



Evaluating ActNow  
BC Programs:  
A Guide for Indigenous Communities  
in British Columbia

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MAY 2008



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## 1) Introduction

This guide has been prepared to help Indigenous communities in BC evaluate their Aboriginal ActNow funded programs.<sup>1</sup> *It is hoped that community based evaluation of Aboriginal ActNow funded activities will strengthen a community's ability to secure funding for future programs.* Because there is no single or best way to evaluate Aboriginal ActNow funded activities in a way that will work for every program, this guide is intended to answer some questions about program evaluation generally and be a *flexible* tool that can be adapted to unique community or program needs. The guide:

- ▶ provides a very brief introduction to some of the theories of health behaviour change;
- ▶ clarifies what the community believes about the program and its results or the link between activities and long term goals;
- ▶ helps communities to determine what kinds of questions they want their evaluation to answer;
- ▶ outlines how and where to collect needed information to answer the question;
- ▶ offers a clear way to make sense of that information using a holistic approach;
- ▶ shows how to report the results; and
- ▶ last but certainly not least, packages this information into a “to do” list for those responsible for evaluation at the program level.

## 2) Getting Started

The first thing you might want to do is develop an evaluation team or committee. This is a big task: you will need help. Your team can include as many or as few people as you want but should have a variety of groups represented (e.g. participants, program deliverers, youth, Elders, program leaders, general community members, program sponsors, leadership, etc).

Once the team is together, they must figure out if the program or program can be evaluated. There's no point in doing all that work only to find out that the program cannot be evaluated. To help you be clear about the 'evaluatability' of a program, answer the following questions:<sup>2</sup>

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<sup>1</sup> Aboriginal ActNow BC is a multi-year health promotion program hosted by the National Collaborating centre for Aboriginal Health's under its BC Initiatives (BCI) stream. BCI's Aboriginal ActNow program is intended to complement the larger, provincial ActNow initiative aimed at reducing tobacco misuse, and increasing healthy choices in pregnancy, physical activity and better nutrition.

<sup>2</sup>Adapted from: Horne, T. (1995). Making a difference: Program evaluation for health promotion. Edmonton, AB: WellQuest Consulting Ltd.

- ▶ Do different groups (e.g., participants, program leaders, program sponsors, staff members) involved in the program agree on its purpose?
- ▶ Does everyone agree on the goals of the program and ways to measure the program's success?
- ▶ Does everyone agree on their roles in the evaluation?
- ▶ How easy will it be to gather the information necessary to answer questions?
- ▶ Does your team have people who can do the evaluation and analyze the results? If not, do you have access to anyone who can provide these services?
- ▶ Does your team have the resources necessary (e.g., time and money) to do the evaluation?
- ▶ Has the team kept track of how the program is being carried out? If you don't know how the program is being conducted, then understanding how to assess the results of the program is impossible.

### 3) What do we believe?

Over the **long term**, we hope program efforts will result in healthy behaviour *changes*: it is **why** the Aboriginal ActNow program exists. To link efforts to desired change, our beliefs must be clear. In other words, what are our ideas about what leads us from running a health program to creating desired health changes in the community? Theories such as the health belief model, social learning theory, and the theory of planned behaviour have been used a great deal to explain why people do or do not adopt healthy behaviours and in each of these models, people's beliefs, not just their knowledge, play a key role in determining their behaviour. These models can help you in the evaluation of your program.

#### 3.1 The Health Belief Model

The health belief model<sup>3</sup> predicts the likelihood of an individual completing a healthy behaviour (e.g., eating a more nutritionally balanced diet) by examining a set of core beliefs held by that individual. This theory explains the adoption of healthy behaviours by examining people's beliefs<sup>4</sup> about their susceptibility to a condition (e.g., diabetes), their beliefs about the severity of the condition (e.g., diabetes is a serious disease), and their beliefs about the barriers (e.g., eating healthy will require more time in meal planning and preparation) and benefits (e.g., eating a healthy diet may help me avoid diabetes) that come along with the behaviour. These different beliefs are thought

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<sup>3</sup> Janz N, Becker MH. (1984). The health belief model: a decade later. Health Education Quarterly, vol. 11, pgs. 1–47

<sup>4</sup> Aalto, A. M., & Uutela, A.(1997). Glycemic control, self-care behaviors, and psychosocial factors among insulin treated diabetics: A test of an Extended Health Belief Model. International Journal of Behavioral Medicine, vol. 4, No.3, pgs. 191–214.

to explain how someone becomes ready to act on a healthy behaviour, but cues to action (e.g., symptoms, reminders to act) are necessary to prompt behaviour change. Lastly, self-efficacy is an important factor that has been added to this model, as researchers feel it is important to consider how confident an individual feels in her or his ability to actually carry out a desired behaviour change.

### **3.2 Social Learning Theory**

Social learning theory explains the adoption of healthy behaviours in terms of (1) how people think about a specific behaviour, (2) environmental factors that encourage or discourage the behaviour, and (3) behavioural factors that lead to successful behavioural changes.<sup>5</sup> When considering how people think about healthy behaviours, it is important to consider not only their knowledge of a particular behaviour, but also the attitudes and expectations that they hold about that behaviour. Environmental factors can also influence a person's decision to adopt a new behaviour or to stop an old one (such as smoking), through things such as norms (e.g., smoking is disgusting) and resources made available in one's community (e.g., smoker's helpline, support group, or nicotine patches). Lastly, behavioral factors (e.g., self-efficacy, skills such as proper exercise training, practicing new skills or appropriate behaviours) are an important part of the health behaviour equation. People need to observe and learn how to do new skills (e.g., healthy shopping or cooking, strength training). After a behaviour change is made, incentives help reinforce positive healthy behaviours (e.g., greater stamina or strength or the approval of friends and family may encourage someone to keep exercising).

### **3.3 Theory of Planned Behaviour**

The theory of planned behaviour is a psychological model that predicts the likelihood of someone doing a particular behaviour, by considering that person's intention to complete that behaviour.<sup>6</sup> The theory of planned behaviour predicts behavioural outcomes (e.g., quitting smoking, exercising regularly) by considering the beliefs a person holds about a specific behaviour, the norms surrounding that behaviour, and the believed amount of control one feels she or he has over that behaviour. Each of these elements when taken together (i.e., attitude toward the behaviour, norms about the behaviour, and perceived control over the behaviour) helps researchers understand the process people go through when changing a behaviour.

### **3.4 Stages of Change**

Healthy behaviour changes can be a complicated and long process, and individuals can vary greatly in terms of their readiness for change. The stages of change

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<sup>5</sup> Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. Health Education & Behavior, vol. 15, pgs. 175-183.

<sup>6</sup> Ajzen, I. (1991). The theory of planned behavior. Organizational Behavior & Human Decision Processes, vol. 50, pgs. 179-211.

model (also called the trans-theoretical model) states that behaviour change happens as an individual progresses through a series of stages, each stage with its own challenge.<sup>7</sup> The stages of change model includes six stages:

- (1) pre-contemplation (people in this stage do not acknowledge a problem);
- (2) contemplation (people acknowledge that there is a problem but are not yet ready to commit to changing their behaviour);
- (3) preparation (people commit to change and begin to search for resources on ways to make their desired health change);
- (4) action (in this stage people have begun to change their behaviour);
- (5) maintenance (this stage involves remaining successful in one's behaviour change and avoiding relapse), and;
- (6) relapse (people who abandon their new behaviour change for their old ways, but can once again move out of this stage).

