Evaluating Innovations in Health Promotion:
A Literature Scan of Best Practices

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Submitted to the Alberta Healthy Living Network
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Acknowledgments

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AHLN Evaluation Team Members, Wellquest Consulting, Inc.

The website for the Alberta Healthy Living Network is www.health-in-action.org/AHLN
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Executive Summary
In March 2004, SWM Consulting was contracted by the Alberta Healthy Living Network (AHLN) to conduct a literature scan of best practices in health promotion (HP) evaluation. The specific focus was evaluation frameworks, models and processes of integrated chronic disease prevention (CDP) initiatives. The results of this literature scan will be used to inform the AHLN’s evaluative process and the Alberta Healthy Living Framework. This recently developed framework will facilitate and evaluate the integration of diabetes prevention in the AHLN priority strategy areas.

Methodology
The methodology of this literature scan was informed by best practice recommendations for reviewing HP literature. The following steps were integral to the process:
- Stakeholders participated in identifying the focus of literature scan.
- A broad search encompassed a variety of types of evidence.
- Clear inclusion criteria were established to ensure high-quality evidence.
- Articles and other information sources were reviewed and summarized.
- Information was organized into a reader friendly format.
- The dissemination plan is to be determined by AHLN.

Results
Peer-reviewed literature
- 13 articles that were published within the past 3 to 5 years were assessed for their philosophical congruence with HP; focus on AHLN priority areas; conceptualization of integration; and research design.
- Article topics were grouped in 3 categories: evaluation frameworks, evaluation processes, and best practices in evaluation.

Grey literature
- Review of 11 CDP websites revealed little evaluation activity.
- Of 13 representatives of CDP organizations, 3 indicated they are currently involved in evaluation projects.

Discussion of Results
Integrated CDP approaches are more common in the grey literature, but no evaluation frameworks specific to CDP prevention were discovered in any of the evidence.
- The concept of integration was typically inferred in the peer-reviewed literature.
- Of the integrated CDP initiatives reviewed, only the Nova Scotia Alliance for Healthy Eating and Physical Activity and the AHLN are engaged in evaluation.

The key characteristics of coalitions, such as fluid membership and few resources, add to the complexity of HP evaluation.
- Health promotion initiatives typically are unable to evaluate their long-term impact on population health status.
- Complexity can be addressed by explicating program’s causal links; establishing theoretical links between process/intermediate outcomes and long-term outcomes; and using sophisticated evaluation designs.

Multiple terms describing organizational collaboration are used (i.e. network, alliance, partnership, coalition).
- Emphasis on roles and relationships may vary among terms, as could evaluation focus.
- Important to clearly define fundamental elements of collaboration and link with evaluation framework.
Future Considerations
Time constraints prevented a broader search.
• Follow-up information is provided for key contacts and articles that did not seem to contribute additional insights to the literature scan, but still may be of interest.

Conclusion
This search of peer-reviewed and grey literature did not reveal an evaluation framework specific to integrated CDP. In fact, it seems the majority of integrated CDP projects are in their infancy and only beginning to consider evaluation issues. The AHLN has an opportunity to make a meaningful contribution to HP knowledge and practice through their efforts to develop an evaluation framework specific to integrated CDP.
Background
In 2003, the Alberta Healthy Living Network (AHLN) developed a framework for intersectoral integration of chronic disease prevention (CDP) in Alberta called the Alberta Healthy Living Framework. The Alberta Healthy Living Framework will facilitate and evaluate the integration of diabetes prevention into the following seven priority strategy areas: partnership development and community linkages; awareness and education; surveillance; best practices; research and evaluation; health disparities; and healthy public policy.

SWM Consulting was contracted by the AHLN in March, 2004 to conduct a literature scan of best practices in health promotion evaluation. The scope of this project was to provide an overview of current peer-reviewed and grey literature, not to prepare an exhaustive synthesis of approaches to health promotion evaluation. This report will discuss the purpose, methodology and results of the literature scan. Definitions of the following concepts are provided in order to make clear their interpretation in this report.

**Health promotion** (HP) is “…the process of enabling people to increase control over, and to improve, their health” (WHO, 1987, p. 3). Some key values and principles in health promotion include the duality of empowerment, a capacity building focus, a multi-level focus, a positive conceptualization of health, socioenvironmental determinants of health, and the need for intersectoral action to improve health (WHO, 1987).

Within the context of chronic disease prevention (CDP), integration may be understood as a process that contributes to “…a consolidation of efforts to address chronic diseases and their risk factors in order to promote healthy living in policy development, research and interventions (AHLN, 2003, p. 29).

The following elements are integral to this definition:
• Common risk factors are addressed in a coordinated manner (Blair & Chenier, 2002).
• Resources are shared through partnerships or collaborative action (Blair & Chenier, 2002).
• Different levels and sectors of society work towards a common CDP purpose (WHO, 2004).

In their recent conceptual review, McLaren, Shiell, Lorenzetti, Ghali, and Huculak (in press) suggest that integration can be more simply conceptualized as horizontal or vertical. These types are not considered to be mutually exclusive, but could co-exist. In this literature scan, integration will be conceptualized in accordance with the horizontal/vertical nomenclature.

**Horizontal integration** describes “…efforts at partnership and collaboration, among organizations or institutes that are at more or less the same “level” (McLaren et al., in press, p. 3).

**Vertical integration** refers to “…efforts at multiple levels being directed toward a common goal, with the expectation of synergy and sustainability accompanying the multi-level effort” (McLaren et al., in press, p. 3).

**Best practices** in a literature scan are the processes that result in an awareness of the strengths, limitations and gaps in evidence (Rychetnik & Frommer, 2002). In this literature scan, it follows that the processes must be congruent with the essence of health promotion (Kahan & Goodstadt, 2002).

Purpose of Literature Scan
The purpose of the literature scan was to learn about current best practices in health promotion evaluation with respect to evaluation frameworks, models or processes. Of particular interest were evaluation processes or approaches with integrated CDP initiatives. It was understood that the results of the literature scan will be used to inform the AHLN’s evaluation process and the Alberta Healthy Living Framework.
**Literature Scan Methodology**

The literature scan was conducted in accordance with recommendations for best practices in reviewing health promotion evidence (Jackson, Edwards, Kahan & Goodstadt, 2002; Rychetnik & Frommer, 2002). The phases and best practice recommendations that guided this literature scan, as well as the resulting activities, are outlined in Table 1.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Best Practice Recommendations</th>
<th>Activities</th>
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<tbody>
<tr>
<td>Identify purpose of literature scan.</td>
<td>• Clarify purpose and expected use of literature scan (Rychetnik &amp; Frommer, 2002).</td>
<td>• Discussed focus with Cynthia Smith (chair, AHLN) and members of evaluation team (Cathie Scott and Tammy Horne, Wellquest Consulting, Ltd.).</td>
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</table>

