G&Cs application platform. This system is being gradually rolled out across both departments.

Promoting intervention impact and sustainability

The HCCF program’s matched funding requirement is a key program element used to encourage funding recipients to form multisectoral partnerships and amplify their project impact. The program requires all funding recipients, with some exceptions, to secure the same amount of funding from other sources as they expect to receive from PHAC, referred to as a 1 to 1 matched funding requirement. Matched funds can be in the form of cash or in-kind contributions, such as staff, equipment, or spaces. Many funding recipients surveyed and interviewed described the matched funding requirement as a major hurdle for their funding application and project implementation. Still, external partners and funding recipients alike agreed that the program’s matched funding requirement promotes project sustainability, relationship building, and alignment of priorities with partners.

The matched funding leveraged across completed projects has improved. Based on the latest available data from April 2019 to October 2024, the program achieved a matched funding ratio of 1 to 0.91, meaning for every dollar of PHAC investment, 91 cents of cash or in-kind funding came from other sources. This is compared to a 1 to 0.80 ratio prior to program renewal, as shown in Table 6. Furthermore, HCCF projects secured more matched funding partners and reported a higher matched funding ratio than MSP ones. Reasons for the improvement include the program’s decision to expand the eligibility of matched funding sources for HCCF. The program also eliminated the special 3 to 1 matched funding ratio for tobacco cessation projects that was instituted under the MSP due to the limited number of organizations providing matched funding in this sector.

Table 6. HCCF matched funding results, April 2019 to October 2024

	HCCF	MSP	HCCF and MSP
Matched funding ratio (completed projects only)	1 to 1.03	1 to 0.90	1 to 0.91
Average number of matched funding partners per project (active and completed projects)	10.1	7.2	8.7

Aside from the matched funding requirement, the HCCF also selects impactful projects by asking application reviewers to evaluate the expertise and capacity of the organizations

applying for funding. However, there are no explicit criteria to assess their intention or ability to sustain interventions beyond PHAC funding. The program also does not require funding recipients to plan for intervention sustainability at the start of their projects.

In final project reports, recipients were asked to outline any strategies for continuing their work and most said they intended to continue their programming beyond their PHAC funding. Similarly, a 2023 program-led retrospective study of MSP projects found that 88% of the 17 surveyed projects sustained their activities in some manner, for 1 month to 8 years, after PHAC funding had ended. Furthermore, the evaluation identified several examples of sustained impact:

- As a result of Dalhousie University's [Uplift Partnership](#) project, youth engagement coordinators have been integrated into regional health systems and schools throughout Nova Scotia.
- Following the Sport for Life Society's [Physical Literacy for Communities](#) project, a few local initiatives were incorporated into municipal planning.
- The National Ballet School of Canada's [Sharing Dance](#) project has expanded into ongoing community dance programs and community engagement events.

Projects often credited partnerships with other organizations as enabling sustainability, noting that partners can support program delivery and provide additional funding and resources once PHAC funding has ended. The HCCF-led sustainability study identified additional facilitators, including ongoing funding from other sources, and existing capacity in the organization or at the higher system or structural levels in which the organization operated. These factors corresponded closely with sustainability best practices identified in related literature. Program staff described how PHAC management is using the results of this research to inform program planning.

