ONTARIO HEALTH PROMOTION RESOURCE SYSTEM
(OHPRS)

RESULTS OF A FIVE-YEAR EVALUATION PLAN

(2003-2007)

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WITH THE SUPPORT OF
OHPRS EVALUATION AND NEEDS ASSESSMENT COMMITTEE

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OHPRS: RESULTS OF A FIVE-YEAR EVALUATION PLAN (2003-2007)

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OHPRS: RESULTS OF A FIVE-YEAR EVALUATION PLAN

(2003-2007)

1.0 INTRODUCTION AND BRIEF HISTORY OF OHPRS

This evaluation report seeks to integrate findings from a range of evaluation projects and activities conducted over the past five years in an effort to both "document the road traveled" and to provide information and insights that may help shape the new horizons that lay ahead for OHPRS.

One of the key strategies of the provincial government for promoting the health of Ontarians is empowering local communities to identify and prioritize health issues and enhance their capacity to develop local solutions. To support this direction the Ontario Health Promotion Resource System (OHPRS) is funded by the Ministry of Health Promotion (MHP) to provide a range of services and supports to organizations and professionals in Ontario that work to improve the health and wellbeing of their community through health promotion and prevention policies and programs[1]. OHPRS is a network of organizations currently comprised of 21 member organizations and several affiliates[2], as well as a central, core Secretariat that provides services and supports to them. A small number of the OHPRS organizations provide information and other services directly to the general public.

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[1] In this report the terms "health promoters" or "health promotion intermediaries" are used to refer to this collective of organizations and professionals in Ontario.

[2] For purposes of this report we refer to both OHPRS Members and Affiliates as the "OHPRS organizations". See Appendix A for a list of current OHPRS Members and Affiliates. The number of OHPRS Members during the implementation of the different parts of the five-year evaluation varied somewhat due to new organizations coming on-stream (e.g., Ontario Injury Prevention Resource Centre) and also changing status of SHAF and OTRU in recent years from Member to Affiliate. For that reason some parts of this report will refer to 23 OHPRS organizations.

The organizations comprising the OHPRS network were funded individually to address specific needs (e.g., knowledge and skills) for practitioners engaged in providing health promotion services and supports to Ontarians. For example, OHPRS organizations provide support for health promotion work related to nutrition, infant and maternal health, tobacco or alcohol and drug use, self-help, and healthy communities, to name but a few domains targeted by the OHPRS organizations individually or in collaboration with one another. They were also funded at different points in time. The concept of OHPRS as a network or "system" developed as a response to the report by ARA Consultants in 1998. This group was contracted to review the various organizations as a collective and make recommendations for better coordination among them. At that time, a key representative from the Ministry of Health and Long-Term Care (MOHLTC) championed the idea of OHPRS as a coordinated "system" of services for the province's health promotion intermediaries such as public health nurses and other professionals, although the idea was not driven by a formal MOHLTC agenda or strategic plan. Some key players within the network itself then advanced the system model, developed a formal proposal for a core network support function, and the OHPRS Secretariat was funded in 2001. In funding the Secretariat, the Ministry essentially endorsed the concept of OHPRS as a system and, in due course, conveyed expectations for system-level administrative requirements to funders such as a common reporting format for reporting activities and annual workplans. There was also an expectation that some administrative efficiencies would also evolve, such as group purchasing and sharing of administrative tools and procedures. Several OHPRS organizations themselves championed specific committee work, such as the Information Coordination Committee, the Communication Advisory Committee, the French Language Services Committee, and the Evaluation and Needs Assessment Committee[3]. Over time it was anticipated that additional forms of project-based collaboration would evolve at both a system-level as well as among individual OHPRS organizations.

The political context *vis a vis* the Ontario provincial government has changed considerably for OHPRS since its inception, and continues to evolve. The major change occurred in 2005 with the creation of the Ministry of Health Promotion to which the funding portfolio for the resource system shifted from the MOHLTC. Major new

[3] This committee was originally called the Impact Evaluation Committee.

government programs and strategies have also been developed and implemented of high relevance to the network (e.g., the new Public Health Agency of Ontario; Ontario Heart Health Action Program; Smoke-free Ontario Strategy; Healthy Eating-Active Living). Over 2006-2007 OHPRS was the subject of a provincial review that, among other things, was intended to determine if the current OHPRS structure, program model and funding provide effective support to the MHP, the MHP and MOHLTC mandatory programs, and the Chronic Disease Prevention Branch strategy and priorities. It was also intended to determine the most efficient and effective relationships among OHPRS and other parts of the health promotion and prevention system (e.g. the new Agency), and local public health units; and to identify the future role of OHPRS as a service delivery system for the MHP strategies and priorities including how it should be positioned in relation to the Agency. The results of this review have been reported to the OHPRS network and several structural and process-related changes will no doubt ensue.

2.0 EXPECTED IMPACTS AND THE EVALUATION PLAN

2.1 THE OHPRS IMPACT MODEL

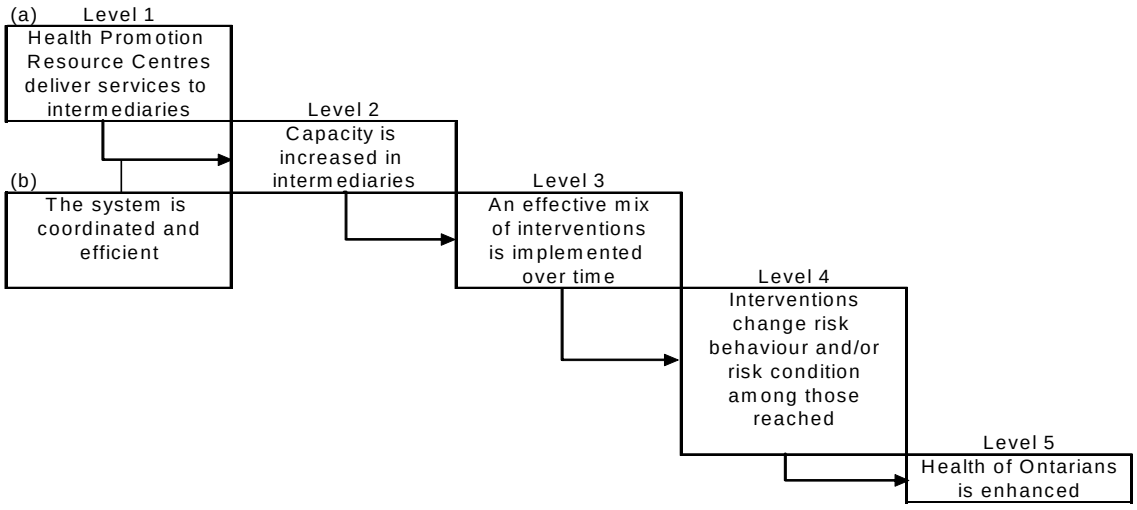
Since its inception a variety of conceptual models have been developed to articulate the core functions and expected outcomes of OHPRS collectively. For purposes of evaluation one such model articulated the multiple levels of impact. These impacts included changes expected within the OHPRS network itself (e.g., better coordination of services), as well as within the ultimate collective target population of the system, namely Ontario health promoters. For the health promoters the expectation was that the services and supports delivered by the OHPRS network would increase the capacity of health promoters in a variety of areas and, in turn, influence the quality and comprehensiveness of health promotion interventions in the community (e.g., the mix of individual, environmental and policy options). The longer-term expectation was to impact risk behaviour and/or conditions as well as health outcomes of the population.

The concept of "health promotion capacity" is central to the rationale underlying OHPRS. A number of authors have tried to define the specific capacities that health promoters must have for impact at a community level. The list below reflects a synthesis from a number of sources (see Rush, 2002, Macdonald, 2001).

- positive predisposition to implement a comprehensive mix of activities (i.e., motivation)

- community values aligned with health promotion
- leadership
- organizational commitment
- adequate financial resources to ensure good penetration and durability of activities
- skills and knowledge for accurate community assessment
- skills and knowledge for effective implementation of "best practices" including advocacy, self-help, health communication, design and implementation of interventions, evaluation and policy development
- access to program materials (for themselves and their clients)
- skills in coalition building and maintenance
- skills in consensus building, financial management, conflict resolution, marketing, planning, government relations, inter-organizational relations
- critical reflection skills for continuous quality improvement

Figure 1. Initial impact model and levels of evaluation for OHPRS



The various organizations within OHPRS build these elements of capacity among health promoters through training, consultation, print and electronic resources, network building opportunities, and referrals. The individual OHPRS organizations undertake

independent evaluations of various scope and focus, and such evaluations complement the approach to evaluation embodied in the more system-level OHPRS evaluation plan.

In the course of planning and implementing a multi-year evaluation plan for OHPRS, a program logic model[4] was developed to articulate the core functions to be delivered in relation to the overall mission of the network, namely:

- to function as a coordinated, well-understood and easily accessed system that supports health promotion in Ontario in a proactive, reactive and interactive manner"

In support of evaluation planning, the logic model also spelled out the expected short and long-term outcomes in more detail than previously articulated and, importantly, added outcomes expected for the MOHLTC itself. This logic model was adapted near the end of the five-year evaluation process in an effort to better interpret some of the evaluation findings. The current "OHPRS impact model" is shown in Figure 2.

Within the context of the (still current) mission statement, the broad system goals of OHPRS remain as:

- to increase the capacity of OHPRS organizations in the achievement of their goals and objectives through the provision of coordinating services *(e.g., OHPRS provides common service definitions, evaluation protocols, Intranet services to the OHPRS organizations);*
- to increase the capacity of its clients (health promoters) through direct collective action (e.g., the system as a whole provides direct services to intermediaries such as a listserv for health promotion intermediaries, a newsletter, training opportunities, a resource dissemination service);
- to improve linkage between the OHPRS organizations and the Ministry of Health Promotion (MHP) through a collective voice *(e.g., OHPRS as a collective provides advice to the Ministry).*

[4] See Appendix B for this initial program logic model for OHPRS.

The impact model shows three vertical streams or "pillars" of activities/processes and expected outcomes that relate to these three system goals.

PILLAR A. SECRETARIAT SERVICES/SUPPORTS TO OHPRS ORGANIZATIONS.

The services and supports provided by the OHPRS Secretariat are bundled into this first pillar and include:

- *System planning and development* (e.g., development of system goals; committee structures and terms of reference; and network meetings to promote collaborative activities);
- Communication (e.g., OHPRS communication plan; Livelink; the OHPRS web site; and other work initiated by the Information Coordination Committee and the Communication Advisory Committee);
- Operational support (e.g., common operating characteristics such as common definitions and guidelines for reporting; planning and needs assessment; and direct support to the work of the individual OHPRS organizations);
- System needs assessment and evaluation (e.g., evaluation planning and implementation; provincial needs assessment; preparation of reports; and use of the findings for system accountability and quality improvement).

These various activities and processes are expected to achieve a range of outcomes for the network of organizations itself, including better communication and coordination of services; increase in perceived value of health promotion (among external stakeholders), and more cost-effective delivery of services and supports. Indirectly these network level outcomes are anticipated to influence the capacity of health promoters (as indicated by the horizontal arrow).

PILLAR B. OHPRS ORGANIZATION'S INDIVIDUAL AND COLLECTIVE SERVICES/SUPPORTS TO HEALTH PROMOTION INTERMEDIARIES

There are four main groupings of services and supports provided to community health promoters, and embodied in the middle pillar of the impact model:

- *Training* (e.g., transfer of skills through workshops (face-to-face or by distance learning), on-line courses, train-the-trainer sessions;

- *Consultation* (e.g., problem solving or advice-giving on such topics as health promotion program planning, evaluation of health promotion programs, conducting focus groups);
- *Networking and referrals* (e.g., regional and provincial network-building events, conferences, participation on advisory committees);
- *Info & knowledge exchange/diffusion* (e.g., distribution of fact sheets (e.g. Self-Help 101), newsletters, e-bulletins, listservs, dissemination of new research, production of toolkits.

The array of activities in these core functions impact a chain of outcomes for the health promoters that is similar to that articulated in the initial impact model (Figure 1). These outcomes include increased capacity for a variety of dimensions of health promotion-related work, a more effective mix of interventions, and ultimately changes in health behaviours and health outcomes. The distinction made between individual and collective services and supports is important in that it conveys the idea that some services and supports may be provided by a single resource centre (e.g., THCU's workshop on Introduction to Health Promotion Planning; OSHNet's fact sheets and workbooks, networking meetings and conferences; HHRC's regular feature publication, *@heart*, focusing on topics of current interest to provincial heart health partnerships); others by two or more resource centres working together on a project (e.g., on-line proposal writing course – by THCU and OHCC; *Have a Ball! A Toolkit for Physical Activity and the Early Years* - developed by BSRC in partnership with PARC and NRC; *OHPE e-bulletin*, a weekly electronic bulletin produced through a joint project of OPC and THCU with 4900 subscribers (with articles and related resources, news and upcoming events, job postings, announcement of new resources); and still other services and supports may be raised and discussed at the overall system-level[5] and with additional resources provided to the system as a whole to implement. (e.g., HP 101, much of the work of the OHPRS French Language Services Committee). These distinctions between the level of joint planning and engagement of the various resource centres became particularly important in the interpretation of the results of the main components of the evaluation plan.

[5] Importantly, even system-levels projects may still be planned in detail and operationalized by a group of key resource centres.