Search for peer-reviewed articles and grey literature. | • Search multiple databases of published literature (Jackson et al., 2002). | • Searched the following scientific databases: MEDLINE, EMBASE and CINAHL.  
• Searched systematic review databases, such as Cochrane Collaboration and NHS Centre for Reviews and Dissemination.  
Examples of key words and phrases used in the search:  
• Evaluation frameworks, Evaluation models; Outcome assessment, Process assessment; Public health, Health promotion; Community networks, Coalitions, Partnerships; Healthy eating, active living, healthy living  
• Contacted leaders in Chronic Disease Prevention. |  
• Search grey literature (i.e. internet sources, unpublished papers). |  
• Contacted leaders in Chronic Disease Prevention. |  
• Contacted CDP organizations via e-mail in Canada and US (see Appendix A for complete list).  
• Posted message on Click4HP listserv. |

Select articles for review. | • Establish inclusion criteria in order to ensure high-quality review (Jackson et al., 2002). | The following inclusion criteria were established through discussions with C. Smith (AHLN), C. Scott (Evaluation Team, Wellquest Consulting, Ltd.) and in accordance with best practices recommendations (Jackson et al., 2002): |
### Assess articles and summarize results.

- Review each article to determine congruence with key HP qualities, such as population focus, multidisciplinary approaches and presence of HP theories (Jackson et al., 2002).
- Critically assess research approach in each article (i.e. consider issues such as design and transferability of approach) (Rychetnik & Frommer, 2002).

### Prepare report.

- Ensure report provides specific information on review process and results.
- Develop “user-friendly” report (Jackson et al., 2002, p. 25).

### Disseminate report.

- Tailor dissemination plan to specific audiences (Jackson et al., 2002).

### Results of Literature Scan

#### Peer-Reviewed Literature

As previously mentioned, each peer-reviewed article was assessed with respect to four criteria. Examples of the key questions that guided the assessment are outlined below.

**Philosophical congruence with HP**

Was the article based on HP philosophy, values, beliefs and principles? Did it involve intersectoral stakeholders or action? Was there a population or community level focus?

**AHLN priority areas**

Did the article focus on any of the AHLN priority areas (i.e. partnership development and community linkages; awareness and education; surveillance; best practices; research and evaluation; health disparities; healthy public policies)?
Conceptualization of integration
Was the concept of integration present in the article? If so, how was it conceptualized? What, if any, were the specific lessons learned about evaluation of integrated approaches?

Research design
Was the research framework epistemologically consistent with constructivism rather than positivism/scientific reductionism? Was the research conducted in a capacity-building or participatory manner? Did it involve the use of both qualitative and quantitative methods?

At the end of the search, 13 articles that met the inclusion criteria were found. The results of the literature scan are presented in Tables 2, 3 and 4. Please note that the relevant AHLN priority strategies are indicated in italics following the example from the article. Brief summaries of the articles are also found in Appendix B.
### Table 2: Evaluation Frameworks and Models

<table>
<thead>
<tr>
<th>Article</th>
<th>Description of Article</th>
<th>Philosophical Congruence with HP</th>
<th>AHLN Priority Strategies</th>
<th>Conceptualization of Integration</th>
<th>Research Design</th>
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<tbody>
<tr>
<td>Baum (2001)</td>
<td>A pragmatic approach to the evaluation of community coalitions involves consideration of the logic of participation, logic of action and logic of research.</td>
<td>Not identified as HP approach, but philosophically congruent.</td>
<td>Speaks to evaluation challenges with community coalitions/partnerships (research and evaluation).</td>
<td>Integration not overtly identified in article. [However, community coalition’s planning and implementation processes may have been more focused and productive if integrated approach had been pursued—efforts were fragmented and often lacked follow-through.]</td>
<td>Article is a review of pragmatic approach. Approach is described through a case study.</td>
</tr>
<tr>
<td>Cramer, Mueller &amp; Harrop (2003)</td>
<td>The TOP (Targeting Outcomes of Programs) model is used to guide the process and impact evaluation of a tobacco reduction community coalition. Model information available at <a href="http://citnews.unl.edu/TOP/">http://citnews.unl.edu/TOP/</a></td>
<td>HP principles are inherent to evaluation project • Capacity-building • Stakeholder participation • Population focus</td>
<td>Tobacco reduction coalition is focus of case study (partnerships).</td>
<td>Horizontal integration described as part of the impetus for coalition development (i.e. sharing scarce resources, minimizing duplication, ensuring broad stakeholder representation).</td>
<td>Quantitative time-series research design used surveys and census-type data (i.e. data from Nebraska Social Climate survey). Comparisons will be made with another Nebraska county that has no tobacco prevention program (no elaboration on matching of county characteristics).</td>
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<td>Glasgow, Vogt &amp; Boles (1999)</td>
<td>The RE-AIM framework was developed specifically for public health interventions. Website contains essentially the same paper with added detail in sections (see Appendix B for link).</td>
<td>Identified as a public health framework (elements of HP evident). • Congruent with socioecological and systems theory. • Population-level focus. • Facilitates consideration of broader context. • Critiques scientific/reductionist paradigm as failing to capture complexity of community realities.</td>
<td>Framework could be used to assess any of the AHLN priorities. <em>(research and evaluation)</em></td>
<td>The article does not provide any examples or case studies.</td>
<td>Testing or application of RE-AIM not included in article (identified as area for further research). Well referenced article.</td>
</tr>
<tr>
<td>Petrosino (2000)</td>
<td>The causal-model approach to evaluation is an orientation that enables the testing of an intervention’s program theory.</td>
<td>Not identified as a HP model, but congruent with some important elements of HP philosophy. • Encourages participatory processes in developing causal model. • Honors stakeholder knowledge of intervention. • Facilitates clear</td>
<td>Examples in article drawn from criminology literature.</td>
<td>Concept not included in article.</td>
<td>Well referenced review article, but testing of model not included in article. States that causal-model approach is appropriate with • Experimental or non-experimental designs • Qualitative or quantitative methods • Multiple methods of data collection</td>
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<tr>
<td>Article</td>
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| Thurston, Vollman, Wilson, MacKean, Felix & Wright (2003) | Presentation of 2-part framework for assessing HP evidence. | Completely philosophically congruent with HP. | Does not address priority strategies specifically, but could be used to assess each of the areas. | Concept not specifically included. | Framework developed through mixed methods and participatory process:  
- Quantitative and qualitative data sources  
- Data collection through face-face meetings, teleconferences and electronic communication;  
- Informed by peer-reviewed literature  
- Expert review by 8 Albertan colleagues and 2 international experts  
- Internal consistency reached through discussion and consensual decision making process. |
| Thurston, Wilson & Felix (1999) | Applied the HP Effectiveness Framework across 17 Alberta HP | Completely philosophically congruent with HP. | Intersectoral/community collaboration and coalition building were | Concept not identified. | Only data source was written evaluation reports. |
### Article Description of Article Philosophical Congruence with HP AHLN Priority Strategies Conceptualization of Integration Research Design

**Vingilis & Pederson (2001)**  
Advocate causal-model evaluations in health sector in order to accurately learn why complex interventions did or did not work.  
Approach is philosophically congruent.  
- Sensitive to multiple influences and determinants  
- Long-term focus.  
- Complexity inherent to HP interventions requires explication of causal model  
Supports efforts to promote best practices in evaluation (research and evaluation).  
Evaluative suggestions relevant to AHLN because integration increases complexity and multi-causality of interventions  
Integration not part of article’s focus  
If project did not have written evaluation it was excluded from study.  
Article a review of other evaluations.  
Calls for use of more complex research and statistical designs, such as time-series, hierarchical regressions, structural modeling equation (p. 13).