### 3.5 Beliefs about Program Implementation

Given the complexity of behaviour change, it would seem that to achieve a long term goal, things must happen along the way, which we will call **short term benefits** (e.g., increased access to information or opportunity or improved understanding of the impact of smoking on health). The **short term benefits** are **WHAT** we want tomorrow, next week, or this year. Short term benefits are achieved by performing **day to day activities** or **HOW** we are going to achieve our goals. This sequence is most simply illustrated in Figure 1) below:

**Figure 1) Our Beliefs: The Short and Sweet Version**

**Day to day activities**  
(How we did it)      (      **Short term benefits**  
(What we want)      (      **Long term goals**  
(Why we are involved)

There are several ways to “picture” our beliefs about program activity and goals: two examples have been provided for you. The first example on the following page pictures the logical sequence of activities, short-term benefits and long-term goals in very general terms, followed by a logic model for BC Initiatives Act Now programs. A blank model is included in Appendix A for your use.

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<sup>7</sup> Prochaska, J.O., & DiClemente, C.C. (1983). Stage and processes of self change of smoking: toward and integrative model. *Journal of Consulting and Clinical Psychology*, vol. 51, pgs. 390–395.

**Figure 2) One View of Change**

					<b>Long-term</b> Environment or community change
				<b>Intermediate</b> Individual behaviours change	
			<b>Short-term</b> Changes in Ideas		
<b>Evaluate Outcomes</b> <b>Evaluate Processes</b>		<b>Outputs or service delivery objectives</b> sessions, products, participation			
	<b>Interventions</b> Activities				
<b>Inputs</b> Resources					

### 3.6 ActNow

With ever increasing rates of chronic disease and strains upon the health care system, Canada's ability to provide illness care is being challenged. In an effort to address common risk factors, ActNow was developed to improve activity and nutrition levels, reduce tobacco consumption, as well as optimize healthy choices in pregnancy.<sup>8</sup> Key activities of the provincial initiative include education and awareness campaigns, program and service delivery, advocacy for policy and legislative change, as well as knowledge development and transfer. The Government of BC has transferred the resources to BC Initiatives with the intent to:

- ▶ *promote wellness and support chronic disease prevention;*
- ▶ *promote physical activity in schools and communities;*
- ▶ *promote wellness and healthy lifestyles in British Columbia; and*
- ▶ *increase the capacity of the aboriginal communities to create and sustain health promoting policies, environments, programs and services.*<sup>9</sup>

<sup>8</sup> Ministry of Health, Province of British Columbia, About ActNow Backgrounder (2006health0017-000253) March 23, 2006

<sup>9</sup> From the Ministry of Health and National Collaborating Centre for Aboriginal Health's transfer agreement for ActNow.

To retain focus, the key activity for ActNow *pilot*<sup>10</sup> is culturally appropriate innovations in a variety of Aboriginal community settings. In other words, **all** action taken under the ActNow 'umbrellas' is to discover programs, services, approaches and materials that work better and feel right. The main activities for ActNow are:

**Knowledge development:** including environmental scans, systematic reviews, and exercises to identify gaps and explore innovation;

**Synthesis:** profiling promising practices, determining risk and risk mitigation strategies, and ultimately generating evidenced based policy recommendations;

**Translation:** supporting communities, developing educational and promotional materials; and

**Exchange:** building on existing processes and infrastructure, reciprocally strengthening capacity by offering information sessions, conferences, workshops and consensus building gatherings, as well as establishing supportive partnerships.

The underlying assumptions are that these activities will lead to the following short-term outcomes:

- ▶ Increased stakeholder (e.g., partners and Aboriginal community) receptivity and engagement;
- ▶ greater availability of Aboriginal specific health promotion materials and programs; and
- ▶ greater community skill in delivering health programs.

The underlying theory is that these short-term outcomes will lead to the longer-term goals of:

- ▶ greater sustainability of Aboriginal health promotion programs and services;
- ▶ increased use of Aboriginal health promotion programming;
- ▶ enhanced Aboriginal community independence in health programming; and
- ▶ greater sensitivity to Aboriginal cultures in provincial health promotion policy.

In turn, these will lead to the ultimate vision of:

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<sup>10</sup> A pilot program is a preliminary trial with a variety of intricate 'unknowns' that allows for learning and refinement before full-scale use or distribution. It is an effort to 'work out the bugs' before more substantial investment is made.

- ▶ increased life expectancy;
- ▶ improved quality of life;
- ▶ improvements in infant health and longevity; and
- ▶ increased Aboriginal control over health.

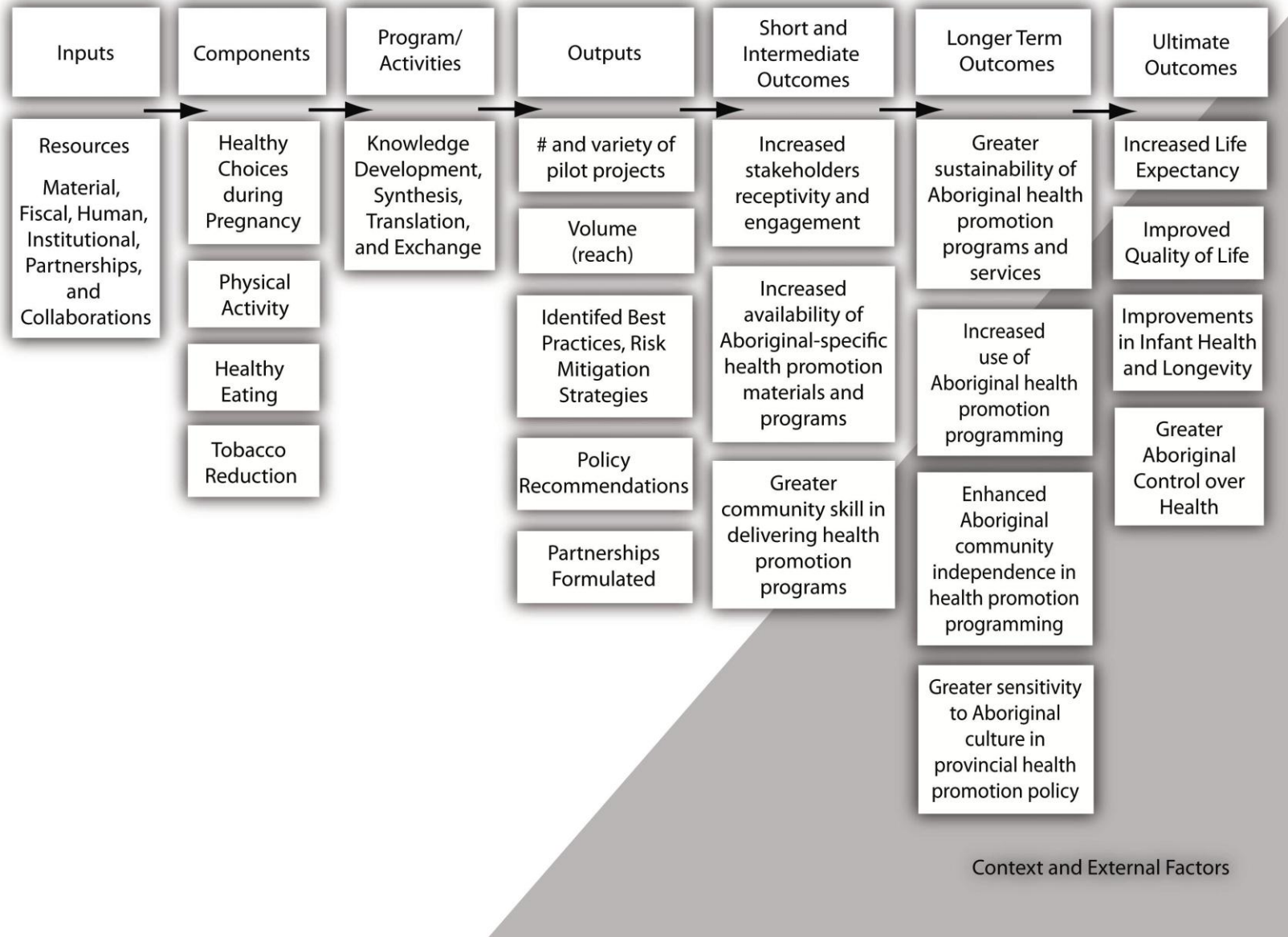
Before an illustration of the program's logic, we need to understand our goals. In an effort to bring some degree of specificity to BC Initiative efforts, Table 1 highlights questions that must be answered to ensure clear goals.