PILLAR C. OHPRS SUPPORTS TO MINISTRY OF HEALTH PROMOTION

The third pillar of activities/processes within the impact model is the support provided to the MHP by OHPRS, both through the Secretariat and through the engagement of the OHPRS membership. This includes:

- Activities to increase consistency across the various organizations in the network in their planning and reporting to the Ministry (e.g., development and use of customized service tracking software (the OHPRS STA) with ongoing technical support and training to members; development, training and use of an electronic template for submitting annual activity plans and reports to the Ministry);
- Coordinated efforts to address MHP priorities (e.g., Forum discussion and mapping activity of the MHP's Healthy Eating and Active Living (HEAL) Action Plan);
- Provision of evaluation information on capacity and needs of Ontario health promoters. (e.g., provincial needs assessment; OHPRS evaluation plan and results).

The expected outcomes of the work in support of the MHP include improved cost-efficiencies within the system, increased confidence (within the Ministry) in the ultimate link to health outcomes, and better promotion/retention of value of health promotion.

2.2 THE OHPRS EVALUATION PLAN

Working from the initial OHPRS impact model and program logic model, a set of evaluation questions was developed that would guide a comprehensive five-year evaluation plan (Rush, 2002). The plan was developed collaboratively between the OHPRS evaluation committee and the evaluation consultant, with considerable input subsequently obtained from representatives of the many OHPRS organizations on the detailed design of each component. The evaluation plan also articulated the many principles that guided its development and implementation (e.g., the recognition that the provincial evaluation plan would focus on the common objectives shared among the OHPRS organizations and was, therefore, intended to complement rather than replace their individual program evaluations).

Table 1 shows the various evaluation questions developed as part of the plan, and as they relate to each of the three pillars of the OHPRS impact model. In addition, each question is aligned with a methodological component of the evaluation. While each component is

briefly summarized below the reader is referred to the specific project report for more details on methodology of each of these components.

Table 2 places all the evaluation and needs assessment activities and processes in temporal order over the course of the evaluation plan. The baseline and follow-up network surveys and the baseline and follow-up capacity surveys of health promotion intermediaries were the principal components of the five-year evaluation plan. However, a range of other projects was also implemented in the intervening years and these are also shown in the table. These projects were intended to both complement the findings from the network and capacity surveys, and also provide useful information in their own right to the planning and evaluation of OHPRS services and supports. These five complementary components included:

- Qualitative assessment of capacity of health promoters (2003)
- Mid-term integrated evaluation report (2003)
- Qualitative interviews with Ministry representatives (2004)
- Literature review: Establishing the links between health promotion capacity building and health outcomes (2004)
- Provincial Needs Assessment (2004)

Figure 2. Impact Model for OHPRS

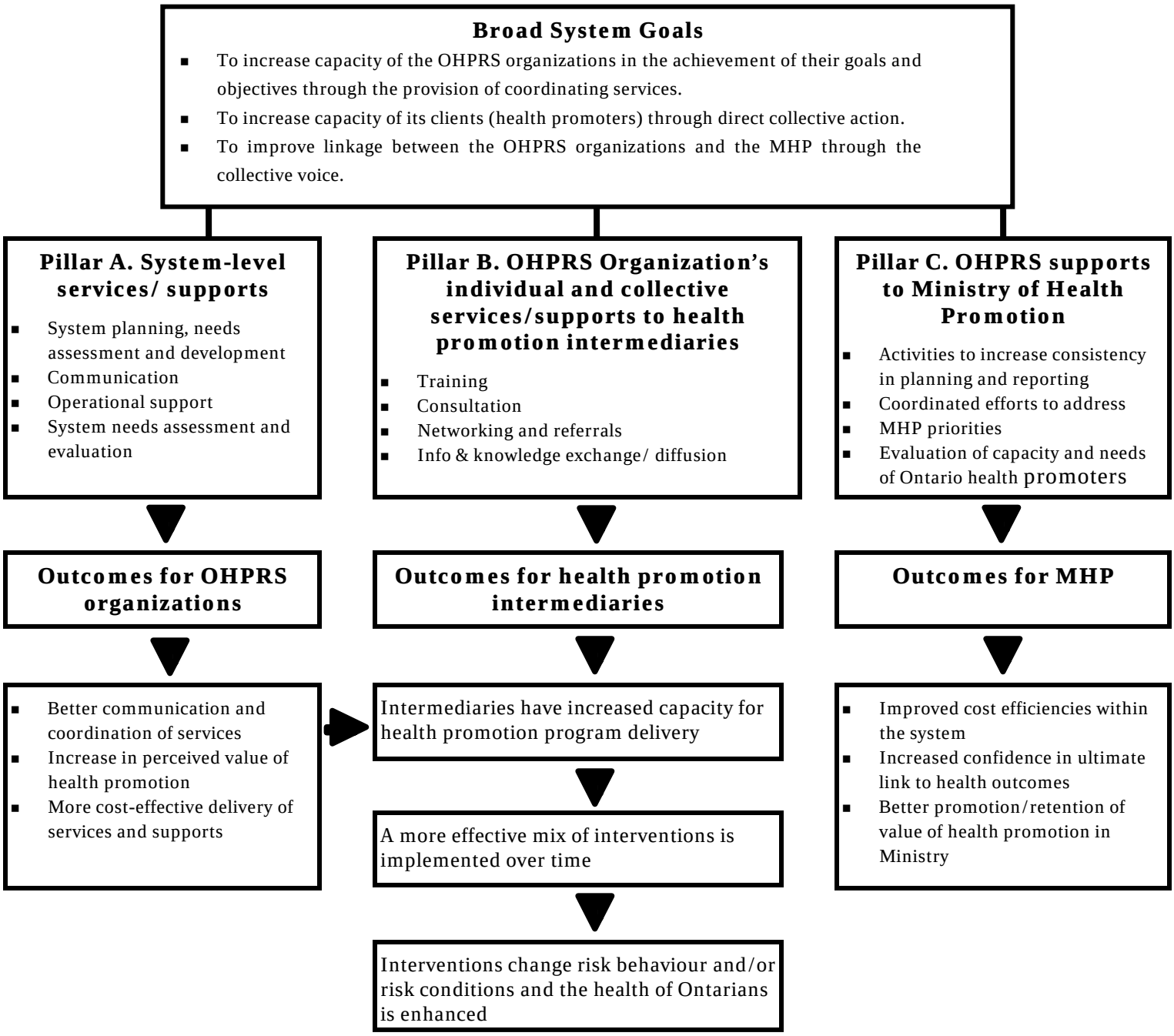


Table 1. Evaluation questions and components in relation to each of the three pillars of the OHPRS impact model

Pillar A. System-level services/supports to OHPRS organizations		**Pillar B**. OHPRS organization's *individual and collective* services/supports to health promotion intermediaries		**Pillar C.** OHPRS supports to the Ministry of Health Promotion	
Evaluation Questions	Evaluation Component	**Evaluation Questions**	Evaluation Component	**Evaluation Questions**	Evaluation Component
Is there an increase over time in the level of coordination and communication among the organizations? Among the managers and staff of the organizations do the perceived benefits of network participation outweigh the perceived costs and is there an increase over time in the perceived benefits of participation? What services and supports are provided directly to the organizations and what is the perceived level of satisfaction with these services and supports?	2002 baseline and 2004 follow-up network survey 2002 baseline and 2004 follow-up network survey 2002 baseline and 2004 follow-up network survey	What is the nature and extent of services and supports provided on an annual basis to intermediaries by the collective network of OHPRS organizations? What is the level of satisfaction with services and supports received from the collective network of OHPRS organizations? Is there a change over time in the capacity of individual and organizational intermediaries for health promotion[6]?	Analysis of system "outputs" in the context of an integrated evaluation report Baseline and follow-up capacity survey Baseline and follow-up capacity survey	From the perspective of the MOHLTC, what are the tangible and intangible benefits of the OHPRS coordination activities with respect to the OHPRS organizations? Do the perceived benefits of the dedicated OHPRS funding and the system-level activities outweigh the perceived costs from the Ministry perspective?	Qualitative interviews with Ministry representatives Qualitative interviews with Ministry representatives

[6] Sub-questions are identified in the Section 3 of this report.

Table 2. Overview of the components of the multi-year OHPRS evaluation plan

Evaluation Projects/Activities	**2001/ 2002**	**2002/ 2003**	**2003/ 2004**	**2004/ 2005**	**2005/ 2006**	**2006/ 2007**	**2007/ 2008**
OHPRS Evaluation Plan							**Update planned**
Network Survey of OHPRS Organizations							
Capacity Survey of Health Promoters							
Qualitative Assessment of Capacity of Health Promoters							
Integrated Evaluation Reports (incl. systems 'outputs')						Current report	
Qualitative Interviews with Ministry Representatives							
Literature Review: Establishing the Links Between Health Promotion Capacity Building and Health Outcomes							
Provincial Needs Assessment on Health Promotion							

3.0 EVALUATION COMPONENTS AND METHODS

3.1 BASELINE AND FOLLOW-UP OHPRS NETWORK SURVEYS

The first pillar of the impact model is primarily concerned with the extent to which the OHPRS organizations are evolving into a coordinated network of services and support organizations. The repeated baseline and follow-up survey of the OHPRS organizations was the evaluation component that addressed this expected outcome (Rush & Urbanoski, 2003a; Rush, 2006). This component was guided in large part by the literature on the evaluation of inter-organizational networks (Provan & Milward, 2001), and the methods underlying network analysis more broadly (Durland & Fredericks, 2005).

Drawing from this literature the evaluation committee derived several suggestions for indicators of network effectiveness of particular relevance for the evaluation of OHPRS. These indicators included:

- the extent to which the relationships established within the network contribute to the planning and implementation of new programs or activities which take advantage of new opportunities;
- the extent to which the members actually function as a network;
- the range of services and supports provided by the network as a whole;
- the strength of the relationships between and among network members
- the extent to which individual members of the network perceive the benefits of their involvement.

It is also widely recognized that there are many ways to conceptualize and measure "coordination", and experts from a wide range of disciplines have contributed to current thinking in this area. Network analysis (Fredericks & Durland, 2005) was decided upon as an appropriate method for unbundling the term "system coordination" into more measurable indicators. Following an extensive process of soliciting input from the OHPRS organizations and the Ministry, six coordination-related relationships were selected for subsequent rating by representatives of the OHPRS organizations in both a baseline (2002) and follow-up survey (2005). The six items used in the network surveys included:

- Centre's website link appears on the website of other centres;
- Level of familiarity with the mandate and roles of staff of other centres;
- Use of materials produced or distributed by other centres;

- Referral of clients for services and supports between OHPRS members;
- Formal work ties to other centres in areas such as joint service delivery, policy development or advocacy;
- Informal work ties to other centres (e.g., problem-solving, reviewing proposals).

The baseline survey occurred in the fall of 2002 and was repeated again in the fall of 2005[7]. In each survey a 100% participation rate was achieved. Change over time was derived from statistical measures from the network analysis (e.g., network "density" and "centrality" of the network, both of which reflect the level of connectivity across the system), as well as a more qualitative assessment and interpretation of network diagrams that depict the system at each point in time. Other questions were also added to the survey to supplement the formal network analysis and address the remaining evaluation questions for the network goals. This included questions tapping into perceived benefits and costs of network participation; services and supports provided directly to the organizations by the OHPRS Secretariat; and the perceived level of satisfaction with these services and supports.

3.2 OHPRS PROVINCIAL HEALTH PROMOTION CAPACITY SURVEY

The baseline and follow-up health promotion capacity surveys (Rush & Urbanoski, 2003b; Rush, 2007) targeted the middle pillar of the OHPRS impact model, and were concerned specifically with the short-term outcomes related to the "capacity" for health promotion among Ontario health promotion intermediaries. A review undertaken by Jen Macdonald for the Ontario Prevention Clearinghouse (Macdonald, 2001), as well as several papers drawn from the academic literature (e.g., Hawe et al., 1997; 1998; Smith et al., 2001; Freudenberg et al., 1995) suggested that capacity for health promotion can be conceptualized and measured at three levels: individual, organization and community. With respect to the OHPRS evaluation plan, the focus was on the first two of these levels. Further, the literature suggested that within each of the levels of health promotion capacity there are several important sub-dimensions (e.g., skills; knowledge; empowerment; leadership; responsiveness and transferability to new problems;

[7] The 2002 and 2005 surveys were completed by 21 and 23 OHPRS organizations, respectively.

networking; sustainability as support is diminished; and commitment to planning, evaluation and organizational learning). A significant task before the evaluation committee was to review and priorize these many dimensions of capacity building in order to arrive at a condensed list of indicators for system-level monitoring and evaluation. The consultative process of selecting the indicators and pilot testing them and the survey process are described in more details in the survey reports (Rush, 2002; Rush & Urbanoski, 2003b; Rush, 2007). A final set of 30 indicators was selected (see Appendix C) covering the following five domains:

- needs assessment and planning (10 indicators)
- program implementation (15 indicators)
- program evaluation (3 indicators)
- sustainability (2 indicators)

In a survey format, health promoters would eventually rate themselves and, if appropriate, their organization and coalition, on each capacity indicator. Six additional indicators were identified at the organizational level (e.g., extent to which there are internal champions for health promotion; availability of opportunities for staff development with respect to health promotion). Two French language-related capacity indicators were subsequently embedded in the body of the main scales (i.e., develop and implement services in French)[8]. The remainder of the survey instrument asked questions about their involvement with, and views concerning, the services and supports offered by OHPRS; additional indicators concerning needs and capacity for health promotion services in French, and selected respondent and organizational characteristics. The time frame of reference for the survey respondent would be the last year.