**von dem Kensebeck, Joksimovic, Badura & Siegrist (2002)**  
Creation and implementation of Developmental evaluation framework guided by theory of change was used to evaluate a community policy initiative.  
Completely philosophically congruent with HP:  
- Process and outcomes linked  
- Focus on short term and intermediate outcomes  
- Sensitive to context  
- Honored different ways of knowing  
- Qualitative and quantitative data  
- Triangulation  
Policy initiative being evaluated had several objectives in common with AHLN:  
- Improving health reporting/monitoring (surveillance)  
- Improving collaboration and coordination among community-level agencies (partnerships)  
- Developing recommendations for community based  
Term “integration” not explicitly used, but project goal of improving horizontal integration at community level was achieved.  
Vertical integration (i.e. including state level) not accomplished.  
Mixed method research design included qualitative and quantitative approaches.  
Data collection techniques included  
- Semi-structured interviews  
- Standardized surveys  
- Content analysis of meeting proceedings/minutes, reports, etc.
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<tr>
<td>Chalmers, Housemann, Wiggs, Newcomb-Hagood, Malone &amp; Brownson (2003)</td>
<td>This monitoring system, which is based on event logs, is believed to be an effective method for tracking a coalition’s progress towards process and intermediate outcomes.</td>
<td>Elements of HP philosophy evident. CVD prevention coalition is • Multidisciplinary (not intersectoral) • Multi-level (individual and community)</td>
<td>Some risk factors targeted by coalition (diet, physical inactivity, smoking) are consistent with AHLN areas of focus. (partnerships) Activity logs could assist with capturing work of AHLN in 7 priority areas. Longitudinal record created over time (i.e. months, years) would show where emphasis and work occurred.</td>
<td>Although approach isn’t explicitly integrated, risk factors are common to other chronic diseases.</td>
<td>Process evaluation consisted of reviewing event logs and interviewing the log recorders. Information gathered believed to contribute to understanding of intermediate outcomes.</td>
</tr>
<tr>
<td>Sharp, A. &amp; Eddy, C. (2001)</td>
<td>Intersubject certifiability is a particular concern when evaluating socially sensitive topics. Techniques Sensitive to personal and social context. Not a population focus-all case studies at individual level of</td>
<td>Although case studies did not address priority areas, some strategies may have merit for AHLN evaluation.</td>
<td>Concept not included in article.</td>
<td>All evaluation case studies implemented qualitative methods.</td>
<td></td>
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<tr>
<td>Article</td>
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<td>Process evaluation consisted of reviewing event logs and interviewing the log recorders. Information gathered believed to contribute to understanding of intermediate outcomes.</td>
</tr>
</tbody>
</table>

| Shortell, Zukoski, Alexander, | This evaluation added to the | Project evidences elements of HP philosophy: | Evaluation generated 6 characteristics present in successful partnerships | Strong focus on horizontal integration | Mixed methods used to evaluate process and intermediate outcomes; |

Table 4: Best Practices in Partnerships
<table>
<thead>
<tr>
<th>Article</th>
<th>Description of Article</th>
<th>Philosophical Congruence with HP</th>
<th>AHLN Priority Strategies</th>
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<th>Research Design</th>
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<tbody>
<tr>
<td>Bazzoli, Conrad, Hasnain-Wynia, Sofaer, Chan, Casey, &amp; Margolin, (2002).</td>
<td>partnership literature by examining both the processes and outcomes of 25 large public-private partnerships.</td>
<td>• Intersectoral partnerships  • Consideration of socioenvironmental determinants of health  • Focus on population health status  • Purpose includes reorienting health services</td>
<td>(partnerships). Overall Partnership Management Capability Index contains indicators for assessing partnership management (research and evaluation).</td>
<td>• Partnerships pursued varying degrees of integration across issues addressed.  • Successful partnerships pursued horizontal integration of health services.</td>
<td>unable to evaluate long-term outcomes (too soon in project lifespan). Qualitative data sources:  • Original grant applications  • Quarterly progress reports  • Site visits  • Phone interviews  • Discussions at conferences. Quantitative data sources:  • Partnership self-assessment survey developed and distributed to 820 members of CCNs (response rate 55%)</td>
</tr>
<tr>
<td>Emanuel &amp; Titlow (2002)</td>
<td>Article is a supportive response to Shortell et al. (2002).</td>
<td>Acknowledge that intersectoral work is critical for improving population health outcomes.</td>
<td>Endorse the partnership and research/evaluation insights presented by Shortell et al. (2002). (partnerships; research and evaluation)</td>
<td>Comment that integrated efforts very difficult to administer and evaluate.</td>
<td>Confirm appropriateness of measuring process and intermediate outcome levels in a 3 year project.</td>
</tr>
<tr>
<td>Spitz &amp; Ritter (2002)</td>
<td>Article is a critique of Shortell et al. (2002).</td>
<td>Express concern re: lack of consideration of power differential within partnership groups.</td>
<td>Critique focused on improving evaluation practice. (partnerships; research and evaluation)</td>
<td>Integration not directly addressed, but comments on sensitivity to power issues within partnership are relevant to integration.</td>
<td>Criticize Shortell et al. (2002) on several elements of research design:  • Quantitative analysis incomplete  • Failure to clearly...</td>
</tr>
<tr>
<td>Article</td>
<td>Description of Article</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>articulate project sponsorship</td>
<td>Potentially biased key informants</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lack of consideration of context.</td>
</tr>
</tbody>
</table>
Grey Literature

Websites
Eleven CDP websites and their promising links were searched for evaluation information. The specific focus was to find evaluations that were completed, planned or in-progress.

The only project to report evaluation plans was the Nova Scotia Alliance for Healthy Eating and Physical Activity. The Alliance’s membership originally planned to evaluate their network using a framework based on the principles of collaboration. Resource constraints, however, have resulted in a narrower evaluative focus in which only Alliance-sponsored events or work are evaluated (personal communication, March 2004, C. Chenhall).

The Heart Health Resource Centre (Ontario) reviewed evidence of effectiveness in two consecutive reports (International Best Practices in Heart Health, 1998, 1999). These documents, which were conducted to inform community heart health initiatives in Ontario, provide comprehensive reviews of international best practices in heart health. Assessments of the initiatives were based on evaluation reports, which are cited in the documents’ reference lists. These sources were not pursued for this report, however, as they were not published in the past three to five years.