**Table 1) Ensuring Clear Goals for ActNow<sup>11</sup>**

<b>Source of Change?</b>	Knowledge Development, Synthesis, Translation and Exchange
<b>Who will change?</b>	Aboriginal communities participating in pilot programs or being supported by ActNow resources  Human service agencies (Aboriginal and non-Aboriginal) and policy makers
<b>What will change?</b>	Stakeholder receptivity and engagement in Aboriginal health promotion  Access to Aboriginal specific health promotion programs and materials  Skills to deliver health promotion programs
<b>When will it change?</b>	By 2010
<b>How will it change?</b>	There will be more receptivity and engagement of key stakeholders, greater availability of culturally appropriate health promotion resources and improved capacity to deliver health programs at the community level.
<b>How much will it change?</b>	Not specified at this time due to the exploratory nature of the endeavour.
<b>How long will the change last?</b>	The change will last for an indeterminate period of time.

<sup>11</sup> Adapted from Gremboski, D (2001) The Practice of Health Program Evaluation, Sage Publications.

**Figure 3) Thinking Logically about ActNow**



There are some very basic questions that need to be answered that can help illustrate how program efforts will lead to desired results, as well as help to figure out if program efforts are working. Once the following questions have been answered, the team can develop its own picture of the relationship between activities, short-term benefits and long-term goals.

T ∈ ***Why are we doing this?***

(What are the long-term outcomes that we hope for?)

T ∉ ***What do we want?***

(What do we hope will happen in next 6 months to a year?)

T ∠ ***Who do we expect to influence?***

(Who is most likely to benefit from this activity?)

T ∇ ***How are we going to do it?***

(What activities, services, and products do we believe will help us get what we want?)

T ® ***How will we know that things have changed?***

(What things will indicate to us that change is happening? What “thermometers” or indicators of change will we use?)

T © ***What will we see, hear and feel?***

(How will we measure that change?)

T ™ ***How much have things changed?***

(Is there a clear difference from before we started ACT NOW activity? What “thermometers” tell us that?)

T [] ***Who else sees the change?***

(What is the opinion of key community members? [e.g. teachers, parents, nurses, leaders, etc.]

Again, to help you organize the evaluation tasks, a “to do” list has been prepared.

### **“To Do” List**

#### **What do we believe?**

- ▶ Is it clear how the program will get from activities right now to desired changes in the short term (let’s say in the next 6 to 12 months) and then ultimately to the long term goals that the program hopes to achieve?
- ▶ Is the relationship between cause and effect clear too? In other words, what is the underlying theory about how health behaviours will change?
- ▶ Is the link between program activities clearly illustrated in a “picture” or model?
- ▶ Has a logical “picture” or model for each program component or activity (e.g., quitting smoking, healthy eating) been prepared?

## **4) What’s the Question?**

Once our beliefs about change are clear, the team must consider what they want to learn when doing their evaluation. The questions will then drive the evaluation and form the foundation for all other evaluation plans. If there is more than one program activity (e.g. nutrition workshops and smoking cessation clinics), then these questions should be answered separately for each program or program type. The following questions highlighted in Table 2 below are drawn from the overall evaluation of BC Initiatives and its involvement with ActNow.

**Table 2) BC Initiatives Evaluation Questions**

Question	Sub Questions
<b>What have we learned about how <i>individuals</i> catalyze community transformation?</b>	What is unique about personal leadership in health promoting role?
	What creative efforts most effectively ‘enabled’ communities to improve their health?
<b>What have we learned about how <i>communities</i> catalyze individual transformation?</b>	What creative efforts most effectively ‘enabled’ individuals to improve their health?
	What is useful in an urban context?
	How is service best provided and sustained in historically under-serviced communities?
	What are the most promising practices with respect to building capacity and sharing information?
	What facilitates community application of knowledge?
<b>What culturally appropriate methods were applied to the inquiry?</b>	Where is it clear that a decidedly Indigenous approach was used to gather information?
<b>What implications does this have for funding policy?</b>	What breakthroughs or paradigm shifts supporting an Indigenous public health approach or model have emerged?
<b>To what degree have these interventions influenced systems that have been generated by the cultural and historical context?</b>	Have either ActNow or PVSII programs functioned to ‘decolonize’ health care and maintenance in the community?

## 5) Answering the Question

When collecting data for your evaluation of ActNow programs, it is important to obtain **informed consent** from the people (e.g., participants, staff members, parents,

nurses) you plan to interview, survey, or observe. An informed consent form will contain the following information<sup>12</sup>:

- ▶ the purpose of the evaluation
- ▶ that their participation is voluntary
- ▶ what information will be requested
- ▶ whether providing such information poses any risks to them
- ▶ how information will be gathered (e.g., interviews, questionnaires, observation)
- ▶ who will have access to information they provide
- ▶ how confidentiality will be assured
- ▶ how evaluation information will be used
- ▶ with whom to speak about any concerns

A sample of informed consent is provided in Appendix B. It is also very critical that you observe and follow all ethical guidelines for research with Indigenous communities established by the Canadian Institutes for Health Research handed out during our training session. For your convenience, they have been added to Appendix C.

### **5.1) Ways to Answer the Question**

The greatest opportunity for a run in baseball is when the bases are covered. The greatest opportunity for good judgment in evaluation also comes from “covering all the bases”. In other words, get different kinds of information (e.g. numbers and stories) from the greatest variety of sources (e.g. program documents, program teams, other professionals in the community, leadership, participants, etc) through many different ways (e.g. face to face interviews, observation, checking thermometers or indicators, questionnaires, surveys and other measurement tools). Below is a table that outlines different ways to gather information<sup>13</sup>.

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<sup>12</sup> Adapted from Horne, T. (1995). Making a difference: Program evaluation for health promotion. Edmonton, AB: WellQuest Consulting Ltd.

<sup>13</sup> Ibid.

**Table 3) Summary of Data Gathering Methods**

<b>Method</b>	<b>Strengths</b>	<b>Limitations</b>
Questionnaires or Structured Interviews	<ul style="list-style-type: none"> <li>- consistent</li> <li>- easy to code</li> <li>- good when you need data for large numbers of people</li> <li>- provides information on “scope” (how many people are affected)</li> </ul>	<ul style="list-style-type: none"> <li>- little flexibility in opinion</li> <li>- little opportunity for depth</li> <li>- usually limited to quantitative data</li> </ul>
Unstructured or Semi-Structured Interviews	<ul style="list-style-type: none"> <li>- people can raise issues important to them in their own words</li> <li>- encourages sharing</li> <li>- provides “depth” (why people feel or act as they do)</li> <li>- open-ended responses can be analyzed qualitatively or quantitatively</li> </ul>	<ul style="list-style-type: none"> <li>- time-consuming</li> <li>- fewer people can be interviewed than surveyed</li> <li>- more difficult to code</li> <li>- interviewers need in-depth training to interview well</li> </ul>
Focus Groups	<ul style="list-style-type: none"> <li>- interaction encourages people to elaborate</li> <li>- ideas can be shared</li> <li>- groups of people can be interviewed at one time</li> <li>- can receive many good suggestions in a short time</li> </ul>	<ul style="list-style-type: none"> <li>- time-consuming</li> <li>- fewer people can be interviewed than surveyed</li> <li>- more difficult to code</li> <li>- facilitators need in-depth training to do focus groups well</li> </ul>
Journals	<ul style="list-style-type: none"> <li>- provide an ongoing record of people’s felt experiences</li> <li>- focus participants and others on their experiences as they happen</li> <li>- can provide extensive detailed data and ideas for interviews or focus groups</li> </ul>	<ul style="list-style-type: none"> <li>- time-consuming to keep</li> <li>- some people do not communicate well in written English</li> <li>- some people may feel uncomfortable</li> </ul>
Observation	<ul style="list-style-type: none"> <li>- provides data other than self-reporting</li> <li>- in-depth study of behaviour, nonverbal communication and the context</li> </ul>	<ul style="list-style-type: none"> <li>- time-consuming, expensive</li> <li>- may seem intrusive</li> <li>- need extensive training</li> <li>- role conflict may arise (e.g., to what extent can observer be participant)</li> </ul>
Population Statistics	<ul style="list-style-type: none"> <li>- information about change on a broad scale</li> <li>- useful if program is geared to a large population</li> <li>- easily available and regularly collected</li> </ul>	<ul style="list-style-type: none"> <li>- limited to quantitative data</li> <li>- influenced by many factors</li> <li>- short-term changes may be chance fluctuations rather than trends</li> </ul> <p>only useful if large samples</p>