Based on response rates to a pilot test of the survey questionnaire and procedures, it was decided to survey only those health promoters working for public health units and Community Health Centres. The OHPRS organizations were contacted and a list was requested of clients from these two sectors in the past two years for whom (a) they had

[8] The addition of two core French language indicators brought the number of indicators to 32 in the main capacity scale.

delivered a "significant" level of service[9]; and (b) they had accurate contact information[10]. Variation in interpretation of this guideline, and other issues of feasibility for some centres, meant that the nature and intensity of services received by the intermediaries on the submitted contact lists were highly variable[11]. The combined list, minus duplicates, comprised the actual sampling frame from which individuals were eventually selected to receive the survey questionnaire. This process was repeated for each of the two survey years, each year collating a new sample. That is to say, the survey did not track the same individuals over time.

For the baseline survey a total of 1200 individuals were invited to participate in a mailed survey (with an electronic option), although a small number were excluded when their survey package was returned due to an inaccurate addresses. A total of 288 completed the full questionnaire, for a response rate of 26.6%. Some PHU and CHC respondents from the pilot test were then included in the final sample for analysis, yielding a total of 341 respondents.

Given advances in electronic surveys since the implementation of the 2002 baseline survey, as well as previous success with an on-line provincial needs assessment survey, an electronic survey approach was adopted for the follow-up capacity survey in 2005. The contact lists, with email addresses, were again provided by the OHPRS organizations. A combined list of 3051 email addresses was created and then cleaned (e.g., duplicates removed) resulting in a sample of 2476 addresses for the survey mailout. Based on these mailings a total of 481 emails were bounced back from addresses that were either out-of-date, their mailbox was full, or their server rejected and returned the email invitation (i.e., identified as potential spam). This yielded a total of 1995 people

[9] The term "significant" was defined in the request for the contact list as "clients who had received more than a mail out of information/materials or other passive service initiated by the OHPRS organization.

[10] The 2002 survey required a mailing address and the 2005 survey required an email address.

[11] The quality of the client lists improved dramatically over the course of the two survey administrations.

who received the invitation email with the link to survey questionnaire. A total 391 completed the full questionnaire yielding a response rate of 21.1%[12].

3.3. QUALITATIVE ASSESSMENT OF CAPACITY OF HEALTH PROMOTERS (2003)

The five-year evaluation plan called for a rotating emphasis on quantitative and qualitative approaches, with a qualitative assessment of health promotion capacity in Ontario to be conducted in the intervening years between the baseline and follow-up capacity surveys (Rush & Andrew, 2004). Subsequent to the preparation of the evaluation plan, discussions also ensued about another qualitative element, namely the in-depth exploration of health promotion capacity among Francophone health promoters in PHUs, CHCs, and elsewhere (OHPRS, 2004).

The plan for the English language component was to gather information from health promoters working in sectors that had been specifically excluded from the capacity survey based on their low return rates in the survey pilot work (e.g., NGO's voluntary organizations, coalitions, education, workplace). It was also seen as an important way to more fully involve several OHPRS members that serve a client base largely outside the PHU and CHC systems (e.g., OSHnet, Ontario Healthy Communities Coalition). To help priorize the target group even further, OHPRS staff provided a breakdown of the top three client groups, excluding the PHUs and CHCs, for each of 14 OHPRS members for which these data were available. Based on the submitted information it was decided that the 2003 qualitative work would focus on three sectors, namely NGO/volunteer organizations, community coalitions and education.

Five OHPRS organizations were considered to be particularly relevant to this component of the evaluation because the three sectors of NGO/volunteer, coalitions and education are well represented among their clients. These OHPRS members include: OSHnet, OHCC, CSBHRC, FOCUS and OPC. Through discussions with the manager/staff of each of these five OHPRS organizations, a list of potential participants was obtained. Prospective participants were pre-screened to ensure some recall of their having accessed the services and supports of at least one OHPRS member in the past two years.

[12] 574 people responded to the survey invitation (31.0%) but did not complete the full on-line instrument.

The locations of the focus groups were Barrie (one group: Coalition), London (2 groups: NGO and Coalition) and Toronto (one group: NGO). Participants in the London and Barrie groups were drawn from a large geographic area around these cities. In total the four groups involved 26 participants. Each group was about two hours in duration.

The topic areas covered included:

- *Health promotion capacity*, for example, what this term meant to the participants; how knowledge and skill building fit with the notion of "capacity building"; and whether something important was being missed in the project's definition and approach to developing and measuring health promotion capacity;
- *Barriers and challenges*, for example, their self-assessment of health promotion capacity; and the kinds of services and supports they need to continuously improve your health promotion capacity;
- *Familiarity with OHPRS and access to supports*, for example, what the acronym "OHPRS" meant to them; how they conceptualized the relationship of the various Centers to one another; and whether they had ever had any difficulty accessing the health promotion services and supports you needed;
- *Satisfaction with, and impact of, OHPRS services and supports*, including satisfaction with the services and supports received to date from OHPRS generally or individual members with whom they had worked; and how experiences to date had directly impacted on their health promotion work.

Due largely to time pressures on teachers, and the fact that focus groups would need to be held outside school hours, the evaluation committee opted for individual semi-structured interviews to be conducted over the phone with teachers. Self-completion of the interview guide, and submission of their response by email or fax, was deemed acceptable if required. Teachers and other educators were identified for the evaluation interviews through a contact list provided by the Ontario Physical and Health Education Association (Ophea). A small number of additional people who were prepared to contribute to our evaluation process were also identified via snowball nominations. In total 11 people participated from the education sector.

3.4 "MID-TERM" INTEGRATED EVALUATION REPORT

Midway through the five-year plan a report was prepared that summarized the results of the baseline network and capacity surveys (OHPRS Impact Evaluation Committee, 2003). The report also presented, for the first time in an evaluative context, a rolled-up statistical summary of the collective services and supports provided by the OHPRS organizations. This summary is of particular relevance to Pillar B of the impact model (see Table 1).

To help all OHPRS members report their activities consistently, the Information and Coordination Committee (another sub-committee of OHPRS) had previously developed a standard set of definitions for reporting their engagement in the following external functions: consultation, healthy public policy, information and knowledge exchange, networking, planning, referral and training. These definitions, plus a document giving concrete examples of what is, and is not, included in each category, support standardized reporting. For the integrated evaluation report a statistical summary of the "reach" of OHPRS organizations was developed from existing quarterly reports on these various services and supports. Reach was described by units of service, broken down into the above categories, as well as by region of Ontario and sector.

The integrated report also pulled together the highlights of the capacity survey deemed to be most relevant to questions related to reach (e.g., percentage of clients served by multiple OHPRS organizations) as well as perceived satisfaction with OHPRS services and supports, and information on familiarity, ease of access and perceived gaps in service.

In the present report we include the summary statistics rolled up in 2003-4 as well as an update of summary statistics for the past year, 2006-7.

3.5 QUALITATIVE INTERVIEWS WITH MINISTRY REPRESENTATIVES

In addition to the qualitative data collected from selected sectors of health promotion intermediaries in the intervening years between the network and capacity surveys, the evaluation plan called for a small number of semi-structured qualitative interviews to be

held with key Ministry representatives[13]. This component is of particular importance for Pillar C in the OHPRS impact model that is concerned with outcomes from the perspective of the Ministry. Results of these interviews and details on the methodology were reported with the results of the qualitative assessment of health promotion capacity (Rush & Andrew, 2003)

Potential Ministry representatives to be interviewed were identified in collaboration with the MOHLTC liaison person for OHPRS and input from the Ministry itself. The primary groups to be included were Managers and Program Coordinators within Health Promotion and Wellness, Public Health Branch. One private consultant was interviewed in her role as a Ministry representative to OHPRS. In total seven people were interviewed. Following the first one-on-one interview, and at the request of the other Ministry representatives, a group interview was conducted with the remainder of the participants. The one-on-one interview was about an hour in length.

The focus of these Ministry interviews was the tangible and intangible benefit of coordination activities with respect to the various OHPRS organizations. Efficiencies that may have resulted from more consistent reporting and better system coordination were also probed, as well as other potential outcomes such as perceived improvements in accountability processes and new funding support that may be attributable to improved system coordination.

3.6 LITERATURE REVIEW: LINKS BETWEEN HEALTH PROMOTION CAPACITY BUILDING AND HEALTH OUTCOMES

The middle pillar of the OHPRS impact model shows the presumed link between increased capacity of health promotion intermediaries and improved health promotion programs and policies, reduced prevalence of risk factors/risk conditions, and ultimately reduced incidence of preventable disease or improved health (all other factors being equal). A literature review was undertaken to gather together the current evidence underlying these assumptions (Sahay, 2004). An earlier and less systematic assessment

[13] At the time, the Ministry of Health and Long-Term Care.

of this literature was also included in the mid-term integrated evaluation report (OHPRS, 2003).

A search was conducted of select electronic databases (Medline, CINAHL, CANCERLIT) using key words such as "health promotion", "capacity", "health outcomes", and, "health status". Following this search, key informant interviews with eight international leaders in the field of capacity building research were conducted to identify additional unpublished or published documents. Several articles were found demonstrating links, or partial links, among the intermediary levels of the OHPRS framework. There were also two studies found that provide evidence in support of the complete framework. The database search showed, and the interviews confirmed, however, that there are no studies that have deliberately followed the framework all the way from capacity building (level 1) to health outcomes (level 5). Given this finding it was decided to search for studies that discussed capacity building alone. Because the collection of studies for this review was not meant to be exhaustive but, rather, was intended to identify relevant work which could provide evidence in support of the relationships depicted in the OHPRS causal framework, studies were selected which were well-designed and which provided the best examples of the evidence sought.

3.7 PROVINCIAL NEEDS ASSESSMENT (2004)

In lieu of the follow-up capacity survey that had originally been planned for 2004, the evaluation committee developed a comprehensive provincial needs assessment focused on the broad range of clients seen by the OHPRS organizations (Rush, 2005). Since many of the OHPRS organizations routinely engage in systematic needs assessment activity, the committee consulted with the various organizations to identify areas where a collaborative needs assessment project would bring the most significant "added value" to them individually. This process began with an initial consultation at a Network Forum and then continued with interviews with representatives of the individual organizations.

The survey materials consisted of a set of core questions that all respondents were asked to complete, as well as eight supplementary modules specific to their interests and/or areas of responsibility. The core questions covered barriers to accessing information and technical support for health promotion work, including language and multicultural issues; familiarity and past use of the various organizations comprising OHPRS; self-help/mutual aid strategies; preferred approaches to meeting education and training needs; and French language services and supports. Other questions tapped into a range

of characteristics of the respondent in order to support various sub-analyses of the data (e.g., years of working in health promotion, region, type of organization if applicable).

Eight supplementary modules to the questionnaire were also included to support the OHPRS organizations directly:

- Alcohol and Other Drugs
- Evaluation, Health Communication, Community Mobilization/Capacity Building
- Heart Health
- Maternal and Infant Health
- Nutrition
- Physical Activity
- School-based Health Promotion
- Tobacco Control

The survey was targeted at past users of the services and supports provided by the OHPRS organizations, as well as individuals who had not as yet accessed these organizations (i.e., non-users). Each OHPRS organization was invited to submit a list of past clients/contacts who would receive an invitation to participate. A general guideline was also given to each organization to include clients who had received some services or supports over the past two years, although flexibility was allowed in this regard given variation in the nature of the organizations' contact databases.

Many of the submitted names were duplicated across the various lists as they had been nominated by more than one organization. The lists were first separated into those who had an email address and those who would be receiving the survey material by regular mailout. After removing duplicated names, the email list was comprised of 4235 people, and the mail out list had 780 entries, for a total of 5015 to be mailed out by both methods combined. After managing a substantive number of bounced back emails and "return to sender" postal packages, a total of 4277 survey invitations were considered as distributed to the target individual. A notice about the survey and the web link to the questionnaire also went out on the APOLnet listserv (est. 400 members) and to the Media Network

membership (est. 300). An invitation to participate was also posted on the OHPRS website and 51 additional organizations[14] also posted an invitation to their stakeholder group to participate. Thus, the survey was promoted in many different ways to both users and non-users of OHPRS services and supports. The survey response rate was estimated at 20.5%, although it was also estimated that this could range up to 25% if potential respondents from the various Web-based invitations were included. A total of 875 respondents completed the majority of the items in the core component and a total of 614 people completed at least one module.

4.0 EVALUATION RESULTS WITHIN THE THREE PILLARS OF THE OHPRS IMPACT MODEL

4.1. PILLAR A: SYSTEM-LEVEL SERVICES/SUPPORTS TO OHPRS ORGANIZATIONS

In summarizing the findings from the many aspects of this component the evaluation committee was guided by the three original evaluation questions addressed by the OHPRS baseline and follow-up network surveys (Table 1).

1. Is there an increase over time in the level of coordination and communication among OHPRS members?
2. Among the managers and staff of the OHPRS members, do the perceived benefits of network participation outweigh the perceived costs and is there an increase over time in the perceived benefits of participation?
3. What services and supports are provided directly to the 23 centres and, among the various managers and staff, what is the perceived level of satisfaction with these services and supports?

[14] The organizations supporting the needs assessment had previously been identified by the various OHPRS organizations.

Is there an increase over time in the level of coordination and communication among OHPRS members?