E-mail Correspondence
Electronic mail correspondence occurred with 13 representatives of CDP organizations in Canada and the United States. Of these, six resulted from a message posted on the listserv “click4hp”.

Three people indicated that they are involved in evaluating CDP/HP initiatives. R. Ritzman of the Eat Smart-Move More North Carolina project indicated that their evaluation uses a framework developed by Fawcett, Paine-Andrews, Harris, Francisco, Richter and Lewis (1995). The monograph outlining the framework, which was developed for evaluating cardiovascular disease prevention, was requested through the University of Alberta interlibrary loan service. Unfortunately, it was not received before this literature scan was completed. According to E. Ready, a diabetes prevention initiative in Winnipeg is at the beginning of an evaluation process. N. Hall from the Interim Authority for Community Living British Columbia reported developing a monograph on process evaluation of community-based projects. Unfortunately, due to time restrictions, further information from Ready and Hall was not obtained.

Discussion of Results of Literature Scan

Integration
In this literature scan, integrated approaches to CDP were more commonly found in the grey literature than the peer-reviewed literature. In both cases, evaluation frameworks specifically tested with integrated CDP initiatives were not found.

Grey literature
• Several provinces have organized alliances or networks to enhance their CDP efforts (i.e. Nova Scotia, Ontario, Manitoba and Alberta).
• Only the Nova Scotia and Alberta initiatives are at the evaluative stage.

Peer-reviewed literature
• The terms “integration” or “integrated approach” are not common in peer-reviewed literature.
• It was possible to infer the concept in many of the articles in this literature scan.
HP Evaluation
All of the frameworks reviewed in this literature scan identified that the complexity of health promotion interventions makes their evaluation challenging.

• This challenge is intensified by the nature of coalitions, as characterized by unstable membership, few resources, and members who are primarily accountable to their own organization.
• Adequately evaluating such complex interventions calls for an approach that clearly explicates an initiative’s causal links and uses a sophisticated methodology (i.e. mixed methods, time series design).

Another significant challenge to HP and population-level evaluation is an inability to directly determine the intervention’s impact on population health status.
• The ultimate outcomes sought by HP initiatives are too long-term to be captured in a single project’s lifespan.
• Consequently, the links between short term or intermediate outcomes and long-term outcomes are theoretically specified. This reinforces the call for clearly explicating causal links in HP evaluation.

Not all of the evaluation approaches reviewed were empirically tested.
• Four of the seven in this literature scan were supported by reviews of existing evidence and case studies.
• The remaining three were empirically tested with sophisticated designs.
Note: It is possible that an evaluation approach may have been tested elsewhere in the literature (peer-reviewed or grey) or that the approach is too new to have been widely implemented.

Terminology
Multiple terms, such as network, alliance, coalition and partnership, were used in the grey and peer-reviewed literature to describe a group of organizations working collaboratively to address identified issues.
• The elements of the terms describing interorganizational collaboration were often implicitly assumed by the authors.
• Since each term may be defined with a different emphasis on roles or relationships, the evaluative focus may also vary.
• In order to enhance the sharing and replication of best practices in evaluation, it may be advisable to clearly define the fundamental elements of the interorganizational collaboration and their link with the evaluation framework.

Future Considerations
Time constraints prevented follow-up on a number of potential information sources. Future work on best practices in health promotion may benefit from the information available from the following sources:

Pursue information from Hall and Ready (contact information in Appendix A).

Note: not received from Interlibrary Loan service in time for inclusion.

Note: reviewed draft section Conceptual Examples of Integration

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After reading the abstracts of the following articles, I decided not to include them in this literature scan because the information either did not fit the scope of investigation or failed to make a novel contribution. The citations are included in case further evidence is desired.


**Conclusion**

Several different approaches to best practices in HP evaluation were reviewed in this literature scan. At this time, it is apparent that discussions of integrated CDP are more common in the grey literature than the peer-reviewed literature. Further to this point, a significant gap in the literature is the absence of an evaluation framework specific to integrated CDP. The AHLN has an opportunity to make a meaningful contribution to HP knowledge and practice through their efforts to develop an evaluation framework specific to integrated CDP.
References