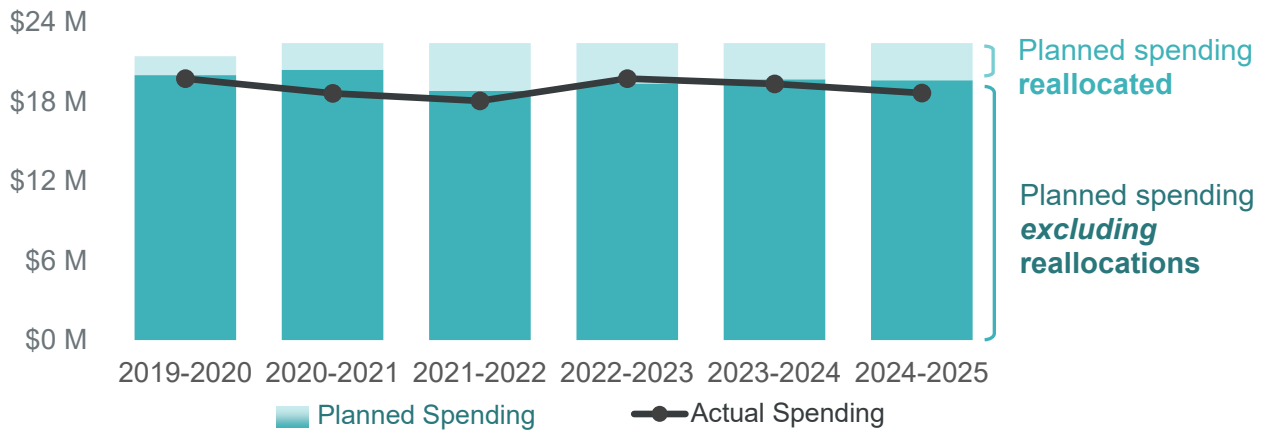
Resource management

From 2019-2020 to 2024-2025, the HCCF spent \$128 million of its \$149 million budget, averaging \$21 million in spending per fiscal year. Grants and contributions (G&Cs) made up most (89%) of this spending, followed by 10% on salary and employee benefits, and less than 1% on operational expenses. A full financial data summary is available in Table 12 in [Appendix C](#).

As described earlier, the HCCF reallocated \$15.6 million, or approximately 12%, of its planned G&Cs spending to other PHAC programs and priorities during the examined period. Excluding these transfers, the program's actual spending on G&Cs is well-aligned

with the planned amount, averaging a variance of 3% per fiscal year, as shown in Figure 7. According to program staff, reasons for the remaining variance included delays in getting Agency-level approvals to disperse funding and pandemic-related interruptions that prevented certain projects from spending all their funds.

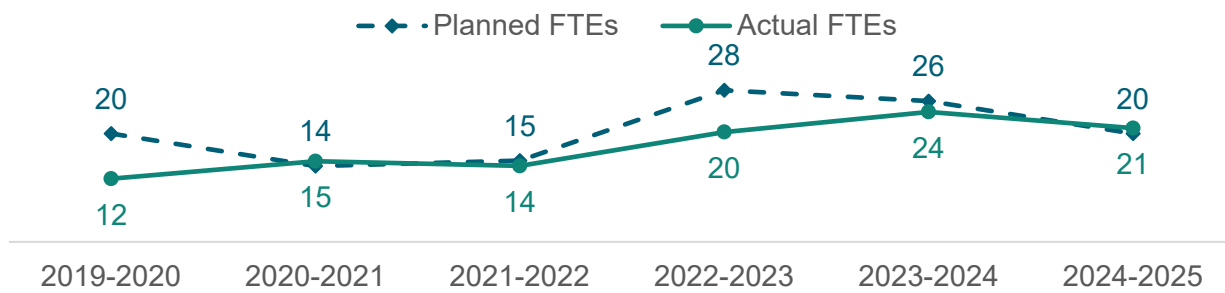
Figure 7. HCCF **G&Cs** spending and reallocations by fiscal year (in \$ Millions)



After reallocations, the program’s remaining G&Cs funding faced high demand. In the two most recent open solicitations for Design Phase and Implement Phase projects, the program funded 14% to 22% of eligible project applications. While a portion of applicants were screened out for not meeting the funding eligibility criteria, the program also implemented a cut-off score to limit the number of applicants invited to submit for a full proposal. The targeted Design-to-Implement solicitation had a higher funding rate of 35%, though only half of projects that passed the review process and that were recommended for funding have actually been funded to date.

The program’s staffing resources fluctuated significantly over the past 6 years, as shown in Figure 8. On average, the program reported 17.6 actual full-time equivalents (FTEs) per year, representing 86% of its planned FTE budget. Meanwhile, the program consistently spent less than anticipated on operations and maintenance (O&M), averaging 35% of the O&M budget over the past six fiscal years. However, the impact on the actual spending was minimal as O&M makes up only about 1% of the program’s annual budget.