With respect to this first question the findings were clearly mixed. For example, a small decline between 2002 and 2005 in reported involvements such as OHPRS committee work was offset by increased involvement with respect to the French Languages Services Committee and the sustained high level of participation in the network forums. There was a substantive decline in the percentage of organizational representatives feeling involved and connected to the system - findings that were offset by more positive perspectives on the overall level of OHPRS coordination (about 75% at follow-up feeling coordination was at a sufficient or appropriate level). Website links were substantially increased at follow-up (with the exception of the tobacco centres), and the level of familiarity among the organizations remained at a high level. At follow-up, respondents were less likely to consider differences in program philosophy as a challenge to coordinating with other centres' role and way of doing business. Other challenges to coordination remained highly salient, however, such as time, different target audiences and different funding levels. The mixed results in this area were also evident in the responses to the question about administrative tools or practices that had been developed or used with other OHPRS organizations and which had resulted in more efficient business operations. Although several good examples were cited, about 50% could not provide an example.

The data from the statistical network analysis also showed a net decline in network connectivity as reflected in the overall density and centrality measures. This part of the overall picture was somewhat different when the tobacco centres, with the exception of PTCC, were separated from the analysis (see below additional reflections on the tobacco centres). The results, however, still reflected a general decline in connectivity on four of the six indicators.

In sum, there were some indications of increased coordination and communication among the OHPRS organizations but overall there was no clear pattern in the findings. The evaluation committee was also challenged in answering the first evaluation question by the lack of clear expectations from the outset of the evaluation period with respect to what would be an appropriate level of change in system coordination. For example, in examining the centrality scores of individual organizations there may be a tendency to inappropriately assume that more linkages in the system are somehow desirable and that those with high centrality scores are somehow "better" than those with comparatively

lower centrality scores. There may be several legitimate interpretations of such data including the fact that some organizations serve quite unique target audiences and this diversity could be seen a measure of healthy system performance.

As noted earlier in the introductory section, the OHPRS centres were funded independently and each remains an autonomous organization. In this context, efforts to move the network to more "systemness" are largely voluntary, with the support of the Secretariat and, indirectly, the MHP as the funder of the Secretariat and its functions. In addition, the expected level of coordination may be somewhat of a moving target. That is to say, the expectation for more coordination may well be evolving over time. For example, after a period of the OHPRS organizations getting to know each other and their respective mandates, the expectations for joint projects may have actually diminished somewhat in light of the unique services and target audiences of many of the organizations. Similarly, it may be that the type of engagement of the organizations in OHPRS has shifted over time, with more reported involvement in the work of OHPRS in the earlier phase of network development as there was so much to be done to structure the system. Engagement in system activities may have diminished to now be more focused on the network forums and perhaps more targeted collaborative opportunities that make sense for one or more organizations to work on together. Further, the nature of such collaborative activity may actually be shifting from organization-level projects to more system-level projects which, although fewer in number, may potentially have more impact across the province as a whole. The 2004 Needs Assessment project would be an excellent example of this, as would the joint development of the HP101 course in health promotion. During the discussion of the network survey results at a network forum the point was also made that, in the early days of developing the system, the focus was on the Ministry as the "client" (e.g., improving reporting formats; and demonstrating the collective reach of OHPRS as a "system"). As time has elapsed the focus may be shifting to the health promotion intermediary as the "client" for more centralized initiatives and the opportunities to work together on behalf of these intermediaries may require more time and resources, both of which are cited as "barriers" to increased collaboration.

Also with respect to the first evaluation question about possible increased coordination among the OHPRS organizations important findings emerged with respect to the tobacco–related centres in the OHPRS network. The apparent separation of the tobacco centres was noted in the baseline network assessment. This was reflected back to the network as a cause for concern since the linkage to the rest of the system was being managed largely through PTCC and such an arrangement could potentially introduce

instability in the system. The situation remained largely unchanged, if not even more separated in the follow-up data. Discussions about these data with the various stakeholders confirmed that the tobacco centres, as a group, had been extremely busy "ramping up" the implementation and management of the new Smoke-free Ontario Strategy. Further, since the regional reporting structure for the strategy did not line up with the MOHLTC regions at the time, the tobacco centres were given permission by the MOHLTC to report activities in a manner different from the other OHPRS members. It would seem that the tobacco-related centres, again with the exception of PTCC, may well have interpreted this as a signal to pull away from OHPRS generally, and thus began to view their primary responsibility as being to the Strategy and, secondarily, to the OHPRS collective.

While these tobacco centres have been extremely busy and pulled into other things, this is not necessarily ideal for the network as a whole, nor should it necessarily be the established pattern for the future. The tobacco cluster has benefited from the OHPRS involvement (e.g., adoption of the OHPRS capacity assessment methodology as an evaluation tool for the Ontario Strategy) and, in turn, the network has certainly benefited from the inclusion of the tobacco centres (e.g., early OHPRS leadership role of one of its key organizations). It is also important to keep in mind the extent to which tobacco use and health consequences are linked to the mandate and work of most of the other OHPRS organizations, and that a great many health promoters in the field engage in multiple health promotion topic areas in addition to their work on tobacco. This was certainly very clear in the 2004 OHPRS needs assessment (Rush, 2005). It was suggested on the basis of the evaluation findings, and follow-up discussions and considerations, that the tobacco "cluster" monitor its involvement in OHPRS and find ways to effectively re-engage in the larger network in the future. It was also noted that the data be interpreted as a red flag to funders and policy makers that large-scale provincial initiatives and strategies that are disease or risk-factor specific may result in some short-term destabilization of a system of support services for health promotion and prevention without clear expectations for coordination and collaboration on a broader scale.

Among the managers and staff of the OHPRS members, do the perceived benefits of network participation outweigh the perceived costs and is there an increase over time in the perceived benefits of participation?

In contrast to the mixed results discussed above in terms of increased communication the evaluation findings were generally more consistent with respect to a shift in perceived benefits over costs. The expressed ratio of benefits over costs was increased for both the system as a whole and respondents' individual organization. That said, there was still considerable *variability* in the reports of perceived benefits versus costs, and one certainly could not conclude that the representatives of the OHPRS organizations are unanimous in their view that the OHPRS coordination activities are beneficial. There was some evidence that the level of involvement in system activities was related to perceived benefits but this must be interpreted cautiously given the small sample size in the cross-tabulations, as well as the unique perspective and challenges of the tobacco control centres. Although mixed results were also obtained with respect to the value of the network meetings for the individual organizations, these meetings were almost universally declared of significant value to the system as a whole. The open-ended comments with respect to benefits versus costs also suggested that the value lies largely in the networking opportunities that come with OHPRS participation, as well as the opportunity for collaborative activities. Importantly, although the opportunity for, and some examples of, collaborative projects were cited, the benefits of OHPRS *for the community health promoter* were not salient in the responses of the participants. This was also the case at baseline and the evaluation committee again reinforced that the ultimate goal of networking and collaboration is improved comprehensive and effectiveness of the community interventions developed, implemented and evaluated by the intermediaries in the community.

What services and supports are provided directly to the centres and, among the various managers and staff, what is the perceived level of satisfaction with these services and supports?

Positive satisfaction from the representatives of the OHPRS organizations was expressed most clearly for the HP101 course and, to some extent, the Network Forums and technical support. Beyond these services and supports the results were much more equivocal. Indeed, between roughly one third and a half of respondents were basically neutral in their satisfaction ratings of seven of the nine services/supports listed. In terms of changes over time, the ratings were more positive in four areas at follow-up,

especially the network meetings and the OHPRS website, but down by a small margin in three others. Although the data did not indicate any overwhelming dissatisfaction with OHPRS services and supports, they do contrast with the kind of positive satisfaction ratings typically expected in client satisfaction surveys. The evaluation committee noted that these data warranted some follow-up discussion between the Secretariat and the OHPRS organizations. In the end, three potential explanations for the moderate levels of client satisfaction were offered for further discussion. One point was that the organizations may generally under-recognize the work that is being done on their behalf by the core OHPRS resources. There is some support for this in the evaluation data in that the familiarity ratings that were given with respect to many of the core services and supports were also quite modest (e.g., typically 40% to 50% only "somewhat familiar" with any services beyond the network forum).

A second possible factor was the need for a more clear and distinct role for OHPRS as a key player in health promotion in Ontario. It was considered that the lack of distinctness as a health promotion *system* that is composed of unique and diverse members might be compounded by some confusion regarding the sponsorship of OHPRS within the Ontario Prevention Clearinghouse (OPC). This is not an uncommon difficulty with system coordination functions that are housed within the administrative boundaries of one of the system members themselves. In addition many of the OHPRS organizations predate the OHPRS. They also spend considerable efforts promoting their own activities and services, many of which may be similar to that of OHPRS collectively. These considerations suggest the work of the Secretariat and the collective OHPRS be more visibly separate from the individual OHPRS organizations, including the OPC. It was suggested that this could be achieved, for example, with more independent profile raising activities, such as an OHPRS-sponsored health promotion conference.

Lastly, the modest satisfaction data begged the important question as to whether the OHPRS organizations are in fact looking for something from the Secretariat other than what is currently being offered. With the "system" and the administrative processes required by the Ministry now largely in place, and with organizational representatives expressing a high level of familiarity with each other and their respective roles (the tobacco centres being the notable exception), it was suggested that perhaps the organizations would now place a higher value on the Secretariat becoming a more proactive leader on various issues on behalf of the system. While the MHP might have been viewed as the primary "client" of the Secretariat in the early stages of OHPRS development, it was considered that the Secretariat might now more closely align its

energies with the needs of the network for leadership and support of the network as a whole. This is no doubt a matter of nuance and balance since the Secretariat has clearly devoted a great deal of time and energy in a supportive role for the OHPRS organizations. This may mean, for example, serving a more clearly defined and proactive sentinel role looking for opportunities for support, high level networking on behalf of the system, and collaborative opportunities across OHPRS and with other key players in the health promotion sector. It was suggested that the creation of the MHP, and the completion of a five-year slate of important work on system development and integration, may well signal an opportune moment to do a "member check" and see what the OHPRS organizations now hope to gain from the central pool of resources allocated for system support and coordination.

4.2. PILLAR B: OHPRS ORGANIZATION'S INDIVIDUAL AND COLLECTIVE SERVICES/SUPPORTS TO HEALTH PROMOTION INTERMEDIARIES

Within the middle pillar of the OHPRS impact model there were three main evaluation questions to be addressed (Table 1):

1. What is the nature and extent of services and supports provided on an annual basis to intermediaries by the collective network of OHPRS organizations?
2. What is the level of satisfaction with services and supports received from the collective network of OHPRS organizations?
3. Is there a change over time in the capacity of individual and organizational intermediaries for health promotion[15]?

To address these questions we draw upon the summary statistical roll-ups regarding services and supports provided by the OHPRS organizations, the information gleaned from the baseline and follow-up capacity surveys, the complementary qualitative assessment of health promotion capacity and, to some extent, selected results of the provincial needs assessment. We also report key findings from the literature review that summarized available evidence linking increased health promotion capacity with improved outcomes associated with the comprehensiveness of community programs and

[15] Sub-questions are identified in the text below.

policies and, in turn, changes in individual and community risk factors and health-related outcomes.

What is the nature and extent of services and supports provided on an annual basis to intermediaries by the collective network of OHPRS organizations?

Both the provincial needs assessment project and the qualitative assessment of health promotion capacity were quite successful in showing the multi-dimensional, multi-topic nature of the work of health promoters. Since their work is complex and multi-dimensional, health promoters' needs for information and support are also complex and multi-dimensional. These needs were reported in the capacity surveys. For example, in each survey about 10% of respondents reported "very high needs" and over 75% reported "high" or "moderate" needs. This need for services and supports is reflected in the rolled-up summary statistics for the OHPRS network.

The 2002-2003 quarterly reports (11 members reporting) showed that OHPRS organizations had approximately 504,500 client contacts, and conducted over 200 training sessions and 1600 consultations. The core function related to the Information and Knowledge Exchange function was particularly strong with over 400,000 client contacts[16]. Boards of Health, Community Coalitions, and NGO/Voluntary organizations were the dominant client sectors. Reach of the network was clearly evident in each region of the province. As noted earlier in the discussion concerning the capacity surveys, the large majority of survey respondents rated the quality of health promotion services and supports as good to excellent and as generally being quite accessible.

The 2006-2007 final reports (14 members reporting) showed a total of 10,609,901 client contacts by OHPRS members. This included 8,870 training sessions and 9,514 consultations. As in previous years, the dominant client sectors in 2006-2007 were Education, Boards of Health, Health, and NGO/Volunteer Organizations. Information and Knowledge Exchange (IKE) contacts were over 10 million (10,541,637), for example,

[16] These data are limited by variation in the interpretation of common definitions of services and supports.

(email, listservs and bulletins). The inclusion of this wide range of Internet-based contacts distorts comparisons to the earlier years' data presented above, as does probable variation in number of organizations reporting and more consistent use of the software program (Service Tracking Application (STA)) developed by OHPRS for reporting services provided by members.

These system-level data provide an impressive record of activity. There are, however, several factors to consider in making the link between this record of "output" to anticipated individual and organizational outcomes. For example, participants in both the qualitative focus groups on health promotion capacity as well as the provincial needs assessment noted the major challenges they face in effectively translating capacity building services and supports into sustained health promotion programming and, in turn, population health outcomes. The major challenges included *funding-related issues, limited time* (typically related to resources); and *managerial/organizational support*[17].