# Appendix A: Information from Grey Literature

## Table 1: CDP Websites

<table>
<thead>
<tr>
<th>Organization</th>
<th>Website</th>
<th>Evaluation Activity</th>
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<tbody>
<tr>
<td>Alliance for the Prevention of Chronic Disease</td>
<td><a href="http://www.preventionalliance.mb.ca">www.preventionalliance.mb.ca</a></td>
<td>No information provided on website; no response to e-mail request for information.</td>
</tr>
<tr>
<td>Canadian Consortium for Health Promotion Research</td>
<td><a href="http://www.utororonto.ca/chp/CCHPR/">www.utororonto.ca/chp/CCHPR/</a></td>
<td>Information not listed on website, pursued through e-mail.</td>
</tr>
<tr>
<td>Centre for Behavioural Research and Program Evaluation (University of Waterloo)</td>
<td><a href="http://www.ist.uwaterloo.ca/phone/dept_dir.html">www.ist.uwaterloo.ca/phone/dept_dir.html</a></td>
<td>No information provided on website; no response to e-mail request for information.</td>
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<tr>
<td>Centers for Disease Control and Prevention, US Department of Health and Human Services</td>
<td><a href="http://www.cdc.gov">www.cdc.gov</a></td>
<td>Two programs with similar focus areas that have evaluation components were listed in “State Programs in Action: Exemplary Work to Prevent Chronic Disease and Promote Health”&lt;br&gt; • Eat Smart- Move More North Carolina&lt;br&gt; • Hawaii Project</td>
</tr>
<tr>
<td>Chronic Disease Prevention Alliance of Canada</td>
<td><a href="http://www.cdpac.ca">www.cdpac.ca</a></td>
<td>No evaluation frameworks or projects listed on website. Robert Charrois provided the reference list of reviewed strategies on integrated chronic disease prevention from the Canadian Action Plan on Integrated Chronic Disease Prevention (draft document to be released in April 2004).</td>
</tr>
<tr>
<td>Health Promotion Clearinghouse</td>
<td><a href="http://www.hpclearinghouse.ca">www.hpclearinghouse.ca</a></td>
<td>No evaluation of CDP initiatives at this time. Anticipate some form of evaluation as part of Nova Scotia Chronic Disease Prevention Strategy.</td>
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<td>Name</td>
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<tr>
<td>Anne Lessio</td>
<td>Manager, Heart Health Resource Centre Ontario Public Health Association</td>
<td>See Table 1</td>
</tr>
<tr>
<td>Suzanne Jackson, PhD</td>
<td>Director Centre for Health Promotion University of Toronto</td>
<td>See Table 1</td>
</tr>
<tr>
<td>Contact name unknown (no name signed on e-mail)</td>
<td>Health Promotion Clearinghouse Nova Scotia</td>
<td>See Table 1</td>
</tr>
<tr>
<td>Robert Charrois</td>
<td>Assistant, Chronic Disease Prevention Alliance of Canada (CDPAC) 1010-116 Albert Street</td>
<td>See Table 1</td>
</tr>
</tbody>
</table>
| Nancy Dubois and Tricia Wilkerson | Health Promotion and Planning Consultants, DU B FIT  
Contracted by the Best Practices Consortium and Health Canada | • Establishing Canadian perspective of a definition of best practices in health promotion.  
• Preparing a synthesis of literature.  
• Will ultimately establish a database linking all best practices. |
| Paula Migliardi | Sexuality Education Resource Centre  
Manitoba  
* student at Manitoba Summer Institute on Population Health Promotion | • Provided specific contact information for Manitoba Heart Health Project  
Room 421 Faculty of Education Building, University of Manitoba  
R3T 2N3  
Phone: (201) 474-7043  
Fax: (204) 474-7550  
Email: heart1@bldgeduc.lan1.umanitoba.ca  
Note: No response from project. |
| Elizabeth Ready | Elizabeth Ready, PhD  
Professor  
Associate Dean (Academic)  
Faculty of Physical Education and Recreation Studies  
University of Manitoba  
Winnipeg, MB  
R3T 2N2  
Ph: (204) 474-8641  
Fax: (204) 474-7634  
Email: readyae@ms.umanitoba.ca | • Provided brief information on The Winnipeg Diabetes Strategy for Older Adults.  
• This is a community-based project with multi-level partners (i.e. St. James-Assiniboia Senior Centre (Karen Pirnie, Project Coordinator), the Winnipeg Regional Health Authority, the Anne Ross Health Resource Centre, and Mount Carmel Clinic).  
• In beginning stages of evaluation |
| Tracy Howson | Manager, Ontario Chronic Disease Prevention Alliance  
700 Lawrence Ave., West, Suite 310  
Toronto, Ontario  
M6A 3B4  
Tel.: 416-367-3313 ext. 251 1-800-267-6817  
Fax.: 416-367-2844  
email: ocdpa@opha.on.ca | • Referred to the Centre for Behavioural Research and Program Evaluation (519-888-4503) and also The Programming Training and Consultation Centre (see their website PTCC) |
<table>
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<tr>
<th>Name</th>
<th>Contact Information</th>
<th>Comments</th>
</tr>
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| Nancy Hall            | Senior Advisor  
Interim Authority for Community Living British Columbia  
Cell: 604-868-2171  
Fax: 660-3353  
Email: nancy.hall@shaw.ca | • Developed a process evaluation framework for community health promotion programs (available in monograph form).  
• Currently evaluating a Seniors Health Promotion grant program. |
| Rosemary Ritzman, PhD | Program Evaluator  
Physical Activity & Nutrition Branch  
NCDHHS/Division of Public Health  
1915 Mail Service Center  
Raleigh, NC 27699-1915  
Phone: 919/715-6728  
fax: 919/715/0433  
email: rosemary.ritzman@ncmail.net  
website: www.EatSmartMoveMoreNC.com | • Project has multi-level partners, surveillance, healthy eating and physical activity strategies, targets children 2-5 years old.  
• Evaluation based on framework developed by Kansas Workgroup on Health Promotion and Community Development and the Centers for Disease Control and Prevention (Fawcett et al., 1995). |
| No specific contact- accessed from web link | Hawaii Project  
e-mailed for info Feb 27/04 | • Website report refers to information on assessment, monitoring and evaluation of physical activity in Hawaii.  
• No response to e-mail. |
| Colleen Rand, RD,CDE  | Diabetes Program Specialist  
Winnipeg Regional Health Authority  
2nd floor 490 Hargrave St.  
Winnipeg, Manitoba  
R3A 0X7  
phone: 204-940-3648  
fax: 204-957-0884  
crand@wrha.mb.ca | • Informant for project at University of Waterloo (2003) that involved conducting an international scan to identify 'exemplary programs, policies and protocols with the potential to reduce the incidence of type 2 diabetes' for the Heart Health Resource Centre of Ontario.  
• Contact names from University of Waterloo are Steve Manske and Rhona Hanning; phone #(519) 888-4567 ext. 3443.  
• Contact from HHRC is Tracy Howson. Note: did not pursue due to time constraints. |
| Lindsay McLaren, PhD | Centre for Health and Policy Studies  
| G230 Health Sciences Centre  
| University of Calgary  
| 3330 Hospital Dr. NW  
| Calgary (AB) T2N 4N1, Canada  
| phone: (403) 210-9424  
| fax: (403) 210-3818  
| email: lmclaren@ucalgary.ca | • McLaren and colleagues are preparing a report entitled "Integrated Approaches to Chronic Disease Prevention: A focus on promoting healthy weights and preventing obesity" (see reference list for complete citation).  
• Provided a section of draft report on "conceptual examples of integration". |

Many factors interact to create complex conditions for the evaluation of community-based initiatives, such as coalitions. Examples of confounding factors include vague goal statements, shifting priorities for action, membership changes, and inadequate resources for evaluation. The premise of a pragmatic approach to evaluation is simply to do the best with what you have.

The case example provided in this article demonstrates the operation of a large, multi-level, intersectoral community coalition and a pragmatic approach to evaluating its efforts. The coalition’s purpose was to identify community issues, develop a plan of action and make changes. It did not have adequate funding allocated for evaluation.

**Nature of community**
The complexity inherent to community initiatives makes evaluation difficult.

**Goals**
- It is difficult to capture the synergy of multisectoral, multilevel change.
- Explicating specific causal links is challenging because they are intertwined and interdependent.
- The uniqueness of each community means a comparison group is not possible.

**Strategies**
- In spite of planning efforts, community initiatives often “develop incrementally, often disjointedly…” (p. 148)
- Planning processes are responsive to everyday needs and resources; planning often becomes a political process rather than a rational, evidence-based process.

**Development of community initiatives**
Community dynamics often make rational planning difficult (i.e. too little time/insufficient expertise to develop explicit change theory; different participants conceptualize intervention differently; frequent membership turnover). The development of community initiatives may be described through the following interrelated processes.

**Participation**
Who is involved in the initiative often determines what is addressed. Issues of membership, retention, and internal politics influence the planning of initiative.

**Action**
At this stage the act of participating changes into a commitment to do something. Since the action must be congruent with participants’ beliefs and interests, it is often oriented towards the memberships’ interests.

**Research**
Research is defined as “the systematic collection and analysis of information as a method for making decisions” (p. 149). It is more oriented to the external requirements place on initiative (i.e. establishing goals, securing resources).
**Evaluation of community initiatives**
Evaluation of community initiatives often occurs under unfavorable conditions, such as lack of consensus among participants regarding project goals or insufficient human/financial resources for evaluation. The pragmatic approach to evaluation focuses on the processes that are elements of the development of a community initiative. Baum notes, however, that an evaluator's attitude is more important than the methods selected. When evaluating community initiatives, the evaluator must tolerate ambiguity, manage complexity and use common sense.