Figure 8. HCCF planned FTEs and actual FTEs by fiscal year



Conclusions and recommendations

Conclusions

The HCCF is a well-established funding program that helps PHAC and the Government of Canada prevent chronic disease, a leading cause of morbidity and mortality in Canada. The program's broad authorities, large funding envelope, and willingness to fund novel interventions have enabled it to reach people from priority populations in Canada, adapt to emerging issues, and collect evidence on promising practices. In several cases, the program's matched funding requirement helped to expand and sustain project impacts beyond PHAC funding by providing additional resources and encouraging partnerships.

Recently, the program underwent a renewal process that improved its design and delivery. In particular, the HCCF now prioritizes addressing health inequities by targeting funding towards populations that are underserved or at greater risk of developing chronic diseases. The program recently designed solicitations to increase the accessibility of applications and the diversity of applicants, and to incorporate greater consideration for social determinants of health. The impacts of program renewal on the health behaviours and health status of participants from priority populations are not yet known, though the program's overall reach has declined given the more targeted approach. Available data show that the program met expectations for improving participant skills, health behaviours, and health status for most years, though improving participant knowledge has declined over time. Earlier results for improving environments to support healthy behaviours were mixed, though there is emerging evidence of improvements since program renewal.

Meanwhile, since its last evaluation, the program has improved its governance and its processes for performance measurement, continuous improvement, and knowledge mobilization. Still, there are opportunities to increase the reach and awareness of the

program's knowledge-sharing activities and products based on interest expressed by program stakeholders.

Finally, the program faces some resource management challenges due to persistently high demand for its funding. In addition to receiving many applications for each solicitation, the program has had to earmark or redirect a sizable portion of its G&Cs funding over the past 6 years to other Agency priorities, some of which do not align with program objectives. An ongoing internal G&Cs modernization initiative offers the program an opportunity to clearly outline its purpose in PHAC's broader portfolio of health promotion funding programs to improve resource allocation. Additionally, exploring further joint funding opportunities with other federal departments could promote efficiency and reduce overlaps.

Recommendations

Recommendation 1: Explore further collaborative funding opportunities with complementary federal programs.

The HCCF faces growing demands that make it difficult to allocate its existing resources to meet program objectives. At the same time, based on evidence of what works in chronic disease prevention, the program has expanded its activities to better address some of the underlying causes of chronic disease, such as healthy built environments and food security. Furthermore, other federal departments currently support the infrastructure costs required to effectively deliver program interventions in these spaces, which are not eligible expenditures under the HCCF's current terms and conditions. There is an opportunity to better coordinate funding with other departments to maximize impact, achieve efficiency, reduce potential overlaps, and simplify the application process.

Recommendation 2: Identify strategies for improving knowledge dissemination and uptake.

Benefits of the program's various knowledge mobilization efforts are not fully realized. Despite keen interest among stakeholders to access program evidence, there is limited awareness and uptake of current products and activities. It should be noted that PHAC's G&Cs modernization initiative identifies a need for the development of a G&Cs knowledge mobilization strategy that is aligned with related PHAC initiatives. As such, any actions to improve HCCF's knowledge mobilization will need to align with the PHAC-wide strategy.

Appendix A: Evaluation questions, methodology, and limitations

Evaluation questions

- 1. Relevance:** How does the Healthy Canadians and Communities Fund (HCCF) contribute to the Public Health Agency of Canada's (PHAC's) role and priorities for chronic disease prevention?
- 2. Effectiveness:** What progress has the HCCF made towards achieving expected outcomes in chronic disease prevention and health equity?
 - a) To what extent is the program addressing the needs of priority populations who face health inequalities and are at greater risk of developing chronic disease?
 - b) What progress has the program made in identifying and implementing promising approaches for addressing behavioural risk factors for chronic diseases in priority populations?
- 3. Design and delivery:** What are the strengths, facilitators of success, and challenges of how the HCCF is delivered?
 - a) How has the program changed since its last evaluation in 2019? What are the impacts of these changes?
 - b) What are some opportunities to improve program design and delivery?