Another important contextual factor that assists in interpreting the "output" data is the reported level of familiarity of Ontario health promoters with OHPRS. Results from the qualitative capacity assessment suggested that familiarity with OHPRS, *as a network of services and supports,* was not well known among those sectors included in that component (NGO's, Coalitions, Education), despite familiarity with several individual organizations. More than once in the focus groups a "wow" factor was elicited when the nature and scope of services and supports available across the OHPRS membership as a whole were articulated. In the two capacity surveys the percentage of respondents who were "somewhat" or "very familiar" with each OHPRS organization was moderate-high and highly variable. An overall familiarity index was also created from the familiarity ratings for each organization and there was no evidence that familiarity of the overall network increased between the baseline and follow-up surveys. The provincial needs assessment survey included *non-users* of the system and the familiarity ratings were lower than found in the capacity survey. Also in the needs assessment survey about 10% of those finding access to information to be "difficult" or "very difficult", commented on the challenge of knowing what information was available to them and from whom.

[17] Many other challenges are noted in the respective reports.

Indeed the survey itself prompted about 90% of all respondents to indicate they may now consider accessing one or more of the organizations that they may not have accessed before. Taking all these factors together, while the summary statistics reported above for the overall network are impressive as measures of "system output", there is a potential for better communication of the services and support available from OHPRS. Of course any additional promotion of the system must be consistent with the ability of OHPRS to respond to the expressed needs.

Several aspects of the evaluation data also pointed to the fact that a large percentage of clients of the OHPRS network use multiple OHPRS organizations. The qualitative data showed that multiple organizations may be accessed in a sequential manner as the strengths and gaps in local programs change over time. These stories of "support histories" conveyed the often hidden potential of several OHPRS members working together more systematically with one organization or community. In the provincial needs assessment survey it was clear that health promoters not only work in multiple health-related domains but also that a large majority of respondents accessed the services and supports of more than one OHPRS organization in the past two years. About one third had accessed six or more of the organizations a finding consistent with the results of the 2002 health promotion capacity survey, although there was a slight decline at follow-up in the average number of OHPRS organizations used from 7.1 to 6.2. Importantly, at both baseline and follow-up, there was an association between individual health promotion capacity and the number of resource centres used. Such multiple contact with several of the OHPRS organizations represents an opportunity to share information about other services and supports that may be available. In addition there is obvious potential for inter-organizational collaborations that make sense in terms of efficiency and role/mandate of the organizations.

The provincial needs assessment also showed that about 60% of health promoters surveyed accessed services and supports from organizations outside OHPRS in the two years prior to the survey. This suggested that the OHPRS organizations consider a systematic mapping of their own respective inter-organizational networks in order to identify shared partnerships and collaborations that may further increase the reach of the network as whole.

Lastly, the range of mandates of the OHPRS organizations and several aspects of the evaluation data clearly show that the OHPRS organizations provide a broad coverage of most of the topic areas in which Ontario health promoters are engaged, for example,

nutrition, tobacco, alcohol and other drugs, school-based health promotion, and physical activity to name only a few. That said, there were several topic areas frequently endorsed by respondents to the provincial needs assessment that did not have a clear "home" within the OHPRS network of services and supports. These are mental health, injury prevention[18], violence, multicultural topics, French language health promotion; work related to determinants of health such as poverty/income/housing/employment, and lastly, topics related to the physical environment. While these may well be cross-cutting, thematic areas of high relevance to many of the OHPRS organizations it would be of value for the system as a whole to consider how the needs of health promoters working in these areas are currently being supported.

What is the level of satisfaction with services and supports received from the collective network of OHPRS organizations?

Satisfaction with services and supports was probed by questions in the two capacity surveys, the qualitative capacity assessment and the provincial needs assessment that were related to perceived *quality* and *accessibility* of services and supports.

With respect to perceived *quality* of services and supports there was no difference in the average rating of quality of service over the baseline and follow-up surveys. The combined rating of "excellent" and "good" quality was high and also changed little over time (77.4% to 78.9%).

Respondents to the capacity surveys also provided a rating of the *accessibility* of health promotion services and supports on a four-point scale. The combined rating of "very easy to access" and "easy to access" was high and changed little over time (89.2% to 84.3%). The average rating on the four-point scale was 3.13 at baseline and 2.96 at follow-up and, although this small difference over time was statistically significant, it is of little practical importance. Overall, the data suggested reasonably high perceptions of service accessibility among past users of the OHPRS network, with some modest room

[18] While injury prevention was also among these topic areas, Smartrisk, which has a focus on injury prevention, subsequently joined the OHPRS.

for improvement. One factor challenging the interpretation of these data is the lack of a benchmark or "gold standard", especially given the complexity and highly specific nature of the work for the majority of health promoters, as well as the issue of turnover with some new people coming into the field each year and the time required to learn what is available and from whom. The qualitative data also suggested that rural and remote issues also come into play, with unique challenges in delivering training and accessing resource materials in such areas.

The provincial needs assessment was able to go more in-depth into the question of accessibility of information and supports for health promotion-related work, and from both past users and non-users of the OHPRS network. On the one hand, the large majority of respondents cited their access to information as "easy" (64%) or "very easy" (9.5%). Probing further, however, of the almost 25% of respondents who indicated that their access to information for their health promotion work was "difficult" or " very difficult" it was clear that the most difficult access was being experienced by those working with broad determinants of health such as poverty, income, housing and employment. Furthermore, a large majority of survey participants cited specific challenges to accessing the information they needed. These challenges included whether the required information was available on specific topics; was relevant for certain cultural groups and in the appropriate language; or available for their jurisdiction.

Is there a change over time in the capacity of individual and organizational intermediaries for health promotion[19]?

This evaluation question was addressed with data from the baseline and follow-up capacity surveys. We also point to key findings from the literature review that summarized available evidence linking increased health promotion capacity with improved outcomes associated with the comprehensiveness of community programs and policies and, in turn, changes in individual and community risk factors and health-related outcomes.

[19] Sub-questions are identified in the text below.

Each of 30 indicators of health promotion capacity was rated on a scale of 1 (poor) to 5 (excellent). Results at both baseline and follow-up showed the capacity ratings at the individual, organizational and coalition levels to be quite high with the average score on almost all the items falling between 3.5 and 4.0. There was, however, *no significant change* in the average level of health promotion capacity at the individual level over time. There were small but significant changes over time in average ratings for organizational and coalition capacity. There was no evidence that any of the small changes in capacity scores were higher or lower for any particular sub-group of health promoters.

Despite this limited evidence for significant change over time in the capacity indicators, open-ended feedback in the capacity surveys suggested that the scope and nature of the work of the participating health promoters had changed substantially at the individual and organizational level. This included changes in the *health promotion strategy used* (e.g., more focus on policy and determinants of health; stronger and more diverse community partnerships), *changes in their workplace* (e.g., more resources dedicated to health promotion; more coordinated approach); more emphasis on *evidence-based practice and program evaluation*; and a personal *increase in knowledge, skills, and collaborative contacts.*

A related sub-question in the evaluation plan was whether there was a change over time specifically with respect to capacity for *French language health promotion*. In this area there were large and statistically significant increases in virtually all the indicators of French language health promotion capacity. This included a rating of *overall capacity* to deliver services in French (combined rating of good or excellent increased from 14.3% to 30.0%); *access to materials and information in French*; as well as significant changes in six more specific *individual, organizational and coalition capacity* French language capacity indicators (e.g., developing and implementing services/activities in French). These increases in capacity tended to occur across the province as a whole and not within specific regions.

To a large extent these French Language Services (FLS)-related findings validated the process by which health promotion capacity was being measured in the baseline and follow-up surveys (i.e., that a change in capacity was indeed measurable by a set of quantitative indicators and a self-report survey method). More importantly, however, the changes in capacity were not unexpected given the concerted activities undertaken by the FLS committee of OHPRS across the province. That said, it must be noted that the work of the FLS committee was part of a much broader system of support for French-language

health promotion across Ontario and this makes attribution of the changes in capacity to the work of the FLS Committee a challenge. In addition, the committee cautioned that the field not be overly complacent with these findings since the perceived need for French-language health promotion services and supports remained high, particularly among those most closely engaged with the Francophone community. Collapsing across all participating health promoters, the perceived needs for support from the OHPRS tended to be in the areas of more French language materials, more support for translation, better communication/coordination of what was available, and advocacy to sensitize or change attitudes and demonstrate the need for French language services. The lack of resource materials and training opportunities in French, as well as access to French-speaking health promoters, are particularly challenging across the province. The provincial needs assessment showed, for example, that those working more than 50% of the time with the Francophone community stood out in terms of the many challenges faced in their work and their needs for training, education and networking opportunities.

The evaluation committee also felt constrained in its ability to address the evaluation question about change in health promotion capacity over time because of the low return rate to both the baseline and capacity surveys (although respondent characteristics were largely similar). Also, for reasons described above, the surveys also focused exclusively on those health promotion intermediaries working within the public health units/departments in Ontario as well as Community Health Centres. While the data used to plan the surveys suggested that these health promoters represent the major client base of the organizations within OHPRS, they are clearly not the only sub-group of intermediaries served by the system. Therefore the results can not be generalized to the system as a whole.

Finally, the survey results challenged the evaluation committee to return to a central question in the evaluation plan as to what role the OHPRS *as a network*, may have played in changing the capacity for health promotion among intermediaries more broadly than solely within the Francophone community. There are two mechanisms implied in the OHPRS impact model by which OHPRS as a network can have impact above and beyond the work of the individual resource centres. One mechanism is through the first pillar whereby the OHPRS aims to improve the *work of the individual centres* by providing coordination and communication support services to them. The other means is through the middle pillar via *centralized activities* aimed specifically at the intermediaries. With respect to added impact that may have been achieved by more centralized activities by the OHPRS itself, the OHPRS did develop the very popular

course HP 101 On-line. However, with the exception of this course, and the proactive work of the FLS committee, such direct activities for intermediaries was given much less priority by the OHPRS Secretariat and the various OHPRS committees than activities that were undertaken largely for the MOHLTC, and more recently for the MHP. These Ministry-focused activities include, for example, the development and roll-up of a common format for reporting centre activities and the annual centre workplans. There is no question that for accountability purposes the standardization of these activities is critical for presenting the collective activity and outcome data across the various resource centres. For example, these aggregated data no doubt help to build the case for health promotion in the Ministry, and the government more broadly. However, this work is essentially invisible to the health promoter in communities as it doesn't translate into direct services and supports for their work. Thus, the link between such centralized OHPRS activities and expected outcomes in terms of health promotion capacity is not a strong connection.

It was noted further that the OHPRS work in structuring the harmonization of information across the OHPRS organizations is also largely completed and that it may now be time to turn to a more concerted planning process to identify opportunities for making a more direct impact across the province. In this regard the evaluation committee felt that the improvements in capacity for French-language health promotion should provide some motivation and confidence that this work can possibly have an impact. It will, however, be important to keep in mind that the Ministry has direct representation on the FLS committee and also secured additional funding for the direct service activities that this group was able to mount so successfully. Centralized development of HP 101 On-line was also possible only through additional funding support. The committee noted that if the OHPRS as a system is going to embark on more collective activities aimed directly at health promotion intermediaries, over and above its duties for supporting the various OHPRS organizations, similar engagement and financial support from the Ministry may be needed.

The link between capacity and health risks and outcomes – literature review: Although clearly beyond the scope of the five-year OHPRS evaluation plan it is important not to lose sight of the fundamental rationale underlying services and supports aimed at building health promotion capacity. The logic behind this rationale is that enhanced individual, organizational and coalition capacity is translated by health promoters and their collaborators into a more comprehensive and effective mix of community interventions which, in turn, change risk behaviour and/or risk conditions and enhance

the health of Ontarians. This logic chain is reflected in the intermediate and longer-term outcomes of the middle pillar in the OHPRS impact model.

The mid-term integrated report provided a brief summary of the research and evaluation literature underlying this rationale (OHPRS, 2003) and this was updated more systematically by a literature review pulled together the findings from several key studies (Sahay, 2004). Importantly, other systems much larger than OHPRS such as the public health sytem, the health care system, and systems that influence the broader determants of health such as employment and social services impact on program/policy implementation, or impact directly on health outcomes. Changes in these other systems can easily overshadow or complement the impacts of the OHPRS. To make the OHPRS singularly accountable for impacts on program implementation and health outcomes would therefore be inappropriate. That said, the literature review found some evidence substantiating the link between different steps in the logic chain (e.g., increased capacity contibuting to more comprehensive mix of programs; community interventions contibuting to risk reduction and improved health outcomes). Methodogological challenges such as limitations in research design that make it challenging to isolate the impact of capacity components of much larger projects and the ways in which capacity is measured preclude strong casual conclusions to be drawn from the relevant literature. This should not be seen as a flaw in the fundamental logic underlying the OHPRS impact model but rather a challenge for OHPRS to be mindful of, and vigilant for, the research evidence linking health promotion capacity and health outcomes. Ideally this should be part of ongoing attepts to build the business case for health promotion , something reported as needed by the community health promoters as well as the Ministry (see below).

4.3 PILLAR C: OHPRS SUPPORTS TO MINISTRY OF HEALTH PROMOTION

Within this third pillar of the OHPRS impact model there were two main evaluation questions to be addressed (Table 1):

1. From the perspective of the MOHLTC, what are the tangible and intangible benefits of the OHPRS coordination activities with respect to the OHPRS organizations; and
2. Do the perceived benefits of the dedicated OHPRS funding and the system-level activities outweigh the perceived costs from the Ministry perspective?