**Logic of Participation**
Evaluators are advised to “Conceptualize strategies and goals in terms of current participants’ views and needs” (p. 154).
- Avoids inappropriate focus on outdated interventions.
- Involves stakeholders currently most committed to initiative.
- Provides for formative evaluation which enables measurement of progress and immediate feedback to group.

**Logic of Action**
The “…evaluation should examine interventions in terms of what is distinctive about community initiatives” (p. 154).
- Examine the synergy of interventions to determine how they potentiate or limit each other.
- Examine the initiative’s effects on the community (i.e. influence on policies).
- Consider how the current conditions contribute to “progress toward long-term goals” (p. 155).
- Include an analysis of the initiative’s processes (i.e. planning, implementation).

**Logic of Research**
- Need to recognize pragmatic constraints on data collection and methods (i.e. financial limits).
- Collect data “opportunistically” (i.e. observe what is important and accessible, use proxy variables, include participants as key informants).


Cramer et al. (2003) present process and impact evaluation of tobacco reduction coalition
- Gap in coalition literature is impact evaluation (usual focus is coalition process).

TOP (Targeting Outcomes of Programs) Model (Rockwell & Bennett, 2000) used- see website [http://citnews.unl.edu/TOP/] (http://citnews.unl.edu/TOP/)
- Model has been tested, implemented and revised for 20 years
- Model consists of 7 hierarchical steps for planning and evaluating program development and program performance; feedback loops link both parts of model.
- Clear links between planning and evaluation facilitate consideration of evaluation needs from the very beginning of project.
- As group ascends the hierarchy of model, it is more likely that broad impact will be achieved.

The coalition described by Cramer et al. was smaller than the AHLN (15 members), but shared a focus on multiple strategies. Initially focused on establishing coalition organizational capacity, then focused on broad, multi-level intersectoral strategies.
Examples include: “…passing a tobacco excise tax, conducting numerous community training sessions, educating community leaders and politicians, initiating media coverage, and coordinating with the police on city-wide compliance checks for tobacco sales to minors” (p. 467)

**Benefits of using TOP framework:**
- Facilitates strategic use of coalition resources (i.e. different members work on framework components that fit with their skill base or experiences).
- Encourages coalition stakeholders to participate in evaluation project.
- Clarity of framework facilitates evaluation capacity-building with stakeholders.
- Facilitates development of relevant indicators with each objective.
- Assists with monitoring and tracking coalition activities.
- Facilitates explication of causal links.

**Limitations of using TOP framework:**
- Older model (unsure if it is considered classic work- not cross-referenced in this literature scan)
- Model was created for health education programs and may implicitly encourage top-down processes.


**Rationale for development of framework**
The scientific paradigm, and RCT studies, oversimplify public health reality (i.e. subjects with single health issue, willing participants, and no lack of human or financial resources for the intervention).
- This approach results in efficacious interventions that often have disappointing effects in reality.
- Capturing the worth of public health interventions requires an alternative way of conceptualizing impact.

RE-AIM calculates the strength of interactions among five elements of a public health intervention in order to calculate its public health impact (PHI).
This quantified score represents the quality of intervention

**RE-AIM Domains**
1. **Reach**
   - Consider both the number and characteristics of participants.
   - Information on non-participants is as important as characteristics of participants (i.e. assessing if program is reaching those who need it most).

2. **Efficacy**
   - Determine if the positive outcomes of the intervention outweigh the potential negative consequences.
   - Consider behavioral and quality of life outcomes.

3. **Adoption**
   - Calculating “the proportion and representativeness of settings… that adopt a given policy or program” (p. 1323).
   - Also consider barriers to adoption.

4. **Implementation**
   - Measure if the program was implemented as intended in terms of participant adoption and organizational compliance.
   - Directly impacts program effectiveness (efficacy x implementation = effectiveness).
• Evaluation of implementation helps to determine practicality of intervention.
• Proper assessment requires data collection for minimum of 6 months to 1 year.

5. Maintenance
• Individual and organizational maintenance of change critical.
• Need to measure if change becomes norm for organization/individual.
• Need data collection to occur over at least 2 years.

Suggested Uses of RE-AIM
• Assessing PHI within organization over time.
• Comparing PHI of same intervention implemented by several organizations over time.
• Comparing PHI of more than 1 intervention within a single organization.
• Facilitate decision making re: resource distribution.

Limitations of RE-AIM
• More research required on all dimensions (i.e. determine their independence or interdependence)
• Need to know more about inverse relationship between PHI and efficacy (i.e. larger PHI = lower efficacy)

Website link www.ori.org/~shawn/public/reaim/reaim.long.pdf
Undated paper at website is essentially same the content as Glasgow et al. (1999).
Contains excellent tables outlining amount of existing support for dimensions, relationship between dimensions and level of analysis


Process and outcome evaluation designs typically do not investigate why a program worked or did not work.

A causal-model evaluation “…establishes an a priori model of how the program will work to affect important outcomes before the evaluation is completed and …empirically tests at least one link in the model apart from implementation or program activity data, along with outcome data” (2000, p. 6).

The term “causal-model” is promoted rather than program theory (i.e. Weiss, 1998) or theory-driven evaluation (i.e. Chen & Rossi, 1992) because the evaluation seeks to examine the causal links within the program, not its theoretical foundations.
• These links can be theoretically derived or rooted in “…the common-sense assumptions of the policy maker and practitioner” (Petrosino & Petrosino, 1999, in Petrosino, 2000, p. 5).
• It is optimal to specify as many links as possible in the program’s causal chain in order to facilitate an understanding of its effects and the necessary conditions for replication.
• Conceptualization of the causal model may be revised as the program evolves and its elements become clearer.
• Clear causal links can facilitate awareness of any negative or unintended consequences of the program.

Benefits
• Specifying causal links enhances program planning and evaluation by making clear the appropriate activities/designs to select.
• Stakeholder involvement in the evaluation is enhanced because of collaboration inherent to development of causal model.
• Knowledge of the important change mechanisms in the program facilitates successful replication. Ultimately, increased knowledge and testing of causal links will contribute to knowledge about effectiveness/best practices.

Limitations
• This evaluation approach is expensive (i.e. more data to collect, evaluators spend more time with stakeholders).
• Stakeholders may be interested only in learning about effectiveness as opposed to why the program worked.
• Intellectual challenges are inherent to development of causal models (i.e. when to stop questioning “why”; how to determine “acceptable effect…for each link in the model” (p. 15).
• Approach may have difficulty capturing the complexity inherent to some programs (i.e. lack of appropriate measures/tools; propensity towards linear causal models).


The framework was developed by a multidisciplinary, Albertan team to facilitate assessment of health promotion effectiveness.
• HP effectiveness broadly conceptualized to include HP principles, values, and processes.