Data collection sources and methods

Lines of evidence

This evaluation focused on the relevance, effectiveness, and efficiency of the HCCF over the 2019-2020 to 2024-2025 period. The evaluation team collected, analyzed, and triangulated data from the following methods.

Document Review

Evaluators reviewed internal documents provided by program staff and publicly posted program documents. A total of 197 documents were reviewed. Reviewed document types include:

- Project annual, final, and evaluation reports prepared by funding recipients;

- G&Cs administrative documents;
- Internal program planning, management, and governance documents;
- Public knowledge mobilization web pages and documents;
- Solicitation documents, funding agreements, and annual reports from G&Cs funding recipients;
- PHAC corporate reports, including the Chief Public Health Officer's annual reports and PHAC Departmental Results Reports;
- Materials shared by interviewees.

Documents were reviewed to extract relevant information using a standardized template. An evidence matrix was developed to synthesize findings by evaluation questions and indicators.

Interviews

Interviews were conducted between February 4, 2025, and May 2, 2025, using Microsoft Teams. Interview notes were created in a standard template using auto-generated transcripts and cleaned with the assistance of Copilot. All AI-cleaned transcripts were reviewed and verified by evaluators. Interview notes were analyzed in NVivo using a combination of inductive and deductive approaches and coding by both interview questions and themes. A summary was prepared describing the frequency and spread of themes across different interviewee groups.

In total, 17 interviews were conducted with 25 individuals from the following groups:

- HCCF program staff and senior management (7 interviewees);
- Other PHAC branch staff (2 interviewees);
- Funding recipient and unsuccessful funding applicants (6 interviewees);
- Staff from other government department (8 interviewees);
- Subject matter experts or academics (1 interviewee).

Survey of funding applicants and recipients

A survey of past HCCF or MSP funding applicants and recipients was conducted via Qualtrics software. The survey was open from February 24, 2025, to March 14, 2025. Out of the 92 invitations sent, the Office of Audit and Evaluation received 31 responses from

26 successful applicants and 5 rejected applicants. The 26 successful applicants were approved and funded for 31 projects, while 5 rejected applicants were denied for 5 project applications.

The survey design combined questions to measure levels of agreement (“Strongly agree” to “Strongly disagree”) and satisfaction on assorted topics, with open-ended questions to capture detailed suggestions and perspectives. Successful applicants and unsuccessful applicants received different questions tailored to their experience. At the end of the survey, respondents were given the option to request an interview for further discussion, with three interviewees selected through this approach.

Survey results were analyzed in Excel to produce descriptive summaries and identify themes by funding cohort, funding recipient vs unsuccessful applicant, and type of organization that applied.

Performance data review

The evaluation reviewed available program performance data from 2019-2020 to 2024-2025. These included datasets with project-level data such as project reach, performance indicator results, and qualitative performance information. The evaluation also reviewed program-level performance data, including client service standards, knowledge mobilization results, and matched funding ratios. Evaluators extracted, cleaned, and analyzed quantitative data in Excel and validated data methods and results with program staff to correct data entry errors and ensure methods to calculate program-level outcomes were consistent with other public reporting products. Evaluators conducted thematic coding of qualitative data in NVivo to develop findings.

Financial data review

The evaluation examined the program’s planned versus actual spending from 2019-2020 to 2024-2025 to identify trends and assess variances.

Literature review

A focused review of academic literature was conducted to inform the evaluation findings. The PHAC Health Library conducted a search in Medline on the Ovid platform of academic publications that addressed the evaluation questions on effective interventions for chronic disease prevention and best practices to support the sustainability of community-based interventions. Results were limited to research publications between 2015 and 2025. After

screening article titles and abstracts for relevance, ChatGPT-4o was used to identify key findings from the included articles. The summarized information was validated by an evaluator and summarized by evaluation question and indicator.