Basic sources of information that you need include: information on selected indicators of change for the program, the opinions of key community informants including those directly involved in the program and those who are not directly involved. In addition, it is ideal if a combination of “hard” (numbers) and “soft” (stories) information is gathered. Before collecting any information, review the answers to the following questions:

**What is the source of change?**

**Who will change?**

**What will change?**

**When will it change?**

**How will it change?**

**How much will it change?**

**How long will the change last?**

When you start checking your “thermometers” or measuring change in an organized way, be sure that your methods are **valid** (are you **really** measuring what you want to measure?) and **reliable** (will your methods perform consistently for you over time?). You may have already thought about this and decided to use a method or tool that has been tested for reliability and validity. This is a powerful tool; use it with confidence! What kinds of things are reliable and valid? Well, let’s take a look at the example of alcohol and drug treatment centres. Some treatment centres use a substance use survey or tool to measure if treatment has made a difference in substance use over time. *Such a measurement tool may have widespread approval in the field of addiction and have been tested and designed to be culturally appropriate: the results from its use would be very valuable to an evaluation of the treatment program.* When a standard, valid, reliable and culturally appropriate measurement tool or method is used, it is usually used at two points in time: before the program and after the program. This is a popular way to measure program performance in evaluation and is known as a “within groups repeated measures” design or the “before and after” design. We can also limit our use of numbers to show simple trends in the form of a graph.

Communities might decide to prepare their own surveys. We know that a good survey not only asks questions clearly but gets useful responses, so when you draft a

survey, you may want to keep some rules in mind (see Appendix D).<sup>14</sup> People's opinions about any differences they may have noticed in participants or the community and how they feel about the program overall are important. Try not to limit yourself to just the opinions of people *directly* involved in delivering or participating in the program *but also those who have a more distant but informed perspective* (e.g. community based professionals, leaders, and general community members). Still, the perspective of participants and their families is very important too. To help measure their satisfaction, a sample survey <sup>15</sup> has been included for your use in Appendix E.

## 5.2) Performance Indicators

Indicators or “thermometers” are normally described by a number like an average or a ratio (i.e. percentage) or a rate (i.e. 16/100,000); however, the usefulness of raw numbers would be much better if a percentage or ratio can then be used (e.g., the percentage of the community's children who are overweight) so that we can make comparisons with other information (e.g., national trends). For example, the percentage of children who are overweight or obese is an index or an indicator that can be compared to national statistics. When an index has comparability, it has more “power” to influence funding decision makers.

You may have difficulty finding information that specifically describes First Nations, Inuit or Métis communities, especially in urban centres. It will help if there are any Aboriginal agencies and institutions that you could ask for help. This should be less of a problem in programs confined to reserves, remote and isolated communities. However, greater care needs to be taken to guard confidentiality, especially when age and gender of individuals is shared with your evaluation team. Now let's look at the kind of “thermometers” of change that the ActNow is keenly interested to explore. British Columbia has identified very specific, measurable and timed goals for ActNow that are highlighted in Appendix F.<sup>16</sup>

Select what indicators are meaningful and useful. Define the indicators and describe their limitations and how they will be interpreted. Identify all the possible ‘landmines’ associated with the index. For example, it is important not to confuse *reported* rates with *actual* rates. *Reported* rates are usually just a small amount of *actual* rates because *actual* rates include *reported and unreported* cases. Recognize that reductions or increases in reported rates can mean a variety of things. To illustrate, more **reported** cases of diabetes may be a good or a bad sign depending upon the extent of screening previously available to the community. Increases in the **reported** rates of

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<sup>14</sup>Narins, P. (1995). Write more effective survey questions, Keywords: Tips and News for Statistical Software Users. SPSS, No. 57, pages 6-16.

<sup>15</sup>Larsen, Attkisson, Hargreaves & Nguyen: Evaluation and Program Planning, Vol2, 1979 as presented by Favaro, P: Consumer Satisfaction Evaluation at Conference 97: Evaluation in Partnership, Canadian Evaluation Society, Ottawa, Ontario, May 1997.

<sup>16</sup> British Columbia. (2006). Measuring Our Success: Baseline Document, ActNow BC pages 42-44.

diabetes may reflect *increased service access* as well as *increased willingness to get tested*. Therefore, **reported** rates must be interpreted *very carefully* because much depends upon *why* the reports have increased.

To get the information you need, you may have to contact public health nurses or health centres, and possibly teachers or parents. In addition, previously conducted needs assessments may offer information about what conditions were like before the Act Now program began.

**Table 4) What Information Do I Need and Where Can I Get It?**

What Information do I Need?	How and Where can I get it?
<p>You will need information on the kind of <b>SHORT TERM</b> changes you expect.</p> <p>You will also need information on <b>LONG TERM</b> changes that you expect. Namely, information about the sustainability of Aboriginal health promotion programs and services and any information showing an increased use of health promotion planning.</p>	<p><b>Just Ask</b> either through surveys, in-depth interviews or group discussions what are the opinions of program participants, staff members, community members, Elders, youth, leaders, program teams, sponsors, advisory committees, teachers, hospital staff, provincial and territorial governments.</p> <p><b>Check all the documents</b> such as needs assessments; records; proposals; submissions; progress, activity and financial reports; eligibility criteria and guidelines; agreements, financial statements; newsletters; minutes, proceedings, studies and annual reports.</p> <p><b>Get the statistics</b> from local health clinics, hospital staff, doctors, teachers or even provincial and territorial governments and coroner’s offices.</p> <p><b>Look at other research</b> that might have been done by Statistics Canada, regional Aboriginal organizations and educational institutes and government departments.</p>

## **“To Do” List**

### **Answering the Question**

- ▶ Have all goals been stated clearly and in a way that makes them “measurable”? What “thermometers” of change will be used?
- ▶ Has data been collected from **a variety of sources**, including those delivering the program as well as those NOT delivering the program (e.g. social workers, teachers and nurses) or any others that would be in the best position to comment on changes (both good and bad)?
- ▶ Is there a complete list of whose opinion was important and why?
- ▶ Have all definitions, limitations and possible interpretations of selected indicators or “thermometers” been identified?
- ▶ Have all measurement methods been described in detail?
- ▶ Do you have “hard” (i.e. numbers) and “soft” (i.e. stories) information?
- ▶ Have you been clear about how “success” was defined?
- ▶ Are there differences in opinion about whether or not the program was successful?

### **5.3) Making Sense of the Information**

Community profiles will be very valuable to use when we begin to make sense of our information. **In other words, what else could explain the results we have achieved?** It will help if you know how your progress compares with other Act Now programs or even other similar programs in the community. Do the different types of information that you have collected (hard and soft) say the same thing or something different? What could explain such differences?