Framework Components
Part I: HP Characteristics
The project is assessed with regard to how it fits with fundamental HP philosophy and elements.
• HP strategies (as outlined in the Ottawa Charter)
• Determinants of Health
• HP principles (i.e. empowerment; equity & accessibility; intersectoral collaboration; community action for health; current knowledge; community capacity)

Part II: Evaluation of effectiveness
The project’s evaluation is assessed in terms of process, outcomes and dissemination. Written evaluation report must be available for consideration.
• Evaluation process (i.e. evaluation design, data collection methods, analytic methods, impact, principles for evaluation of HP initiatives)
• Effectiveness (i.e. short-term/long-term outcomes)
• Lessons learned from the project or project elements with potential for effectiveness.

Implementation of Framework
The sections of the framework can be used together or independently. Each section concludes with a project summary and score. An overall summary and score is provided at the end of the framework.

Four possible conclusions:
1. Keep both the program and evaluation process as they are.
2. Modify the program to address health promotion deficiencies and continue with appropriate evaluation.
3. Keep the program virtually as it is, but improve the evaluation.
4. Discontinue the program, because there is too much missing to invest further in program development and evaluation (p. 315).


The authors make a case for increased use of causal model evaluation frameworks in health services. It is believed that more sophisticated evaluation designs and methods are required in order to accurately capture the complexity of health interventions and enhance understanding of their effectiveness. Since the commonly used “black box”, atheoretical frameworks do not examine causal links, they may ultimately contribute to misinformed decision-making.

Specific case examples of complex health interventions that were inappropriately evaluated with a black box design are provided. An intervention evaluated by time series design as opposed to a black box design is also described. This example clearly demonstrates the significantly better understanding generated by a sophisticated design.

*Conceptualizing Complexity*

Health intervention complexity can be conceptualized as a continuum with simple, direct cause-effect links at one end and complex, multi-causal links at the other. It follows that the evaluation design should be matched with the level of complexity.

*Simple*

Black box evaluations may be appropriate with simple cause-effect links (i.e. immunization, pharmacological interventions) because no extraneous events interfere with physiological reaction.

*Complex*

A causal model must be specified in order to accurately evaluate complex cause-effect links (i.e. multidimensional cause is applied over time and varies with context). At this level of complexity, four sources of error exist: “exogenous variables, implementation system, endogenous variables, and random error” (p. 5). It is also important to match sophisticated evaluation designs with appropriate statistical techniques such as time series analysis or controlled time-series trials.


This paper reports the design, evaluation and results of a health policy initiative in the largest state in Germany that was quite similar to AHLN. Initiative goals included improved health care and social care planning, as well as coordination, at the community level (i.e. improve horizontal integration).

*Evaluation framework*

- The evaluation framework was specifically developed for this project.
The developmental perspective that guided the framework was described as appropriate to use when the “target is difficult to specify and is likely to change over time” (p. 114).

The theoretical foundation of the framework was the Theory of Change. It was defined as “… a systematic study of the links between contexts, activities and outputs of the initiative” (p. 114).

The framework was implemented using a descriptive social research evaluation approach (i.e. descriptive data and case study; seek to learn about context, community conditions, processes, outputs/outcomes).

**Evaluation process**

1. Context
   - Assessed community conditions in very early stages of policy initiative (i.e. before changes began).
2. Process
   - Assessed the work structures established by project (i.e. Round Tables and Working Groups) and their activities (i.e. use of reliable/valid info to assess and plan for pop health within project scope)
3. Outputs/Outcomes
   - Assessed institutionalization of change (new groups firmly established in communities) and “improvements in health monitoring and their determining factors…” (p. 115)

**Results of interest**

- Improvements in local control of health resources/programs were linked with increased local action/program implementation.
- High quality information about population health needs (i.e. from health monitoring systems) was linked with effective local programs. The system, however, required sustained resources to continue.

**Strengths of Framework**

- Authors very clear about philosophical assumptions, methods, processes.
- Able to tap into stakeholders’ view of project.
- Enables comprehensive assessment of policy/coalition work.

**Limitations of Framework**

- Unable to establish causality in community policy initiatives.
- Use of participants as key informants involves risk of social desirability bias.

**Evaluation Processes**


Chalmers et al. (2003) present the results of an evaluation of a multidisciplinary coalition’s monitoring system. The coalition’s purpose was to address known risk factors (i.e. physical activity, healthy eating, high blood cholesterol) in order to decrease CVD related morbidity/mortality.

Event logs were used to record the coalition’s progress towards process and intermediate outcomes at the individual and community levels. The event logs were based on an evaluation system entitled *Evaluating Community Efforts to Prevent Cardiovascular Diseases* (Fawcett, Sterling, Paine-Andrews, et al., 1995 cited in Chalmers et al. 2003) which was developed through experiences with community partnerships. The logs facilitate measurement of changes linked with coalition activities by creating a record of coalition events.
The evaluation did not assess the usefulness of the tool for capturing long-term outcomes due to time restrictions. Coalitions are typically not active long enough to measure outcomes that require several years to develop.

**Evaluation of Monitoring System**

Evaluation data was collected by reviewing event logs and conducting semi-structured interviews with the coalition director and activity coordinator (people responsible for recording information in the logs).

**Description of Event Logs**

- Categories of coalition activities documented in logs included:
  - Community action; community change; coalition building; planning products; services provided; media coverage; resources generated; and other.
- Anticipated relationships among the activities were described (i.e. community actions should lead to community change; coalition building activities will “level off” once coalition is well-established; resources generated linked with services provided).
- The following information was recorded about the activities in logs: Who was involved? What organizations were collaborators? What community sector or objective is this related to? Was this the first time this event occurred? (p. 191)
- The data gathered through the logs were entered into Excel and graphed.

This created a descriptive visual display of coalition activities, turning points (i.e. impact of hiring staff) and progress.

**Process Evaluation**

This was conducted through a review of event logs and semi-structured interviews with staff that completed logs.

- Coalition recorders believed the logs were an effective way to capture coalition activities and impact.
- Duplicated recording was revealed during interviews and suggestions for improved efficiency resulted.
- A more efficient recording system (i.e. consolidated) was expected to contribute to more thorough and accurate recording.
- Annual “training” sessions were recommended to ensure congruence between activity recording and data coding (completed by separate teams).


Often considered when addressing reliability issues, intersubject certifiability is when “…two or more researchers or processes will draw similar results and interpretations after exposure to the same material” (p. 89). Intersubject certifiability is difficult to ensure when evaluating socially sensitive topics because evaluation participants may withhold information or selectively provide information to members of an evaluation team. Improving the reliability of the evaluation results by addressing intersubject reliability requires the evaluator to consider issues of context and power.