Comparative analysis

The evaluation conducted a review of academic and grey literature to identify comparable medium- and long-term outcomes from other programs. The evaluation compared the program’s indicators with equivalent results from diabetes prevention or tobacco cessation programs in other high-income countries and in provinces.

Use of generative AI

The evaluation used a secure version of the Copilot tool integrated into Microsoft Office applications to assist with several administrative and editing tasks. Throughout January to March 2025, Copilot was used to:

- Auto-transcribe interview notes.
- Clean interview notes to remove errors, repetitions, and formatting issues.
- Summarize key findings from evidence summaries prepared by evaluation analysts to inform findings discussions.
- Run data cleaning steps in Excel (i.e., remove spaces, flag and correct inconsistent entries).

All Copilot-generated output was thoroughly reviewed against raw data (e.g., interview recordings, original source documents) for accuracy. Copilot was not used to analyze or interpret raw data.

The evaluation also used ChatGPT-4o from January to March 2025 to synthesize information for the targeted literature review. ChatGPT was used to summarize key findings from articles that were identified by a PHAC Health Librarian and screened in by the evaluation team. Results were reviewed and analyzed by the evaluation team.

Limitations

Table 7. Methodological limitations and mitigation strategies

Limitation	Impact on the evaluation	Approach for addressing the limitation
Interviews and survey responses may not represent the full spectrum of stakeholder views about the program.	Given the retrospective nature of interview and survey feedback and possibility of response bias, there may be under- or over-reporting of certain attitudes. Interview and survey findings cannot be interpreted as representing the views of all stakeholders or categories of stakeholders.	The evaluation sought to collect feedback from a diverse group of respondents to improve representativeness of the feedback. The evaluation also consulted other data sources to substantiate statements and results from interviews and surveys.
There was limited project performance data for recent HCCF projects.	Performance data available primarily represent MSP and HCCF Design Phase projects. Results for most HCCF projects are still being collected, with only 2 such projects reporting preliminary medium- and long-term outcome data in 2024-2025. As such, the evaluation has had limited ability to assess the impact of projects funded since the program renewal. Most results presented in this report pertain to MSP projects that were funded prior to the renewal.	Data limitations were clearly noted in the analysis to maintain transparency and contextualize the strength of the findings. Qualitative data and evidence from program documents were used to identify early evidence of impacts of the program's renewal on its effectiveness.
There are some shortcomings in the program's financial data management.	The evaluation could not assess spending data by behavioural risk factor. The program does not track planned and actual spending disaggregated by risk factor due to many projects targeting multiple risk factors and inconsistent financial coding. Interviewed staff also described inconsistent practices in expense coding that significantly increased the time and effort required to prepare financial data reports for the evaluation.	Where possible, evaluators conducted follow-ups with program staff to fill in data gaps, using additional data and documentation and clarify inconsistencies or large variances in the data observed. Program financial data was also reviewed and validated with staff in the Chief Financial Officer and Corporate Management Branch.

SGBA Plus lens

The evaluation acknowledged how certain populations in Canada are disproportionately affected by chronic diseases and health inequalities. The evaluation applied an SGBA Plus lens to its assessment of the issue, to the program's activities, and to its results.

Evaluation governance

The Office of Audit and Evaluation worked closely with Health Promotion and Chronic Disease Prevention Branch staff to access documents and performance data, and to identify stakeholder groups. The scope for this evaluation was shared secretarially with the PHAC Performance Measurement and Evaluation Committee (PMEC) in January 2025 to receive input and guidance on the evaluation questions. The preliminary findings were presented to PMEC in June 2025 and the final report and Management Response and Action Plan (MRAP) developed by the Health Promotion and Chronic Disease Prevention Branch were presented to PMEC in October 2025.

Appendix B: Summary of HCCF outputs and outcomes

Output: Projects funded

From 2019-2020 to 2024-2025, the HCCF funded 93 ongoing and new projects through regular Multi-sectoral Partnerships (MSP) or HCCF. These projects were mostly identified through open solicitations, wherein applications were open to a wide pool of potential applicants. The exception was the HCCF Design-to-Implement (D2I) solicitation, which targeted past Design Phase funding recipients. While MSP accepted ongoing applications, HCCF solicitations are time limited.