Hard and soft data (i.e., quantitative and qualitative data) often complement one another when trying to explain the results of an evaluation program, but to reach such explanations you need to know how to interpret your soft data, as it does not provide you with clear trends the way numbers do. When making sense of your soft data, it may be

helpful to create a table<sup>17</sup> that compares the opinions of different groups involved with ActNow:

Stakeholder Group	Opinions Related to Successful Process	Opinions Related to Improving Process	Opinions Related to Successful Results	Opinions Related to Improving Results
Participants				
Team Members				
Funders				

If you collected stories and opinions both before and after ActNow program activities, it will be clear if people’s ideas have changed. The table below compares changes in people’s beliefs, levels of confidence, and perceived stress for before and after ActNow activities.

Impact Objective	Themes Before Program	Themes After Program
Beliefs about Consequences of Behaviour		
Confidence		
Perceived Stress		

<sup>17</sup> Adapted from Horne, T. (1995). Making a difference: Program evaluation for health promotion. Edmonton, AB: WellQuest Consulting Ltd.

Sometimes, there is also a need to make sense of the information while taking cost into consideration.<sup>18</sup> When doing **cost-benefit analysis**, both the cost and benefits (i.e., resources and outcomes) of a program are given a dollar value. For example, the costs of a healthy eating program would need to include the estimated dollar value of all resources put into the program (e.g., salaries, price of promotional materials, cost of maintaining online resources, cost of creating and maintaining dietary hotline, etc.), as well as the costs associated with the outcomes or benefits (e.g., estimated reduction in cost of caring for people with illnesses such as diabetes, estimated reductions in potential lost earnings due to premature death from heart disease, etc.). Assigning dollar values to the benefits of a program can be difficult and controversial, which may make a **cost-effectiveness analysis** more appealing. In this analysis, only the costs of a program are given a dollar value. The benefits of the program are stated in terms of their results or successes, and it is up to program funders and stakeholders to decide if the financial investment of the program is worth its outcome. That is to say, this analysis will not tell you if your program has been profitable in the same way that a cost-benefit analysis would. Therefore, a cost-effectiveness analysis is particularly useful when comparing two programs that have the same intended outcomes or benefits. For example, the benefits of a sports program that relies on building an arena could be compared to a program that gathers people in a cycling club. If the benefits of an arena showed a 30% increase in physical activity in the community compared to a 20% increase resulting from a cycling club, and the cost of the arena was 100 times the cost of establishing a cycling club, the cycling club is still clearly more effective.

## 5.4) Thinking Holistically

The community environment is **very important**. Extreme poverty, isolation, poor housing, and air and water quality all have an impact upon any changes we may be hoping for and should not be ignored. To build a story about the community, we need answers to who, what, how, when and where questions.

### Who

First of all, there are a couple of *WHO*'s we need to know about. They include the staff of the health promotion program, participants, their families, and the community. Some of the things we **might** like to know are:

- a) Has the staff worked with health promotion programming before? For how long? Doing what?
  
- b) Does the health promotion staff feel the training they received was adequate and appropriate to prepare them for the task?

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<sup>18</sup> Adapted from Horne, T. (1995). Making a difference: Program evaluation for health promotion. Edmonton, AB: WellQuest Consulting Ltd.

- c) What does the staff like most about the program?
- d) Does the health promotion staff have any opportunity to have questions answered by a professional support network or other people involved in delivering or evaluating a health promotion program?
- e) How did staff members get chosen to administer, run, deliver the Act Now funded program?
- f) What other information about the health promotion programming is important to the community that you think should be included here?

The next group of *WHO*'s that we will need to know about will be participants.

- a) How were participants selected? Recruited?
- b) How many are there in total?
- c) What are their ages, sexes?
- d) Are there some who may need extra help? How have they been accommodated?
- e) What other information about the participants is most important to the community that you think should be included here?

## **When**

Important community and life events will have an impact on ActNow funded activity and these should be recorded too. For example, if there is a suicide in the community or the building where the ActNow activity is to take place is under renovations, these will all affect how the participants engage in the program. Also, if participants are involved in **other** community programs (e.g., substance abuse treatment, family counselling, parenting skills), it will be important to say so because their involvement in other programs will certainly influence your results. A record of when the ActNow activity is implemented should include exactly when the program was delivered and for how long (e.g., from 9.a.m. to 12 p.m. every weekday for six months). In addition, ActNow pilot programs *will benefit* from an environment where a variety of Aboriginal public health endeavors are underway.<sup>19</sup>

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<sup>19</sup> Including the development of the BC Initiatives with such activities as: establishing infrastructure, the growth of BCI through hiring and contracting, interim advisory committee, preparing an environmental scan to guide BCI, and articulating communication and evaluation strategies. BCI is also keen to build relationships with and between Aboriginal communities as well as between Aboriginal communities and existing Canadian health research and delivery systems. To maximize BCI's influence, it also expects to

## Where

We will need to know where the program was delivered (e.g. school gymnasium, community hall, bush camp, through home visits) because different places will encourage different feelings. Once we know where the program has been delivered (let's assume it is the local school), we might want to know how committed the school is to Act Now funded activity. If finding space on a weekly basis is complicated, not guaranteed, or tends to be a low priority, this will have an impact on the program. We will also want to know what kind of relationship the school has with the greater community. Are they linked with other health programs such as the Canadian Prenatal Nutrition Program or local fitness classes? Describe the community "feeling" about the place where Act Now funded activity lives.

## What and How

Perhaps one of the most time consuming tasks will be recording what was done during the program as well as how it was done. It will be important to clearly identify what goals the community wants to focus upon, as well as the activities undertaken to achieve those goals. Much of this information can be easily drawn from your program proposals and agreements. All that needs to be done is to prepare a brief summary of this information and then check to see if it still accurately describes what happened or is happening. Have any changes been made to your plans as a result of what you have learned? Specifically what changes were made and why?

- a) What activities took place? Were program participants involved in decision making? Who else participated? Observed?
- b) Where and when were sessions held?
- c) Were participants enthusiastic? Bored? Un-motivated? Distracted?
- d) What cultural and community information is important here?
- e) What suggestions do you have for changing the approach?
- f) What do program participants or their families think will improve the program?
- g) How have plans or activities changed over time? Why have they changed?
- g) What challenges did you face? How were they overcome?

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engage in collaborative efforts with other key stakeholders in public health. And last, the BCI expects to facilitate the translation of research into action by sharing knowledge in ways that increase understanding and ease its application in programs, policy and practice.

To help you gather your thoughts about what you need to do to make sure that your evaluation shows that you have been thinking holistically, a “to do” list has been prepared for you on the following page.

## **“To Do” List**

### **Making Sense of the Information**

- ▶ How did you make sense of the stories and the numbers that you kept track of and what you found?
- ▶ Have all possible explanations for the results been considered?
- ▶ Did different sources or kinds of information say the same thing or different things?
- ▶ Was there any agreement or disagreement about how the information should be interpreted between community members?

### **Thinking Holistically**

- ▶ Has the community environment (e.g. geographic location, level of isolation, poverty, unemployment, the extent of other health promotion initiatives and programs, etc.) and participant characteristics (total number, age, sex, special needs, etc.) been described in detail?
- ▶ Have all program activities and goals been described clearly? Have any changes to your original plan (i.e. the one submitted in your proposal) been recorded together with the reason for change?

## **6) Reporting Results**

Once you have all the needed information and you have made sense of your results in partnership with your evaluation committee (if you have one or others involved in helping with the evaluation), you will need to carefully report your findings. When results are reported, keep these things in mind:<sup>20</sup>

- a) describe how community program goals were decided;
- b) who information was collected from and why their opinion was important ;
- c) share how you collected information and why you did it that way;

<sup>20</sup>Adapted from Horne, T. (1995). Making a Difference: Program Evaluation for Health Promotion, WellQuest Consulting Ltd.