The results of interviews with Ministry representatives mid-way through the evaluation plan suggested a high level of satisfaction with, and support for, OHPRS organizations both as individual organizations and as an emerging network. That the member organizations were engaged in a *process of change*, and that this *process takes time*, were clearly recognized by key Ministry representatives. The costs or downside of encouraging more "systemness" were seen as minimal in contrast to the perceived benefits, especially those benefits that help the Ministry argue the case for health promotion at a political and senior administrative level. To that end, any system-level activity that can bolster the "business case" for health promotion was said to have high value; good examples being the OHPRS evaluation work and its research synthesis linking health promotion activities to improved outcomes and reduced health care costs. Similarly, of high value to the Ministry are concrete examples of collaboration across centres and, more importantly, across the system as a whole. Evidence of a continuous improvement in system-level coordination and planning helps bolster their case for supporting health promotion at a central level This supports their case since improved coordination is seen as logically connected to improved reach, comprehensiveness of programs and, therefore, population health impact. These impacts, and the corresponding "cost avoidance", were seen as more important to the Ministry than short-term cost efficiencies. To that end, the evaluation committee reported that the OHPRS Secretariat should be actively seeking potential strategic and operational linking points across members' individual workplans in order to find synergies that make sense, and which may maximize impact and be cost-effective. This more proactive search for intuitive and reasonable connecting points had already been initiated within the OHPRS Secretariat. Also it was noted that OHPRS should consider ways to communicate to its members that their collective work, and their reporting of this work in a common format, are of high value to the Ministry.

In addition to these implications for OHPRS planning there were also several consistent themes in the information provided by the Ministry representatives that triangulated with that collected in the qualitative focus groups and interviews as well as the provincial needs assessment. Examples included, the perceived lack of support for health promotion among key decision-makers; the importance of internal champions for health promotion as critical agents to the change process; the acknowledged lack of funding and difficulty attracting and retaining key people to work in the system; the value of outcome and economic evaluation data to support their funding proposals and allocations; their need to sometimes make funding decisions in order to capitalize on short term opportunities; concerns about the level of awareness of OHPRS as a system; but also a

recognition of the need for any increased promotion to be carefully weighted off against the capacity of the system to respond. The fact that there was so much in common with the daily struggles of the Ministry stakeholders and the day-to-day realities of OHPRS members and community health promoters, served as a useful reminder that they are an integral component of the health promotion "system" in Ontario, neither separate from it nor working in a distant and unconcerned bureaucracy.

5.0 SUMMARY AND OVERVIEW OF STRENGTHS AND CHALLENGES IN THE FIVE YEAR EVALUATION PLAN

In 2002 the evaluation committee of the OHPRS laid out a five-year plan to determine the extent to which the network was achieving its goals with respect to improved coordination and collaboration among network members; increased capacity for health promotion-related work among its clientele; and the benefits derived by the Ministry of Health Promotion from its support of the overall "system" of health promotion services and supports. These three areas reflect short-term outcomes within the three pillars of activities, outcomes and longer-term goals articulated within the OHPRS impact model. A multi-method approach to the evaluation was developed and implemented with a heavy emphasis on baseline and follow-up assessment of network integration and health promotion capacity. Within the constraints imposed by the pre-post evaluation design, and other challenges discussed elsewhere in this report the following synthesis of the key findings is presented, organized by the three pillars of the impact model.

Pillar A: Outcomes *for the OHPRS organizations*

- Increase over time in perceived benefits of network participation, although perceptions of benefits versus costs remains highly variable;
- Sustained high level of participation in network forums with a high value placed on networking opportunities;
- Mixed findings with respect to inter-organizational connectivity and collaboration within the network;
- Many indicators of separation of the tobacco-related centres from the network as a whole;
- Moderate levels of satisfaction with services and supports provided by the OHPRS Secretariat, although these centralized services and supports may be under-recognized;
- Opportune moment for a "member check" with respect to expectations concerning the Secretariat services and supports, how best to distinguish

the work of OHPRS generally from that of its members, and any challenges for OHPRS related to sponsorship within the OPC.

Pillar B: Outcomes for health promotion intermediaries

- Health promoters face significant challenges in their work and have diverse needs for information, services and supports. The majority of health promoters work on multiple topic areas and use multiple strategies;
- The majority of health promoters surveyed also report using more than one OHPRS resource centre and these centres may be accessed simultaneously or sequentially as the needs of the local health promotion programs and activities evolve;
- Consistent with the scope and diversity of community needs the network of OHPRS organizations delivers an extensive and multi-dimensional array of services and supports to health promoters;
- There were no substantive changes between baseline and follow-up in perceived quality and access to health promotion services and supports, although perceptions of quality and access were consistently high;
- Significant challenges remain accessing required information for some aspects of health promotion work, such as that concerned with the determinants of health, very specific topic areas of interest, for many cultural/linguistic groups, or for their specific jurisdiction;
- There was little substantive change in health promotion capacity at the individual, organization or coalition levels. On aggregate capacity was moderately-high to high on all capacity indicators;
- There was strong evidence of qualitative changes in the scope and nature of the work of participating health promoters (e.g., more focus on policy and determinants of health, more diverse community partnerships, more resources dedicated to health promotion in their organization, more emphasis on evidence-based practice and evaluation and increased self-report of knowledge, skills, and collaborative contacts;
- There were large increases in all indicators of French-language health promotion capacity, although perceived needs for FLS services and supports remained high;
- The research evidence establishing the link between health promotion capacity and health outcomes of community members is fraught with

methodological challenges that limit interpretation and a stronger "business case" for health promotion is needed in support of the work of health promoters.

Pillar C: Outcomes for the Ministry of Health Promotion

- Concrete examples of collaboration across the OHPRS organizations has a high value, as is gradual improvement in system-level planning and coordination;
- Perceived costs of funding and otherwise encouraging a provincial "system" of health promotion services and supports were seen as minimal compared to the perceived benefits;
- Evidence establishing the "business case" linking community health promotion programs and policies to improved health outcome is also seen as having a high value.

5.1 STRENGTHS OF THE OHPRS EVALUATION

One important strength of the evaluation was the manner in which it emulated "best practice" for the evaluation of health promotion programs (Rootman et al, 2001), specifically with respect to the following steps in evaluation planning: using a logic model as a tool for objectives clarification and assessment of program rationale; development of an evaluation framework with clear questions to be addressed; and the adoption of a sequential yet flexible approach over time. The evaluation plan also included an emphasis on participation of the OHPRS organizations themselves. Although the evaluation was not designed as a "participatory evaluation" *per se*, the input of the OHPRS organizations and the Ministry was sought at several critical junctures (e.g., indicators of network integration; indicators of health promotion capacity) and was critical to the success of the overall process. Results were also returned on a regular basis at network forums. Overall, while the evaluation plan is considerably larger in scope that would be developed for any individual OHPRS organization, or any community health promotion intervention, the planning process serves as a model for others to follow.

One of the key principles underlying the multi-year OHPRS evaluation plan was that the range of evaluation activities complement, rather than duplicate, the evaluation activities of the individual OHPRS organizations. Thus, the focus was to be at a more central

systems level. Although there were clearly lessons learned along the way about the systems approach to evaluation (see below) we were successful in targeting virtually all components of the evaluation to reflect the "added value" of the OHPRS as a system of services and supports. The rolled-up provincial statistics also reflect the aggregate output of the system. In addition to the information gathered from the systems perspective, however, the evaluation also returned specific evaluation tools and concepts that some of the individual centres found useful in their work, for example, the network analysis approach as a tool to assess organizational relationships, and the health promotion capacity framework and measures. The structure of the provincial needs assessment, with both core and topic-specific modules, was also designed explicitly to contribute something above and beyond what would have been possible for any individual OHPRS organization (e.g., much larger and diverse group of respondents, including a sample of non-users; several data points for comparison with other centres), as well as needs assessment data unique to their own domain of interest.

With an eye to the systems-level processes and impacts, the evaluation successfully embedded several key principles and practices of systems evaluation (see Midgely (in press) for a recent review of systems theory and its relationship to evaluation practice). This included a very broad and inclusive definition of health promotion and health promotion capacity; seeking input from multiple perspectives; a multimodal methodology; flexibility to adapt the evaluation to an evolving system (e.g., incorporating a stronger FLS component); a strong focus on inter-organizational relationships and connectivity (e.g., network analysis), and attention to sub-systems (e.g., the sub-system of tobacco centres). In the evaluation of an inter-organizational network such as OHPRS, experts in this area (e.g., Provan & Milward, 2001) also call for multiple stakeholder perspectives, in particular feedback from three broad categories of network constituents: principals, that is those who monitor and fund the networks and its activities (in this case the MHP); agents, that is those who work in the network (in this case the staff of OHPRS and the various OHPRS organizations); and clients, that is those who actually receive the service provided by the network (in this case health promotion intermediaries). These various perspectives were successfully incorporated.

The evaluation plan was built upon both *quantitative* and *qualitative* approaches and each was used to its advantage. For example, the health promotion capacity survey painted a very broad provincial picture while the qualitative focus groups (including the parallel Francophone component) drilled down and revealed in more depth the myriad of challenges and community and organizational contexts for potential improvements in

individual health promotion capacity. The evaluation plan also included both *process-related* components (e.g., summary statistics; Ministry stakeholder perspectives) and *outcome-related* components (e.g., changes over time in network integration and health promotion capacity).

To this list of strengths we would add the strong and evolving FLS component to the evaluation. Although the original plan (and budget) did not consider the special information requirements regarding French language health promotion capacity and needs, the evaluation committee worked closely with the OHPRS FLS Committee to considerably bolster this aspect of the evaluation over time. In the end, not only did all components provide an opportunity for participants to contribute feedback in either French or English, but several areas were also identified for which indicators unique to Francophone issues could be developed (e.g., French language health promotion capacity). This proved to be highly successful in pointing to potential provincial impact of the work of the FLS Committee and also contributing information on the unique needs and challenges of French language health promoters.

Lessons learned in the evaluation process

As comprehensive and informative as the overall evaluation plan for OHPRS has been the many issues and challenges interpreting the findings sparked considerable discussion within the evaluation committee about areas for potential improvement in the evaluation process. With the benefit of hindsight there were several lessons learned and which now set the stage for a renewed evaluation effort as the OHPRS goes forward into its next chapter.

From an evaluation planning perspective: Despite the laudable approach to planning the evaluation, that is with a logic (impact) model and the derived evaluation questions, indicators, etc., insufficient time was devoted to a clear assessment of the needs to be addressed by the creation of the OHPRS by the MOHLTC, and how the OHPRS was to meet these needs both strategically and operationally. The evaluation plan was directed in large part by the initial impact model that articulated the *levels of impact,* but which did not sufficiently articulate the distinction between the impact of collective, system directed initiatives (e.g., HP101) versus impact of the sum of the work of the individual resource centres (e.g., total training sessions, consultations, resources distributed). While a more complete logic model did get developed in the evaluation planning process,

it too failed to capture the nuances of this distinction until well into the evaluation process and a new impact model was prepared.

Recently, Michael Goodstadt (2007) has articulated *four* types of logic models that together: (a) link the nature of the problem to be addressed (explanatory factors model); (b) the change process assumed to reduce or manage the problem (change/influence process model); (c) the specific activities in the workplan and outcomes to be achieved (program/action model); and (d) the sequencing of short, intermediate, and longer term outcomes anticipated on the basis of these change processes (the outcome/evaluation model). Together these four different models represent the overall *raison d'etre* and rationale for the program or intervention in question. In hindsight it would have been helpful to have walked through each of these steps in the evaluation planning process since, over time, a major disconnect became increasingly apparent between where the energies of the OHPRS (as a system) were being directed and the outcomes that were being anticipated and measured. By this we mean the stark contrast between the substantive energies devoted to standardizing and providing information to the Ministry on system "outputs" to support accountability processes and other information needs (Pillar C in the new impact model), and the considerable expectations also advanced for substantive and measurable changes in health promotion capacity among Ontario's health promoters (Pillar B). Following all four steps in Goodstadt's process would have "laid the bones bare" so to speak that, other than the collective work of the individual centres (basically "business as usual"), few new collective activities were actually embarked upon at a system level strategically and/or operationally that might have a reasonable link to large-scale capacity change. System-level interventions that did eventually get off the ground included the work of the FLS committee and the development of HP 101, both requiring additional resources above and beyond the core OHPRS funding envelope. Similarly, there was no clearly articulated statement of need regarding system integration (i.e., coordination of work across the centres) that was tied to a strategic and operational plan to enhance system integration, and indirectly the work of health promoters in Ontario communities. This too seemed secondary to the Ministry-driven goals of improved information and accountability, although feedback in the qualitative aspects of the evaluation did signal that pressure was sometimes brought to bear for the OHPRS organizations to be working together even under circumstances where the added value was questionable in relation to the costs of collaboration. A clearer plan for inter-organizational collaborations that "made sense" to the OHPRS organizations based on role and mandate would have provided clearer direction for developing indicators of success concerning specific plans and activities aimed at system

integration. Such plans and activities would have been articulated in a more detailed workplan-oriented logic model (the third of Goodstadt's steps).

From an outcome evaluation perspective: Fundamentally, the traditional model of outcome evaluation requires three questions to be addressed – (1) whether change has occurred; and (2) whether the program or intervention between studied had any role in producing that change (i.e., attribution). A third question that may be asked is whether the change is substantive enough to matter in terms of the needs to be addressed.