In the examined period, the program also provided full or supplementary funding to 18 other chronic disease prevention-related projects to address special program or Agency priorities. Of these, 14 were HCCF projects funded outside of regular solicitation cycles while 4 were non-HCCF projects belonging to other health promotion and chronic disease prevention initiatives that required additional funding. These projects, except for the Common Vision grants, were funded through directed solicitations, wherein the program identified a specific type of applicant from a specialized field and communicated directly with the potential applicants.

Finally, the HCCF jointly funded through projects with the Canadian Institutes for Health Research (CIHR) through solicitations for the Healthy City Implementation Science (HCIS) program.

Table 8. HCCF-funded projects by solicitation type, 2019-2020 to 2024-2025

Funding opportunity	Solicitation type	# of projects funded
Projects funded through regular solicitations		93
MSP	Open, continuous	44
HCCF Design Phase	Open, time-limited	20
HCCF Implement Phase	Open, time-limited	23
HCCF D2I ⁱⁱⁱ	Targeted, time-limited	6
Projects funded outside regular solicitations		14
A Common Vision for increasing physical activity and reducing sedentary living in Canada: Let's Get Moving ("Common Vision")	Open, time-limited	5
Northern Wellness Agreement (NWA) ^{iv}	Directed	3
Concussion Harmonization Project Phases 2 and 3 (Parachute)	Directed	2
24-Hour Movement Guidelines for Adults and Older Adults (CSEP)	Directed	2
Integrated 24-Hour Movement Guidelines for Children and Youth (Children's Hospital of Eastern Ontario)	Directed	1
Canadian Men's Health Foundation's <i>Don't Change Much</i> initiative	Directed	1
Non-HCCF projects receiving full or partial HCCF funds		4
Framework for Diabetes in Canada	Directed	2
ParticipACTION's <i>Let's Get Moving</i> initiative ^v	Directed	2
Projects funded through a joint solicitation with CIHR		3
HCIS	Open, time-limited	3

ⁱⁱⁱ Additional D2I projects may be funded if more resources become available.

^{iv} One of the NWAs is managed directly by PHAC. The HCCF provides funding to two others through a memorandum of understanding with Indigenous Services Canada, which holds those agreements.

^v Although HCCF authorities were used to roll out the ParticipACTION *Let's Get Moving* initiative, this initiative was primarily funded separately and was already [evaluated in 2023](#), therefore performance data from this project has been excluded from the current evaluation.

Short-term outcome: Participants reached

From 2019-2020 to 2024-2025, projects included in this evaluation and which tracked participation reached a total of 635,645 unique participants, as summarized in Table 9.

Table 9. Number of participants in HCCF-funded projects, 2019-2020 to 2024-2025

Funding opportunity	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	Total
All projects	118,414	130,660	110,864	146,183	76,717	43,723	635,645
MSP	118,414	130,660	110,864	140,221	69,385	21,209	590,753
HCCF Design	Not Applicable	Not Applicable	Not Applicable	6,078	7,587	Not Applicable	13,665
HCCF Implement	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	19,192	19,192
HCIS	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	445	445
NWA - Yukon	Not Applicable	Not Applicable	2,070	2,524	3,779	3,217	11,590
# of active projects	28	30	28	45	41	48	96

Medium- and long-term outcomes: Improved capacity, supportive environments, health behaviour, and health status

Notes for interpreting the results in Tables 11 and 12:

- Expected program outcomes are deliberately broad to reflect the diverse risk factors the program addresses and are composed of more specific indicators. Funded projects are only expected to report on indicators that reflect their activities, with a minimum of one medium-term and one long-term indicator. As such, not all projects are expected to be represented in each outcome.
- Funded projects range from 1 to 7 years. Some multi-year projects are only able to report results in their final year. As such, results variance is due in part to different projects reporting on outcomes each year.
- Results exclude HCCF Design Phase projects, as these projects are not expected to achieve medium- and long-term outcomes.
- These results may vary from other public sources, based the projects included and excluded from the evaluation scope.