- d) highlight what information you felt was important and why;
- e) be clear about who helped with the evaluation and why;
- f) identify what limitations you had with the time and money that was available for the evaluation;
- g) show where program goals were clear and measurable, where your program was successful in meeting its goals, and describe how “success” was defined by the community and what differences in opinion there were about whether or not the program was successful;
- h) illustrate how you made sense of your stories (i.e. qualitative information) and the numbers you kept track of (i.e. quantitative information) and what you found;
- i) discuss whether different sources and kinds of information said the same thing or different things;
- j) describe any agreement or disagreement about how the information should be interpreted between different people at the community level;
- l) prepare a summary of what seems to be working (i.e. best practices) and where improvements have been made (lessons learned);
- m) offer recommendations on how your results should be used (is there any agreement or disagreement about how these should be used?)

## **“To Do” List**

### **Reporting Results**

- ▶ Have you shared all of the programs challenges and successes?
- ▶ Has the way you did your evaluation been described in detail (i.e. all “thermometers” or measurement methods, information sources and their limitations been described)?
- ▶ Is there a summary of best practices and lessons learned?
- ▶ Have any agreements or disagreements been noted?
- ▶ Offer recommendations regarding how the evaluation findings should be used (is there any agreement or disagreement about how these should be used?)

In the end, all your effort should be toward answering the most important questions: **What changed if anything? Why or why not? How do we know?** The answers to these questions are the end result of your evaluation effort.

## 7) My “To Do” List

As an easy way to have all the tasks grouped together, a complete “to do” list, which combines every section of the evaluation guide has been provided.

### Getting Started

- ▶ Do you have a team or committee to help you that includes program participants, youth, Elders, program leaders, sponsors and any other people you feel are important?
- ▶ Has the team determined if the program can be evaluated?

### What do we believe?

- ▶ Has the team answered these questions together for each program activity or component?

T ***Why are we doing this?***

(What are the long-term goals that the community hopes for? Have the long-term goals been clearly stated in **measurable** terms? Is there a description of how community program goals were decided?)

T ***What do we want?***

(What are the short-term benefits that the community hopes for in the next 12 months to a year? Are the short-term benefits clearly stated in measurable terms?)

T ***Who do we expect to influence?***

(Who is the target group? Who will benefit the most - children? youth? elders? families?)

T ***How are we going to do it?***

(What activities and outputs does the community believe will help them get what they want?)

T ***How will we know that things have changed?***

(What indicators have been selected to gather information about change? What information was really important and why?)

T ***What will we see, hear and feel?***

(What methods of measurement have been selected [e.g., observation, interviews, surveys]? and why?)

T ***How much have things changed?***

(What do the numbers say?)

T ***Who else sees the change?***

(What is the opinion of key community members? [e.g., doctors, social workers, nurses, leaders, etc.]. Why was their opinion important to us?)

- ▶ Is it clear how the program will get from activities right now to desired changes in the short term (let's say in the next 6 to 12 months), and then ultimately to the long term goals that the program hopes to achieve?
- ▶ Is the relationship between cause and effect clear too? In other words, what is the underlying theory about how health behaviours will change?
- ▶ Is the link between program activities clearly illustrated in a "picture" or model?
- ▶ Has a logical "picture" or model for **each** program component or activity (e.g. physical activity and healthy eating) been prepared?

## **What's the Question?**

- ▶ Have questions been generated that are of interest to the evaluation committee?
- ▶ Is there agreement about what questions the evaluation will answer?

## **Answering the Question**

- ▶ Have all goals been stated clearly and in a way that makes them "measurable"? What "thermometers" of change or indicators will be used?
- ▶ Is the information readily available or does it need to be gathered?
- ▶ Has data been collected from **a variety of sources**, including those delivering the program as well as those NOT delivering the program (e.g. social workers, parents, teachers and nurses) or any others that would be in the best position to comment on changes (both good and bad)?
- ▶ Is there a complete list of whose opinion was important and why?
- ▶ Have all definitions, limitations and possible interpretations of selected indicators or "thermometers" been identified?
- ▶ Have all measurement methods been described in detail?
- ▶ Do you have "hard" (i.e. numbers) and "soft" (i.e. stories) information?
- ▶ Was the program successful in meeting targeted goals?

- ▶ Have you been clear about how “success” was defined?
- ▶ Are there differences in opinion about whether or not the program was successful?

## **Making Sense of the Information**

- ▶ How did you make sense of the stories and the numbers that you kept track of and what you found?
- ▶ Have all possible explanations for the results been considered?
- ▶ Did different sources or kinds of information say the same thing or different things?
- ▶ Was there any agreement or disagreement about how the information should be interpreted between community members?

## **Thinking Holistically**

- ▶ Has the community environment (e.g. geographic location, level of isolation, poverty, unemployment, etc.) and participant characteristics (total number, age, sex, special needs, etc.) been described in detail?
- ▶ Have all program activities and goals been described clearly? Have any changes to your original plan (i.e. the one submitted in your proposal to Act Now) been recorded together with the reason for change?

## **Reporting Results**

- ▶ Have you shared all of the programs challenges and successes?
- ▶ Has the way you did your evaluation been described in detail (i.e. all “thermometers” or measurement methods, information sources and their limitations been described)?
- ▶ Is there a summary of best practices and lessons learned?
- ▶ Have any agreements or disagreements been noted?
- ▶ Offer recommendations regarding how the evaluation findings should be used (is there any agreement or disagreement about how these should be used?)
- ▶ Has all your effort been made to ensure that you have solid answers to the following questions:

**What changed if anything? Why or why not? How do we know?**

## Appendix A Blank Logic Model

Our Activities					
How we did it					
What we did					
What we want in the short-term					
How we will know that things have changed in the short term					
Why we are doing this in the first place					
How we know things have changed (stories and numbers)					

## Appendix B Informed Consent

The purpose of an informed consent is to ensure that you (or your child) understand the purpose of our evaluation and the nature of your involvement. The informed consent must provide enough information such that you have the opportunity to determine whether you wish to participate in the evaluation of the Act Now program activity.

**Purpose and requirements:** The aim of the present evaluation is to gather information about your experience with the Act Now program. We will be asking you to complete two short questionnaires and an interview (or substitute the strategies that you will use here) in order to understand current Act Now programs and to plan for future activities. Interviews will be recorded to provide us with a complete record of information that will be useful for improving upcoming initiatives. If you would like more information about this evaluation, please contact (name and phone number of program coordinator).

**Potential risk/discomfort.** The interview we will conduct should not arouse any discomfort or pose any risks to you or your child. However, you can decide whether or not you wish to answer a particular question.

**Right to withdraw and confidentiality.** Your participation in this evaluation is entirely voluntary. At any point during the evaluation you have the right to not complete certain questions or to withdraw completely. The data collected in this experiment are confidential. All data are coded such that your name is not associated with the data. The coded data are made available only to the researchers associated with this program.

I have read the above description of the evaluation for Act Now. The data collected will be used to evaluate the current program and plan for future initiatives and funding opportunities. My signature indicates that I agree to participate in the study, and this in no way constitutes a waiver of my rights.

Full Name (please print): \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix C

# CIHR Guidelines for Health Research Involving Aboriginal People

The following is a summary of ethical guidelines from the *CIHR Guidelines for Health Research Involving Aboriginal People* (Her Majesty the Queen in Right of Canada, 2007). A complete version can be found on the Canadian Institutes of Health Research – Institute of Aboriginal Peoples Health website [<http://www.cihr-irsc.gc.ca>]

**Article 1** A researcher should understand and respect Aboriginal world views, including responsibilities to the people and culture that flow from being granted access to traditional or sacred knowledge.

**Article 2** A community's jurisdiction over the conduct of research should be understood and respected. Some Aboriginal communities manage and control matters dealing with health. A researcher should comply with any by-laws, policies, rules or procedures adopted by the community.