Sharp and Eddy (2001) present three evaluation case studies to review this concept and provide techniques for improving intersubject certifiability. All of the case studies relied on qualitative methods. The techniques are directed at the evaluation methodology, researchers and respondents.
Methodology
• Carefully match the data collection method to the participant group when the topic might not be socially acceptable (i.e. traditional indigenous participants (authors’ are Australian) may share more information in a group setting).
• Each researcher is advised to make his/her own notes prior to debriefing so that individual recall is not biased by group discussion.
• Conduct initial interviews/focus groups in teams; follow with debriefing to explore and deal with areas of bias.
• Combine qualitative methods to lessen bias.
• Strategically sequence the methods (i.e. when know little about topic, begin with focus group; ideas snowball in group; pursue identified themes in greater depth through individual interviews).
• Use concurrent methodologies (i.e. simultaneously conduct interviews and focus groups with segments of participants and search for consensus/disparity).

Researchers
• Create heterogenous evaluation team in order to balance attitudes towards topic (i.e. ensure mixed demographics such as age or martial status)
• Researchers advised to clearly state personal biases/values at the beginning of project
• Introduce new team member at the beginning of each phase in longitudinal research (introduces fresh perspective to evaluation project)
• May be helpful for the researcher to share his/her own attitudes with respondents in order to build trust and rapport (may increase respondents’ comfort level so they are able to share more fully).

Respondents
• Seek information from “different but related respondent groups” (p. 96) (i.e. spouse of primary respondent).
• Maintain contact with participants outside of survey period in order to maximize participant retention in longitudinal evaluations.
• Share evaluation results with participants to increase their sense of ownership over evaluation; increases commitment to evaluation and lessens drop-out.

Best Practices in Partnerships


The article describes the evaluation of 25 large, public-private partnerships called Community Care Networks (CCN) in the United States. The partnerships were intended to improve community/population health by enhancing a coordinated, collaborative response to a broad range of community health issues. Three years of funding ($300,000) was provided to “build partnership infrastructure and capacity and …fund specific activities or programs” (p. 52).

Shortell et al. describe a lack of evidence of partnership success in current literature due to the following factors:
• Absence of a shared vision and goals within intersectoral partnerships.
• Challenge of multisectoral integration underestimated (i.e. difficulty of getting diverse groups to work together on intractable, long term issues)
• “Insufficient time allowed” for tracking effects of interventions (p. 51).
Evaluation methodology
The evaluation focused on measuring CCN process and impact; theoretical links specified long-term outcomes.
The CCN operational model was used as the evaluation framework.
• Model consists of 5 interactive components which contribute to achieving the initiative’s vision
• Monitoring and evaluation are a single phase integrated in model; thus, any lessons learned from this component can be used to strengthen implementation in other areas.
• Process indicators are found in the Overall Partnership Management Capability Index in the Appendix.

Results
The following 6 distinguishing characteristics were found to be present in the top performing partnerships and absent in the poorest performers.

1. Successfully manage partnership size and diversity
   • Characteristics of success:
   • Broad membership represented all community sectors.
   • Diversity encouraged.
   • Multi-level political support actively sought.
   • Multiple methods used to ensure public participation.

2. Three component leadership
   Factors for effective leadership:
   • Committed core leadership (i.e. dedicated champion present).
   • Consistent organizational driver (i.e. at least one member organization had adequate resources to quietly maintain partnership stability; enabled partnership to maintain focus on community health issues rather than survival).
   • Subsidiary leadership (i.e. ensuring individual partners with the most expertise in specific areas had the authority to lead the larger group).

3. Focus
   • Initiatives linked so partnerships continually progressed towards their stated objectives/vision.
   • Funding pursued only when contributed to vision.

4. Manage and channel conflict
   • Attended to group processes in order to avoid and manage conflict.
   • A significant challenge to group processes was suspicion and territorialism among members.
   • Top performing group processes characterized by efforts to foster interdependencies among members, maintain trust, fair and transparent decision-making, and clear communication of information.

5. Recognize life cycles and “handing off the baton” (p. 77)
   • Partnership’s organization, structure, composition and leadership changed as it matured (i.e. complexity of issues to address increased over time and partnership evolved in concert)

6. Ability to patch
   • Defined as “…a partnership’s ability to reposition its assets, competencies, and resources to address changing needs and priorities” (p. 79).
   • Evidenced by actions such as blending funds from several sources in order to focus on community needs; adjusting the scope of initiatives to ensure realistic volume of work.
Partnership needed to become central to members’ existence (i.e. less than complete participation not an option because of political/social/financial consequences).


This commentary is very supportive of Shortell et al.’s (2002) evaluative process.

- They suggest that the 6 characteristics for partnership success identified by Shortell et al. (2002) provide a helpful conceptual map to guide other partnerships.
- A missing link in Shortell et al. (2002) is that the necessary conditions/processes for achieving community input are not delineated.
- Support that evaluation approach must be congruent with project (i.e. appropriate to evaluate process and impact of a 3 year project as project too young to expect achievement of outcomes)


This critique of Shortell et al. (2002) identifies concerns with several elements of the study. [The issues are common to HP evaluation/research].

**Sponsorship**

- CCN project is hospital sponsored, so the issues and activities are perceived through this lens. It is suggested that the primary focus of CCN work may implicitly be to further hospital interests.

**Community partnerships**

- Power dynamics are not explored, even though power and control are central issues in partnerships. An imbalance in power exists because hospitals have significantly more power than community agencies. The critical question is whether a partnership truly exists when the power differential is great.

**Potential biases**

- Participation in Shortell et al.’s (2002) study was problematic as the key informants may have been biased (i.e. Project directors’ desire to have their project “look good”).
- The study would have been potentially less biased if the broader public/community members, state officials and other external stakeholders were included.

**Quantitative analysis**

- Not linking internal indicators of success with broader community measures results in false view of partnership success.
- Data collection seems incomplete without more data.

**Guidance provided to other projects**

- Lack of attention to context weakens evaluation– no analysis of how political context and community context interact or relate with partnerships.
Other


and


Both reviews are available at www.hhrc.net

These documents, which were conducted to inform community heart health initiatives in Ontario, provide comprehensive reviews of international best practices in heart health.

The inclusion criteria for a practice/initiative to be considered were that it needed to be multi-risk, multi-factorial, multi-level.

The practices were reviewed in isolation, but in reality they were implemented as part of broader strategy.

The review was conducted by examining evaluation reports of the initiatives.

Three criteria were used to assess and categorize the practices:

Effectiveness criteria

- Focused on outcome and impact evaluation.
- Criteria sensitive to approach, target and level (i.e. individual, policy, etc.) of initiative.

Plausibility criteria

- Assessed if it was likely initiative would be successful “based on its attributes”
- Considered evaluation, content, process attributes.

Practicality criteria

- Initiative must be practical for community implementation to be considered best
- Considered cost effectiveness, availability and fit.

A total of nine initiatives were presented as best/promising practices in 1998; seven in 1999. Although reference lists are provided, the sources too dated for consideration in this lit scan (i.e. mid 1990s). Consequently, this document is not included in the Results table.