Table 10. Results for medium-term outcome indicators, 2019-2020 to 2024-2025

Indicator	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	Average
Medium-term outcome 1: Project participants have increased capabilities to support health							
Project participants demonstrating increased knowledge of chronic disease risk/protective factors	76% of 3,574 participants from 4 projects	64% of 3,918 participants from 5 projects	62% of 613 participants from 4 projects	66% of 515 participants from 5 projects	57% of 2,897 participants from 9 projects	45% of 744 participants from 3 projects	62%
Project participants demonstrating improved skills/abilities to support healthy behaviours	62% of 3,323 participants from 2 projects	62% of 9,159 participants from 8 projects	52% of 4,842 participants from 3 projects	54% of 706 participants from 5 projects	73% of 10,860 participants from 9 projects	53% of 1,070 participants from 4 projects	59%
Medium-term outcome 2: Environments that support health are improved							
Project participants report social, physical/built or food environments are improved to support health	62% of 3,405 participants from 3 projects	79% of 10,897 participants from 6 projects	64% of 524 participants from 2 projects	46% of 583 participants from 3 projects	52% of 1,624 participants from 6 projects	67% of 684 participants from 3 projects	62%

Table 11. Results for long-term outcome indicators, 2019-2020 to 2024-2025

Indicator	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	Average
Long-term outcome 1: Improved health behaviours							
Project participants have improved health behaviours	53%	60%	42%	43%	47%	44%	48%
Healthy eating							
Project participants who have increased their fruit and vegetable consumption	69% of 826 participants from 3 projects	58% of 8,917 participants from 8 projects	59% of 8,244 participants from 2 projects	76% of 432 participants from 2 projects	64% of 1,704 participants from 6 projects	65% of 329 participants from 2 projects	65%
Project participants who demonstrate improved diet quality and/or eating practices	No data	No data	No data	No data	No data	62% of 367 participants from 2 projects	62%
Physical activity							
Project participants who have increased time spent in light physical activity	49% of 1,864 participants from 1 project	73% of 716 participants from 2 projects	78% of 36 participants from 1 project	43% of 150 participants from 2 projects	79% of 10,066 participants from 2 projects	100% of 100 participants from 1 project	70%
Project participants who have increased time spent in moderate to vigorous physical activity	73% of 825 participants from 3 projects	62% of 6,612 participants from 7 projects	51% of 8,305 participants from 3 projects	55% of 210 participants from 3 projects	57% of 2,007 participants from 4 projects	64% of 516 participants from 2 projects	61%
Project participants who have decreased time spent in sedentary behavior	No data	No data	No data	46% of 150 participants from 2 projects	45% of 507 participants from 3 projects	20% of 66 participants from 1 project	37%

Tobacco cessation							
Project participants who decrease the number of cigarettes smoked per day	No data	89% of 840 participants from 1 project	36% of 224 participants from 2 projects	43% of 348 participants from 3 projects	39% of 439 participants from 5 projects	47% of 321 participants from 3 projects	51%
Project participants who have not smoked in the past 30 days	30% of 69 participants from 1 project	31% of 161 participants from 1 project	22% of 227 participants from 2 projects	17% of 299 participants from 2 projects	21% of 131 participants from 2 projects	22% of 373 participants from 3 projects	24%
Project participants who are reporting not smoking at 6 months	16% of 69 participants from 1 project	54% of 2,942 participants from 3 projects	26% of 9,907 participants from 3 projects	10% of 435 participants from 3 projects	20% of 42,872 participants from 4 projects	24% of 478 participants from 4 projects	25%
Long-term outcome 2: Improved health status							
Project participants have improved health status	41%	67%	53%	50%	63%	60%	56%
Improved physiological health							
Project participants with improved cardiometabolic health	38% of 174 participants from 2 projects	32% of 784 participants from 1 project	No data	No data	58% of 1,522 participants from 2 projects	No data	43%
Project participants with improved health related fitness	68% of 133 participants from 1 project	82% of 543 participants from 2 projects	73% of 1,970 participants from 2 projects	48% of 390 participants from 3 projects	83% of 824 participants from 2 projects	No data	71%
Project participants with improved body composition	40% of 204 participants from 2 projects	No data	No data	57% of 14 participants from 1 project	77% of 1,200 participants from 2 projects	49% of 63 participants from 1 project	56%
Improved psychological health							