In terms of the first question the evaluation plan called for a very comprehensive approach to measuring change in both system integration (i.e., the two network surveys) and health promotion capacity (the two capacity surveys). In both instances the main constructs in question were unbundled for more precise measurement drawing substantive guidance from relevant research literature. Capacity was also measured at two levels (organization and individual), although in each instance from the perspective of an individual health promoter. The network integration survey incorporated both the formal methodology of network analysis and specially derived measures tapping, for example, into perceived costs and benefits of network participation. While all of the above augers well for penultimate considerations of reliability and validity several aspects of outcome measurement might still have been improved. This includes complementing what were essentially self-report measures with more objective indicators (e.g., content analysis of key documents to assess inter-organizational coordination and cooperation and perhaps organizational-level health promotion capacity) as well as giving more attention to organizational-level health promotion capacity and community context for the expression of individual-level capacities.

Aside from the conceptual issues discussed above regarding the uncertainty in the mechanisms underlying system-level impact, the second challenge of attributing changes in health promotion capacity to the work of the OHPRS with a pre-post evaluation design was recognized from the outset. Without a comparison group, or a longer time-series of observations, any change that was measured may or may not be deemed attributable to the collective OHPRS, especially recognizing that the network is not the only game in town with a mission and strategic goals targeted at health promotion capacity building. With a straightforward pre-post design the best one can do is assess whether the change is in the direction anticipated from the outset and consistent with the nature and scope of the intervention activities.

More problematic in the case of the OHPRS evaluation plan were issues related to the third question, and in particular the inability to articulate *how much* change would be a desirable outcome. In part this is the challenge of articulating "practical versus statistical significance" and this was played out somewhat in the analysis of the pre-post capacity survey data whereby some of the indicators were statistically significant but represented small absolute changes. More challenging, however, was the lack of historical benchmarks or more theoretically as to what level of capacity is deemed to be "sufficient " or "in need of improvement". Is there a theoretical "capacity ceiling" for a broad-based workforce given departures of very capable senior staff and new recruits with a lot of on-the-job learning still ahead of them? Is a broad-based workforce expected to be fully capable on all indicators or is a basic level required for some and a higher level required for others? Although the baseline survey showed room for improvement in the capacity indicators, both baseline and follow-data showed capacity as measured here was also at a high level and perhaps Ontario is at a theoretical ceiling. The French-language capacity indicators on the other hand had considerably more room to increase and they did so substantively.

This same challenge around "how much" change is expected and desirable plagues the interpretation of the pre-and post-network integration surveys. How much coordination is expected? When would we declare that the level of coordination is sufficient? Are there situations where integration activities may actually be resulting in more cost to the system than benefit to community health promoters? On the latter question it is clear from the network integration surveys that the perceived costs are high for some members and clearly the more system-level work that they do the less they are doing of their own. System-level contributions from a particular resource centre are also most likely to be hidden in routine centre reporting and documentation, in large part because it is often not planned. These are some of the more substantive challenges faced in the interpretation of the outcome data brought forward in this evaluation.

From a process evaluation perspective: Process evaluation typically seeks to determine whether the program or intervention in question was implemented as intended, to the right target audiences, and in sufficient "dosage" to have produced the desired outcomes. Essentially process evaluation is concerned with both the question of attribution (described above) and the desire for replication (if one can determine the critical ingredients of the program or intervention this helps guide what to replicate or recommend to others). Has the OHPRS evaluation lived up to these requirements? The answer, in hindsight, is partially yes but not as thoroughly as it could have. For example,

while the "outputs" of the overall OHPRS network were rolled up and documented for purposes of the evaluation, little attention was given to fully documenting additional system-level activities. This is related to the point made earlier that the initial OHPRS impact model (and first logic model) failed to articulate the nature and scope of broader system-level activities that would impact health promotion capacity (Pillar B). There was also no tracking system in place to prospectively document either the nature of OHPRS collaborations or the more qualitative context surrounding what made for productive versus less productive collaborations (Pillar A). Similarly interactions with Ministry representatives in support of their work, and health promotion more generally, could have been tracked better (Pillar C). Although the 2004 qualitative interviews with the Ministry went some distance in helping us understand the perceptions of value placed on the OHPRS as a network, more might have been done to tease out what information and supports are viewed as being the most helpful.

Another process evaluation issue that arose in the latter stages of implementing the evaluation plan was the limitation imposed by the relatively narrow target population of the baseline and follow-up capacity surveys, that is, health promoters working for Ontario's public health units and Community Health Centres. While the qualitative capacity assessment contributed much in terms of understanding challenges doing health promotion related work in any sector, it also highlighted the complexity and depth of such work across a wide range of sectors (education, self-help, NGO's). The 2004 provincial needs assessment also showed the inter-connectedness of the work of health promoters individually and working collectively in organizations and coalitions (i.e., the same health promoters working on many different topic areas.) Thus the methodological necessity to restrict the capacity surveys to the PHU and CHC client base of the OHPRS resource centres clearly told only part of the story of their potential impact on health promotion capacity in Ontario.

From a systems evaluation perspective: Despite the many strong features noted earlier with respect to a systems approach to evaluation, there were areas that a stronger system model might have been beneficial. For example, a stronger theoretical basis in systems theory may have led a closer examination of the larger system of health promotion services and supports in Ontario in which the OHPRS is itself embedded and to which it is connected in complex ways. The 2004 needs assessment clearly showed the many sources of training, consultation, and information exchange accessed by Ontario's health promoters. Evaluation questions about the integration of services and supports outside

the system itself were not asked although of obvious importance, especially in the context of the recent OHPRS operational review.

Also, while we successfully incorporated multiple perspectives into the evaluation we might have gone deeper in some areas, for example, bringing in the perspective of staff versus managers of the resource centres, OHPRS organizations that work in a natural "cluster" (e.g., tobacco, substance use) versus those not working in a cluster; and external stakeholders as noted above (e.g., managers and/or staff of major NGO's). Recent systems evaluation models dictate that, in some circumstances, the evaluation consciously explore power relationships with systems (in this case an inter-organizational system) and we did not pursue perspectives from larger versus smaller OHPRS organizations or other characteristics that may distinguish power imbalance within the network or among the types of clients served.

The distinguishing characteristic of system thinking is "holism" a term meant to convey the importance of avoiding dogmatic use of methodologies that concentrate attention on a relatively narrow set of pre-defined variables and to focus more on the whole picture. Fundamentally, the OHPRS evaluation plan followed a very reductionist approach based first on a linear impact model (A leads to B which leads to C and so on) and then driven largely by unbundling two major constructs of prime importance in the model (health promotion capacity and integration). It is not that such a reductionist approach may not have a place in a systems analysis but rather that it is too narrow to address larger questions of interest. For example, is the network organized optimally to remain viable? Are the sub-systems in the network helpful or harmful to the overall mission? Do the essential functions within the network communicate well with each other? Are feedback loops in place to quickly show where changes may need to be made internally and in relation to the external environment? What are the perspectives on the essentially voluntary model of system governance system and is it seen as being supportive or hindering the system goals? What are the different perspectives on network integration and how can these perspectives help inform effective collaborations in the interests of the community health promoters? These are the kinds of questions that a broader systems, and less reductionist, evaluation model would lead one to.

Despite the above advantages that may have been derived from a stronger system orientation to the evaluation, some members of the evaluation committee felt that perhaps too much emphasis may have been given to the search for the "added-value" of the system aspects of the OHPRS, as opposed to giving more focus to the work of the

individual OHPRS organizations, including their own evaluation data. In other words was the net sum of the components of the system being lost or downplayed in the search for the added value of the dedicated resources and Ministry policy directives for improved integration for the system as a whole. To put this in perspective it is important to note that of the approximately $9.7 million invested by the MHP in the OHPRS, less than 10% is aimed at system-level coordination functions. A vast array of services and supports are being provided through the other 90% and yet the overall evaluation plan did not call for a roll-up of centre level evaluation on customer satisfaction and other outcomes. Nor did it seek to sum up evaluation data on the many products produced by the centres in their dissemination plans. These products, services and supports are at the heart of the perceptions of high service quality and accessibility we measured at the system level and our finding that health promotion capacity at the individual, organizational and coalition levels as measured in the capacity survey is also very high. It will be incumbent on the various stakeholders involved in the next stage of the OHPRS evaluation to assess the place of the collective work of the OHPRS, including their evaluative work, in the evaluation of the overall system.

From the evaluation utilization perspective: An essential part of a quality evaluation process is that the questions being addressed are of high interest (i.e., the resulting information will be valued) AND the results will be used for decision-making or other purposes. The evaluation planning process benefited from extensive stakeholder input, and the evaluation questions were clearly of interest and agreed upon through due process. The general purpose or overriding goal behind the specific questions was also clear - partly accountability with the Ministry and, in larger part, to return valuable information for ongoing system enhancement.

With respect to accountability purposes the Ministry clearly praised the type and quality of evaluation results mid-way through the plan and to date has given no indication that the results have not been useful to them in supporting funding for the system and for health promotion generally. Indeed the evaluation committee recently worked with the Ministry lead for the OHPRS to identify a basic set of indicators that could be monitored over time to assess progress toward the overall OHPRS goals. In terms of ongoing quality improvement several examples can be pointed to where the evaluation contributed substantively to discussions and decisions. Perhaps the best example was the decision to abandon the cluster structure with the OHPRS based partly on the results of the baseline network survey. Another example is the initiation of the outreach working group based on the results of the provincial needs assessment that noted the need to increase capacity

to reach out and work with different cultural groups. These examples aside, looking back at the scope and quality of the data collected under the auspices of the overall evaluation plan one could question whether the data have been used to the fullest extent possible. A related question is whether the structures and processes within the OHPRS for reviewing and acting on recommendations arising from the evaluation could perhaps be strengthened in the future. Appendix D synthesizes the major recommendations from the various evaluation reports in order to facilitate a review of actions and decisions based on the evaluation and needs assessment findings, in the spirit of strengthening review and decision-making processes for future evaluation results.

Lastly with respect to the use of the findings emanating from the evaluation plan, we note the potential usefulness of the results for decision-making around the recently completed OHPRS operational review. Although the timing of the review and this summary integrated report unfortunately did not coincide in an ideal manner we would anticipate the results will be useful in actioning recommendations that have been brought forward in draft form by the Ministry consultant.

6.0 GOING FORWARD

The results from the many facets of the OHPRS evaluation plan have contributed an enormous amount of information about the network and about the delivery of services and supports to health promoters across Ontario, often working under very challenging conditions. The OHPRS capacity surveys, as well as the 2004 OHPRS provincial needs assessment survey (Rush, 2005), have also provided detailed information about this workforce engaged in health promotion across the province. There are no other equivalent data collection efforts in Ontario, or elsewhere, that tap so deeply into the needs and capacity areas of community health promoters, and in a way that cuts across various sectors of the health and other systems. These health promoters, and the workplaces in which they work, are constantly changing and the data gathered here would suggest the changes have been dramatic in many respects. Although not universal across all areas of the province, there has been a growth in the number of dedicated health promotion managers and staff with public health units and Community Health Centres, as well as important internal realignments that auger well for protecting and promoting their work. The data also suggested a gradual upgrading in the quality of the work being done. This upgrading probably reflects several factors including, but not limited to, a larger more targeted workforce; enhanced formal training of health promotion specialists; and a substantive investment in ongoing skill development

through continuing education and training. The evaluation data suggest that the 21 centres currently comprising the OHPRS no doubt play a critical role in the on-the-job support of health promoters in the field, and the organizations they work for. The challenge now is to develop strategies to get the maximum "added-value" of the various resource centres working together as a true system of services and supports.

The OHPRS awaits the results of the 2006-2007 operational review. Changes may be substantive based on preliminary feedback from the consultant and both structural and process-related changes are likely to emerge. In going forward it is hoped that many of the findings arising from the multi-year evaluation plan will be useful and also that a renewed evaluation plan will help sharpen the strategic and operational plans. To that end we suggest a new logic model be developed building upon the impact models created in the course of the past evaluation work and which articulate concretely the need to be addressed by system integration from different perspectives and how integration will be optimized. In addition it is important going forward to recognize that a broader systems approach to the evaluation is likely to be helpful and will mitigate many of the lessons learned from the past several years' work. Essentially a systems evaluation model is also self-corrective and flexible over time, building upon its own strengths and limitations over time.

Lastly, in going forward into the next phase of OHPRS and its evaluation it is important to acknowledge the value of the OHPRS evaluation activities among the key stakeholders in the Ministry. The evaluation itself is considered to be a good example of a system-wide activity that is returning information of value to them and the OHPRS Secretariat. This support is very much appreciated by the ENAC committee and the consultant team.

Summary of evaluation issues going forward:

- Review and update OHPRS logic model in the context of an OHPRS strategic planning process;
- Establish needs for evaluative information and develop a new evaluation plan. A three-year time horizon for the evaluation plan is recommended;
- In the context of the strategic planning and evaluation planning processes, clarify expectations for the nature and scope of desired inter-organizational coordination and collaboration within OHPRS;
- Improve ongoing process of documentation of system-level activities as well as inter-organizational collaborations;

- Adopt a stronger system approach to the evaluation;
- Clarify and strengthen relationship between the OHPRS evaluation function and structures and processes with responsibility for considering and, where appropriate, actioning the recommendations arising from the evaluation activities;
- Strengthen the link between the OHPRS evaluation activities and results and the MHP accountability processes for the network as a whole.