**Article 3** Communities should be given the option of a participatory-research approach. Participatory research enables a range of levels and types of community participation while ensuring shared power and decision-making. Such partnerships will help to ensure that research proceeds in a manner that is culturally sensitive, relevant, respectful, responsive, equitable and reciprocal.

**Article 4** A researcher who proposes to carry out research that touches on traditional or sacred knowledge of an Aboriginal community, or on community members as Aboriginal people, should consult the community leaders to obtain their consent before approaching community members individually. Once community consent has been obtained, the researcher will still need the free, prior and informed consent of the individual participants.

**Article 5** Concerns of individual participants and their community regarding anonymity, privacy and confidentiality should be respected, and should be addressed in a research agreement.

**Article 6** The research agreement should, with the guidance of community knowledge holders, address the use of the community's cultural knowledge and sacred knowledge.

**Article 7** Aboriginal people and their communities retain their inherent rights to any cultural knowledge, sacred knowledge, and cultural practices and traditions, which are shared with the researcher. The researcher should support mechanisms for the protection of such knowledge, practices and traditions. This type of research should only be done with explicit permission and under mutually-agreed terms that are set out in advance of the research with the guidance of appropriate Elders and knowledge holders.

**Article 8** Community and individual concerns over, and claims to, intellectual property should be explicitly acknowledged and addressed in the negotiation with the community prior to starting the research project.

**Article 9** Research should lead to outcomes that are beneficial to the participating Aboriginal community and/or individual community members as well as the researcher. Benefit sharing vis-à-vis a community should be interpreted from the community's perspective.

**Article 10** A researcher should support education and training of Aboriginal people in the community, including training in research methods and ethics.

**Article 11.1** A researcher has an obligation to learn about, and apply, Aboriginal cultural protocols relevant to the Aboriginal community involved in the research.

**Article 11.2** A researcher should, to the extent reasonably possible, translate all publications, reports and other relevant documents into the language of the community.

**Article 11.3** A researcher should ensure that there is ongoing, accessible and understandable communication with the community. Aboriginal communities often have cultural protocols involving interactions within the community. It is important that researchers learn about these and respect them.

**Article 12.1** A researcher should recognize and respect the rights and proprietary interests of individuals and the community in data and biological samples generated or taken in the course of the research.

**Article 12.2** Transfer of data and biological samples from one of the original parties to a research agreement, to a third party, requires consent of the other original party(ies).

**Article 12.3** Secondary use of data or biological samples requires specific consent from the individual donor and, where appropriate, the community. However, if the research data or biological samples cannot be traced back to the individual donor, then consent for secondary use need not be obtained from the individual.

**Article 12.4** Where the data or biological samples are known to have originated with Aboriginal people, the researcher should consult with the appropriate Aboriginal organizations before initiating secondary use.

**Article 12.5** Secondary use requires REB review. These guidelines set out basic principles for the collection, disclosure, use and transfer of data and biological samples. The details of safeguards protecting the privacy and confidentiality of data and biological samples should be negotiated as part of the research process and specified in a research agreement. Subject to the community's views on traditional or sacred knowledge, co-ownership of data between researchers and communities is recommended because the Aboriginal community and the researcher are both integral to the production of data.

**Article 13** Biological samples should be considered "on loan" to the researcher unless otherwise specified in the research agreement.

**Article 14** An Aboriginal community should have an opportunity to participate in the interpretation of data and the review of conclusions drawn from the research to ensure accuracy and cultural sensitivity of interpretation.

**Article 15** An Aboriginal community should, at its discretion, be able to decide how its contributions to the research project should be acknowledged. Community members are entitled to due credit and to participate in the dissemination of results. Publications should recognize the contribution of the community and its members as appropriate, and in conformity with confidentiality agreements.

## Appendix D

# Survey Development Guidelines

When drafting your surveys always keep these things in mind:

***Y€ Remember the survey's purpose***

All other rules are based on this one. This is why you decided to spend your time gathering information in the first place.

***Y∄ If in doubt, throw it out.***

This is another way of saying the first rule. Never include a question because you can't think of a good reason to throw it away.

***Y∠ Keep your questions simple***

***Y∇ Stay focused - avoid confusing questions***

If you ask "When did you last see a movie?" You might get answers that refer to the last time your respondent rented a video when you are really interested in the last time they went to a theater.

***Y@ If a question can be misunderstood, it will be***

"What time do you normally eat dinner?" means different things to different people. For some, dinner is a midday meal and for others it is the evening meal. Be clear, to the point and always ask for someone else's opinion about the question you have prepared. If you ask, people will tell you if they misunderstand the question.

***Y© Ask only one thing at a time***

How would you respond to this question? - "Please rate your satisfaction with the amount and kind of services you receive from the community government". We are asking about two things here; the amount of service and the kind of service. If you want specific recommendations, you need to ask specific questions. Ask first about the kind of service; then ask another question about the amount of services.

***Y™ Avoid leading questions***

It is easy, but wrong to write a question which suggests there is a right or wrong answer. For example, "Most people believe that Act Now (replace with your own program name) is a good program. Do you agree?" leads the respondent to say yes. We want an honest opinion.

***Y∏ Think of other ways to ask sensitive questions***

Some questions are very sensitive and we need to find ways to help people feel comfortable enough to answer honestly. For example, instead of asking "Do you drink alcohol?", it is better to ask, "How much alcohol have you consumed in the past week?"

Because the question assumes that alcohol has been consumed, it is less embarrassing to admit consumption. Or if you were asking about family poverty, you might start your question by, “There are many reasons why families are not able to provide for themselves. Sometimes the adults are ill or there is high unemployment in the region. Thinking about the past year, has your family experienced any food shortages?”

***Y✓ Make sure the respondent has enough information***

Some community members may not be aware of ACT NOW funded activities. Therefore asking them, “How effective has the ACT NOW program been in the community?” would not be as good as asking, “We recently started “Name of program here” at the health centre. Did you know this?”; followed by, “Have you seen any benefits resulting from the program’s efforts?”

Useful answers are just as important as good questions.

***Y€ Think of all possible answers (exhaustive list) and try to make sure there is only one place for the answer (mutually exclusive).***

You should make sure that response options cover every possibility. If you cannot, then offer an “other” response option where the respondent can tell you what other choice they are thinking of. Also, make sure you get the answer you want. Let’s say you ask:

Where would you like the program to be held? and offered the following responses:

- a) at the school
- b) in the daycare centre
- c) in a home
- d) close to the arena

If the school is close to the arena, then your respondent would have two possible answers when you may want only one.

***Y€ Keep open ended questions to a minimum***

Open ended means the answer is whatever the respondent wants to tell you. For example: “What did you like most about the program?” left open ended could result in a very long answer. These kinds of questions are useful, but they take a lot of time and effort on the respondent’s part.

***Y∠ People interpret things differently, especially when it comes to time***

When you use responses like “always”, “regularly”, “sometimes”, “never”, you need to be clear about what you mean to make sure all respondents understand the same thing. For example, if you ask, “Do participants regularly attend healthy cooking

classes?,” you should also say, “By regularly, I mean they attend at least 90% of the time available for participation.”

***Y∇ Always include a “don’t know” response***

It’s only fair. Let’s say you are asking a grandmother about changes in her grandchildren. She may not always know or see these changes.

***Y® Always use a meaningful scale***

For example, if you ask social workers, “Please rate your satisfaction with ACT NOW funded program,” and you use a scale that says 1 is “dissatisfied” and 5 is “very satisfied,” then choices 2, 3 and 4 should have labels that are meaningful (e.g., 2 could be “room for improvement”, 3 could be “neither satisfied nor dissatisfied” or “neutral,” and 4 could be “satisfied”).

## Appendix E

# Participant Satisfaction with ACT NOW

Please help us improve our program by answering some questions about the ACT NOW programs. We are interested in your honest opinion, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much. We really appreciate your help.