Project participants with increased health related quality of life	30% of 67 participants from 1 project	65% of 947 participants from 1 project	38% of 859 participants from 3 projects	61% of 510 participants from 3 projects	71% of 2,414 participants from 5 projects	62% of 367 participants from 3 projects	55%
Project participants with increased mental health and well being	33% of 3,016 participants from 1 project	64% of 3,947 participants from 5 projects	54% of 7,990 participants from 5 projects	33% of 561 participants from 3 projects	55% of 1,652 participants from 6 projects	61% of 386 participants from 3 projects	50%

Appendix C: HCCF financial information

Planned versus actual spending

The figures in Tables 12 and 13 include all funding authorized under the HCCF’s two funding sources, the Integrated Strategy on Healthy Living and Chronic Disease and Canada’s Tobacco Strategy. They exclude new funding from federal budgets for the delivery of additional projects.

From 2019-2020 to 2024-2025, HCCF transferred \$15.6 million in G&Cs to other programs, initiatives, or priorities in the Agency, accounting for 12% of its planned G&Cs spending. Of this reallocated amount, approximately \$3.4 million were used to provide supplemental funding for the ParticipACTION’s *Let’s Get Moving* initiative, Canadian Men’s Health Foundation’s *Don’t Change Much* initiative, and the Framework for Diabetes in Canada. Another \$12.2 million was transferred out to address budget shortfalls in other areas not related to the program’s objectives for chronic disease prevention. The program does not have oversight on the spending of these transferred amounts and, as such, these amounts were included in the program’s planned funding but excluded from the actuals reported.

Table 12. HCCF planned and actual spending by year^{vi}

	Planned	Actual	% of planned spent
2019-2020	\$23,382,202	\$21,362,371	91%
G&Cs	\$21,446,000	\$19,752,306	92%
Salary & EBP	\$1,832,143	\$1,301,342	71%
O&M	\$104,059	\$308,723	297%
2020-2021	\$24,330,306	\$20,360,535	84%
G&Cs	\$22,446,000	\$18,641,030	83%
Salary & EBP	\$1,611,089	\$1,669,028	104%
O&M	\$273,217	\$50,476	18%
2021-2022	\$24,793,932	\$19,907,074	80%
G&Cs	\$22,446,000	\$18,076,289	81%
Salary & EBP	\$2,134,715	\$1,731,525	81%
O&M	\$213,217	\$99,260	47%
2022-2023	\$25,161,878	\$22,292,075	89%
G&Cs	\$22,446,000	\$19,761,941	88%
Salary & EBP	\$2,240,039	\$2,435,658	109%
O&M	\$475,840	\$94,476	20%
2023-2024	\$26,076,766	\$22,446,044	86%
G&Cs	\$22,446,000	\$19,362,342	86%
Salary & EBP	\$3,355,444	\$2,944,138	88%
O&M	\$275,322	\$139,564	51%
2024-2025	\$25,273,796	\$21,607,735	85%
G&Cs	\$22,446,000	\$18,665,941	83%
Salary & EBP	\$2,769,643	\$2,941,795	106%
O&M	\$58,153	\$0	0%
TOTAL	\$149,218,788	\$128,199,052	86%

^{vi} G&Cs = Grants and Contributions; EBP = Employee Benefit Plan; O&M = Operations and Maintenance

Table 13. HCCF planned and actual FTEs by year

Fiscal Year	Planned	Actual	% of planned spent
2019-2020	20	12	58%
2020-2021	14	15	106%
2021-2022	15	14	94%
2022-2023	28	20	72%
2023-2024	26	24	95%
2024-2025	20	21	105%
TOTAL	123	107	87%

Endnotes

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