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APPENDIX A

MEMBERS AND AFFILIATES OF THE OHPRS, 2007-2008

Core Members

- Alcohol Policy Network (APN)
- Association to Reduce Alcohol Promotion in Ontario (ARAPO)
- Best Start - Ontario's Maternal, Newborn and Early Child Development Resource Centre (BSRC)
- Canadian Council for Tobacco Control (CCTC) [formerly, National Clearinghouse on Tobacco and Health]
- Consumer Health Information Service (CHIS)
- Council On Drug Abuse (CODA)
- Curriculum & School-Based Health Resource Centre (CSBHRC)
- FOCUS Resource Centre (FRC)
- Heart Health Resource Centre (HHRC)
- Media Network for a Smoke-Free Ontario (MN) [formerly, Ontario Tobacco Strategy Media Network)
- Nutrition Resource Centre (NRC)
- Ontario Drug Awareness Partnership (ODAP)
- Ontario Healthy Communities Coalition (OHCC)
- Ontario Prevention Clearinghouse (OPC), Health Promotion Resource Centre
- Ontario Self-Help Network (OSHNet)
- Ontario Tobacco-free Network (OTN)
- Parent Action on Drugs (PAD)
- Physical Activity Resource Centre (PARC)
- Program Training and Consultation Centre (PTCC)
- Ontario Injury Prevention Resource Centre (OIPRC)
- The Health Communication Unit (THCU)

Affiliates

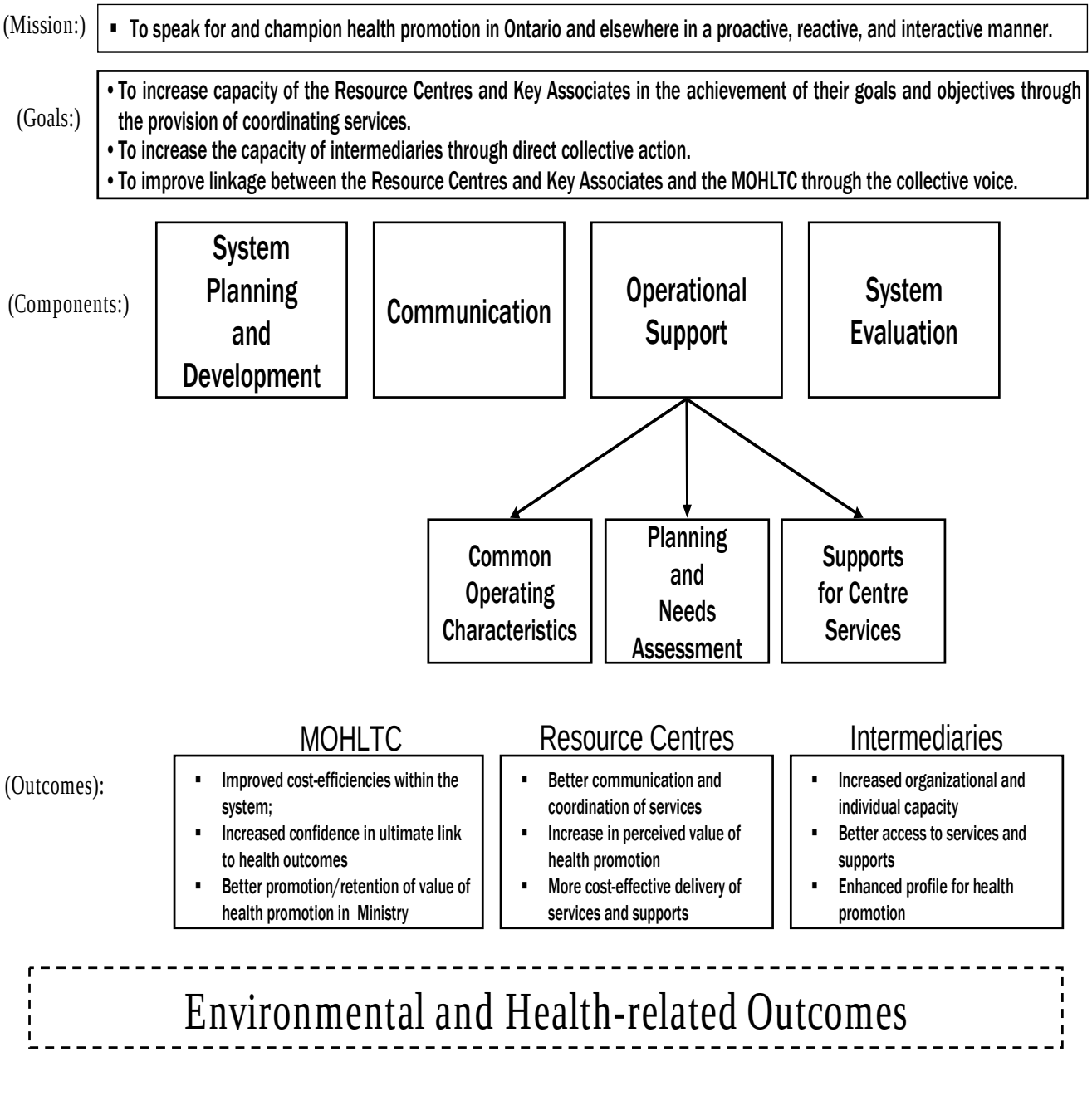
- The Canadian Health Network – Health Promotion Affiliate (CHN-HPA)
- Cancer Care Ontario (CCO)
- Ontario Chronic Disease Prevention Alliance (OCDPA)

- Ontario Chronic Disease Prevention Managers in Public Health (OCDPMPH)
- Ontario Tobacco Research Unit (OTRU)
- Ontario Women's Health Network (OWHN)
- Smoking and Health Action Foundation (SHAF)

APPENDIX B

INITIAL OHPRS LOGIC MODEL

Logic Model for OHPRS



APPENDIX C

HEALTH PROMOTION CAPACITY INDICATORS

ASSESSMENT AND PLANNING:
(1) Involve stakeholders/participants in the planning process
(2) Ensure that the diversity of your community is reflected throughout the planning process
(3) Develop appropriate and measurable objectives
(4) Understand and apply theories to guide design and implementation of programs/activities (e.g., models of community or behaviour change)
(5) Select valid and reliable sources of information on community needs, strengths and issues
(6) Collect valid and reliable information or community needs, strengths and issues where insufficient information exists
(7) Access relevant information on priority issues
(8) Critically analyze research findings to identify practical program implications
(9) Identify and analyze the social, cultural, economic and environmental factors affecting population health status
(10) Develop proposals for funding
PROGRAM IMPLEMENTATION:
(11) Involve stakeholders/participants in program implementation
(12) Ensure that the diversity of your community is reflected throughout the implementation process
(13) Address barriers to participation in programs/activities (e.g., promotion, child care, transportation, cost)
(14) Develop and implement health promotion policy options
(15) Facilitate mutual support or self help, including small group development
(16) Facilitate community development (e.g., conflict resolution; sharing power, nurturing relationships)
(17) Deliver educational/behaviour change programs

(18) Manage projects (e.g., human resources, finances, operations, monitoring the workplan)
(19) Develop and implement health communications activities (e.g., social marketing campaign; working with the media, newsletters)
(20) Demonstrate leadership skills
(21) Recruit, co-ordinate and support volunteers
(22) Build partnership and coalitions
(23) Market the value and cost-benefit of health promotion in the community
(24) Work with health service(s) to go beyond the traditional provision of clinical and curative services
(25) Refer individuals and groups to health promoting organizations and sources of information on health-related issues
PROGRAM EVALUATION:
(26) Collect information to assess implementation of health promotion programs/activities (e.g., tracking number and type of participants; documenting activities)
(27) Collect information to determine if the health promotion activities are meeting outcome objectives
(28) Use evaluation findings to improve your health promotion programs/activities
SUSTAINABILITY AND TRANSFERABILITY:
(29) Identify options for sustainability (e.g., securing funding; transfer to alternate organization)
(30) Transfer skill sets and/or strategies (e.g., from one health issue to another; from one community to another)

APPENDIX D

SELECTED RECOMMENDATIONS FROM ENAC REPORTS

Advocating for health promotion:

It seemed appropriate given the consistency and depth of concern about funding and funding models expressed by participants in this evaluation, for OHPRS to consider ways to collectively voice these concerns on behalf of their clients, and to work with key partners to develop a provincial strategy to advocate for more sustainable funding for health promotion. It may also be important, for OHPRS to coordinate its advocacy efforts with other key national initiatives such as the Chronic Disease Prevention Alliance of Canada (CDPAC) and the Canadian Coalition for Public Health in the 21st Century. The key will be for OHPRS as a system to determine where they will take a lead role in advocacy activities and where they may best play a supportive role. A "business case" for health promotion was seen as a critical component of a provincial promotional strategy and, based on the feedback in the qualitative Ministry interviews, also of high value to them in arguing the case for health promotion internally to the Ministry as well.

Increased organization-level focus:

The literature on health promotion capacity recognizes that there is an organizational level that must be considered in both developing and measuring capacity. There were several signs in the qualitative data that Board-level and managerial support for health promotion was a significant challenge for health promoters as well as Ministry representatives. The results suggested that OHPRS organizations individually and collectively consider how prepared they are to work with clients from an organizational versus individual framework.

As challenging as it is at an organizational and personal level, the current environment for health promotion also leads to creative partnerships and leveraging of existing resources to maximize impact. The evaluation results challenged OHPRS members to model a healthy partnership at the system level for the clients and communities that they serve. Another implication derived from the feedback on partnerships was the need for OHPRS organizations to consider providing skills training for the clients they serve in the area of partnership itself. It was noted that such training should go beyond the

current focus on building and sustaining coalitions, to perhaps engage people at a more personal level in terms of what it takes to be a good partner, for example, how to facilitate reciprocity and trust in the relationship. This should also include the development and widespread use of indicators of *"healthy partnerships"*

Dissemination/knowledge exchange models:

The issues of time, and time management, were also seen as connected to the perceived need for resource material to be packaged as much as possible in a "ready to go" format. At the system level it raised the question for OHPRS organizations about what centralized services and products they might develop or support as time savers that would be of high value across the system. Examples cited by evaluation participants included templates to assist in their health promotion work (e.g., business case, terms of reference, job descriptions; backgrounders, and position papers).

Significant challenges were experienced by participants practicing health promotion in the rural and more remote regions of the province. The most emotionally charged concerns was the feeling of "Toronto-centricity" and the evaluation committee cautioned that OHPRS needs to remain mindful of these perceptions, and do what it can to mitigate these concerns with practical solutions (e.g., the ongoing need for print materials and more traditional distribution strategies; exploring Web-based training technology to help bring training events and materials to smaller communities that have difficulty getting the critical mass needed to make on site- face to face training practical for the training organization).

A wide range of health promotion-related conferences/events were considered appropriate for participation and many of these options were accessed within the past two years. Barriers to conference/event attendance were, however, encountered by about 75% of respondents. Some of these challenges will be more easily addressed by OHPRS organizations than others, for example, supporting the distribution of notices about conferences and events through their centralized web site.

With respect to health promoters' past training and education experiences, a wide range of options had been utilized in the past. In terms of meeting the respondents' needs the highest ratings were given to the more intensive options such as coaching and mentoring, expert consultation, training workshops and conferences or other events. Local and regional training events were clearly preferred over provincial events. Several

people commented specifically on the need to improve the reach of the traditional conference/training approach, for example, through Web casting or subsequent preparation and dissemination of materials electronically.

Content areas for training, education and consultation:

Over the past decade, computers and the Internet have become a critical part of work life in Canada and this was clearly reflected in our data from Ontario's health promoters. 40% to 50% of respondents cited less than ideal access to appropriate software as well as training and support on the use of the computer and the Internet. Such needs were also identified in the qualitative survey data on training and education needs, suggesting that this as an important topic area for inclusion in training and education opportunities led by one or more OHPRS organizations.

A wide range of other training and education needs were identified and which spanned the full range of health promotion topic areas (e.g., smoking, maternal and infant health, alcohol and other drugs, nutrition, physical activity, tobacco control) and capacity areas (e.g., community networking and partnerships, project planning and management, funding strategies, program and policy evaluation, health communication, mutual aid/self-help, and incorporating best/better practice).

Culture and language

The qualitative results also highlighted the critical need for the work of OHPRS organizations, and the system as a whole, to develop their own capacity for working with different cultures, including the development of materials and resources in different languages. Although this arose most clearly in the Toronto-based focus group, it was also acknowledged as a major ongoing issue facing health promotion (and health care for that matter) across the province. While there are no easy solutions, the evaluation report suggested that culture and language issues be a key consideration within *all* OHPRS activities in order to "keep the bar high", and to keep challenging the system to address these issues in a meaningful way at the project level.

Promotion of OHPRS as a system of services and supports

One of the most salient findings to emerge from the qualitative evaluation activities concerned the perceived need to better promote OHPRS as a system of services and supports. Some participants questioned whether health promoters really needed to know that there was a larger network of services behind each OHPRS member they were working with. As long as these services were working together to meet the person's needs they may not require a detailed knowledge of the system (much like a bank has multiple systems of services and supports that are of little interest to the consumer as long as their banking needs are met). In the end, the arguments in favour of increasing the awareness of OHPRS as a system of supports and services were more cogent that those against more promotion of the system, with the added caveat that any additional promotion must be consistent with the ability of the system to respond to the expressed needs. In addition, the results suggested that there be a more systematic effort to describe what each OHPRS organization does, and the kinds of health promoters and health promotion contexts for which they feel they bring the most value. This would help to convey a logical and credible picture of the system as a whole.