### CIRCLE YOUR ANSWER

1. How would you rate the program you participated in?

<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
Excellent	Good	Fair	Poor

2. Did you believe that they are getting what you want from the program?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has the program met your needs?

<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend or family member were in need of similar help, would you recommend the program to him or her?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the **amount** of help that you have received?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Has the program helped you deal more effectively with your health issues?

<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In a general sense, how satisfied are you with the program?

<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you use the same kind of program?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

PLEASE WRITE YOUR COMMENTS

The thing I like best about the program is: \_\_\_\_\_

If I would change one thing about the program, it would be: \_\_\_\_\_

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Adapted from: Larsen, Attkisson, Hargreaves, & Nguyen. (1979). Evaluation & Program Planning, Vol. 2.

## Appendix F

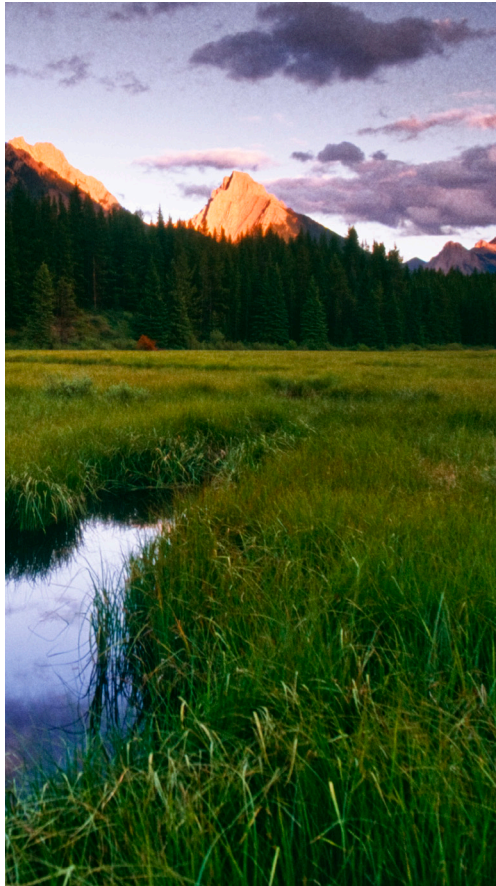
### Key Act Now BC Indicators<sup>21</sup>

Component Area	Indicators	Performance Measure
<b>Physical Activity</b> To increase by 20% the proportion of the B.C. population (aged 12+) who are physically active or moderately acting during their leisure time from the current level (2003) of 58.0% to 69.9% of the B.C. population by 2010	<ul style="list-style-type: none"> <li>% of BC population (aged 12+) who are physically active or moderately active during their leisure time</li> </ul>	CCHS – 2001 & every 2 yrs. Afterward. Detail available summer of following year.
	<ul style="list-style-type: none"> <li>% of schools registered in ASIBC (Provincially by HSDA)</li> <li>% of communities classified as Active Communities (by HSDA)</li> </ul>	Action Schools website – reports monthly (provincial and by HSDA). <ul style="list-style-type: none"> <li># of schools registered</li> <li># of workshops</li> <li># of student participants</li> </ul> BCRPA – monthly updates (provincial and by HSDA) <ul style="list-style-type: none"> <li># of committees registered</li> <li># of grants provided</li> </ul>
<b>Overweight Obesity</b> To reduce by 20% the proportion of the BC population (aged 18+) currently classified as overweight or obese from the current prevalence rate (2003) of 42.396% to 33.8% of the BC population by 2010	<ul style="list-style-type: none"> <li>% of BC population (aged 18+) who are overweight or obese</li> </ul>	CCHS 1.1, 2.1, 3.1, (optional content provincial only)
	<ul style="list-style-type: none"> <li># of clients and families receiving services at ShapeDownBC</li> </ul> Note: please refer to healthy eating and physical activity components for other indicators	PHSA to report semi-annually on # of sites and number receiving services.
<b>Healthy Eating</b> To increase by 20% the proportion of the BC population (aged 12+) who	<ul style="list-style-type: none"> <li>% of adult BC population (aged 12+) who eat 5+ servings of fruit and vegetables/day</li> </ul>	1999 BCNS, CCHS 1.1, 2.1, 3.1 (optional content provincial only)

<sup>21</sup> Reproduced from British Columbia, Measuring Our Success: Baseline Document, (2006).. Act Now BC pages 42-44.

Component Area	Indicators	Performance Measure
<p>eat the daily recommended level of fruits and vegetables from the current level (2003) of 40.1% to 48.1% of the population by 2010</p>	<ul style="list-style-type: none"> <li>• # of communities per region involved in food action networks (food security)</li> <li>• % of schools with food and nutrition policies</li> <li>• # of school fruit and vegetable snack programs</li> <li>• # of call to Dial-A-Dietician</li> </ul>	<p>PHSA – annually (May 2006) by HA</p> <ul style="list-style-type: none"> <li>• # of networks</li> <li>• # of comm. Action plans</li> <li>• # of healthy food policies (municipal and regional)</li> </ul> <p>Survey by Min of Ed. Baseline done April 2005. Done periodically (possibly annually). Goal 90% by 2009</p> <p>BC Agriculture in the Classroom. 10 pilot schools in 2005. Goal: all schools by 2010</p> <p># of calls determined semi-annually (Oct. &amp; May) by region</p>
<p><b>Tobacco</b> To reduce by 10% the proportion of the BC population (aged 15+) that use tobacco from the current prevalence rate (2003) of 16.0% to 14.4% of the BC population by 2010. (Note: these rates apply to the BC population 15 years of age and older)</p>	<ul style="list-style-type: none"> <li>• % of adult BC population (aged 12+) who use tobacco products# of participants using QuitNow services – either quit line or web program</li> <li>• # of homes that are smoke free</li> <li>• # of people aware of Tobacco Free Sports</li> <li>• # of aboriginal communities that participate in Honour Your Health initiative</li> </ul>	<p>1999 BCNS, CCHS 1.1, 2.1, 3.1, (optional content provincial only) QuitNow by Phone Clinidata - # of calls reported monthly – Provincial and HA</p> <p>Interactive Cessation Website: BC Lung Assoc. – monthly reports. Provincial, HA and HSDA levels</p> <p># of new registrants for access to website resource (personalized information)</p> <p># of ongoing members who continue to access website resources</p> <p># of communities with 100% smoke free bylaws</p> <p>#of British Columbians 15+ who are aware of BC's Tobacco Free Sports Program</p> <p># of Honour Your Health Trainers</p> <p># of Community grants</p> <p># of communities that participate</p>

<p><b>Healthy Choices During Pregnancy</b></p> <ul style="list-style-type: none"> <li>To increase by 50.0% the number of women counseled regarding alcohol use during pregnancy</li> <li>By September 2006, for each health authority to have focused strategies for FASD prevention</li> </ul>	<ul style="list-style-type: none"> <li>% of health authorities that have completed comprehensive FASD prevention plans</li> <li># of service providers (by profession) providing services to pregnant women who receive training on counseling women about alcohol use during pregnancy</li> <li>Changes in knowledge in general population and among pregnant women about alcohol use during pregnancy</li> </ul>	<p># of (1<sup>st</sup>) draft plans completed by March 2006</p> <p># of finalized plans completed by Sept. 2006</p> <p>Quarterly report (starting Fall, 2006) from PHSA on # of providers (physicians, Midwives, Public Health Nurses, POPs and Addictions Counselors) who attend educational events by type of event. Number of practice guidelines disseminated to health professionals.</p> <p>Quarterly report on BCRCP data on:</p> <ul style="list-style-type: none"> <li># of pregnant women MD's report they have counseled.</li> </ul> <p>Knowledge levels of general population (including women who are pregnant) on the health risks associated with consuming alcohol during pregnancy (BC Stats, CCHS)</p>
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## ABORIGINAL *Act Now*

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