
Evidence and Practice-based Planning Framework *with a focus on health inequities*

***Based on the New Ontario Public Health Standards and the
Population Health Assessment and Surveillance Protocol***



Region of Waterloo

PUBLIC HEALTH

Please Note:

This Evidence and Practice-based Planning Framework was originally created as an internal planning document for Region of Waterloo Public Health staff, and is supported by many other documents. In sharing this framework with staff outside of Region of Waterloo Public Health, we have done our best to make it relevant for external practitioners as well. However, as you move further into the supporting documents and hyperlinks, you will notice that some documents are mostly relevant only within the context of Region of Waterloo Public Health. When it was decided that a document had very little relevance beyond this internal context, that document was not hyperlinked for external use."

Region of Waterloo Public Health is currently piloting and evaluating this framework. We expect that a new, refined version based on our experience with over ten developmental projects will be developed in 2010.

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Evidence and Practice-based Planning Framework

What is this document?

This document proposes a model which outlines key stages in program and policy planning. Several traditional evidence-based decision making models were combined with the new proposed requirements from the Population Health Assessment and Surveillance Protocol (PHAS) of the Ontario Public Health Standards (OPHS) to outline the data and information sources and steps to use in program planning and decision-making¹.

Why are we proposing this model now?

The new Ontario Public Health Standards will require the modification, to varying degrees, of existing programs and policies and in certain cases, the development of new programs and policies. A sound decision making process, based on multiple sources of evidence and proper documentation of the process, will ensure that decisions made have a strong and documented rationale.

When would we use this model?

This proposed model for program planning is recommended for:

- Creation of new programs, interventions and policies;
- Launch of systematic investigations and responses to disease outbreaks/clusters, environmental contaminants, and emergence of public health issues;
- Decision making regarding further investigation using evaluation and/or research methodologies (Population Health Assessment and Surveillance protocol); or
- Review and significant modification of existing policies, programs, or interventions.

Using the planning model assumes a relatively comprehensive analysis and is not suitable for minor modifications of activities or minor program changes. However, some stages and tools that are referenced here could be used for this purpose.

This model is suitable for internal planning processes, and the expectations may need to be adjusted for community-driven, multi-stakeholder initiatives, and those that include peer interventions. In these situations, rather than fully deploy this model, one could advocate for the use of some elements and tools offered in this document.



¹ Significantly influenced by the Metropolitan Toronto District Health Council's 1996 report: "A guide to Needs/Impact-Based Planning: Final report of the Needs/Impact-Based Planning Committee to the Ministry of Health, Community Health Division".

How do we use this model?

The model offers seven steps to guide the program (and/or policy) planning, development, implementation, and evaluation cycle. Each step is explained as a generic type of activity, typical of many planning models. For each of the steps, there are a few references and appendices offered with specific guidelines and/or samples of tools that could be used.

For some of the steps, information or sources may be already available, easily accessible, or recently collected. The intention of this process is to take advantage of, and not recreate, these sources. If, for example, a relevant literature review is available in the upcoming OPHS support manual, or has recently been completed, then the source of information and conclusions could be briefly documented in the relevant stage of the process.

Key Principles and Assumptions of this model

Several assumptions and values guided the development of the Evidence and Practice-based Planning Framework:

1. To ensure that public health programs and services meet local needs and common outcomes, the Foundations of the OPHS require that our work be guided by the principles of:
 - i. Need
 - ii. Impact
 - iii. Capacity
 - iv. Partnership and Collaboration²
2. New terminology and requirements from the OPHS are incorporated in an attempt to clarify and define steps in such a way that they fit the new OPHS language (e.g., “situational assessment” and “priority populations”).
3. Good evidence is both quantitative and qualitative; research driven and experiential. Likewise, data may be obtained from existing sources and through research and program evaluation, using a variety of methods.
4. The context, strategic directions, unique community characteristics and circumstances, and political and stakeholder perspectives, are legitimate contributors in program planning and need to be considered along with surveillance, health data, research, program evaluation, and other more common sources of evidence.

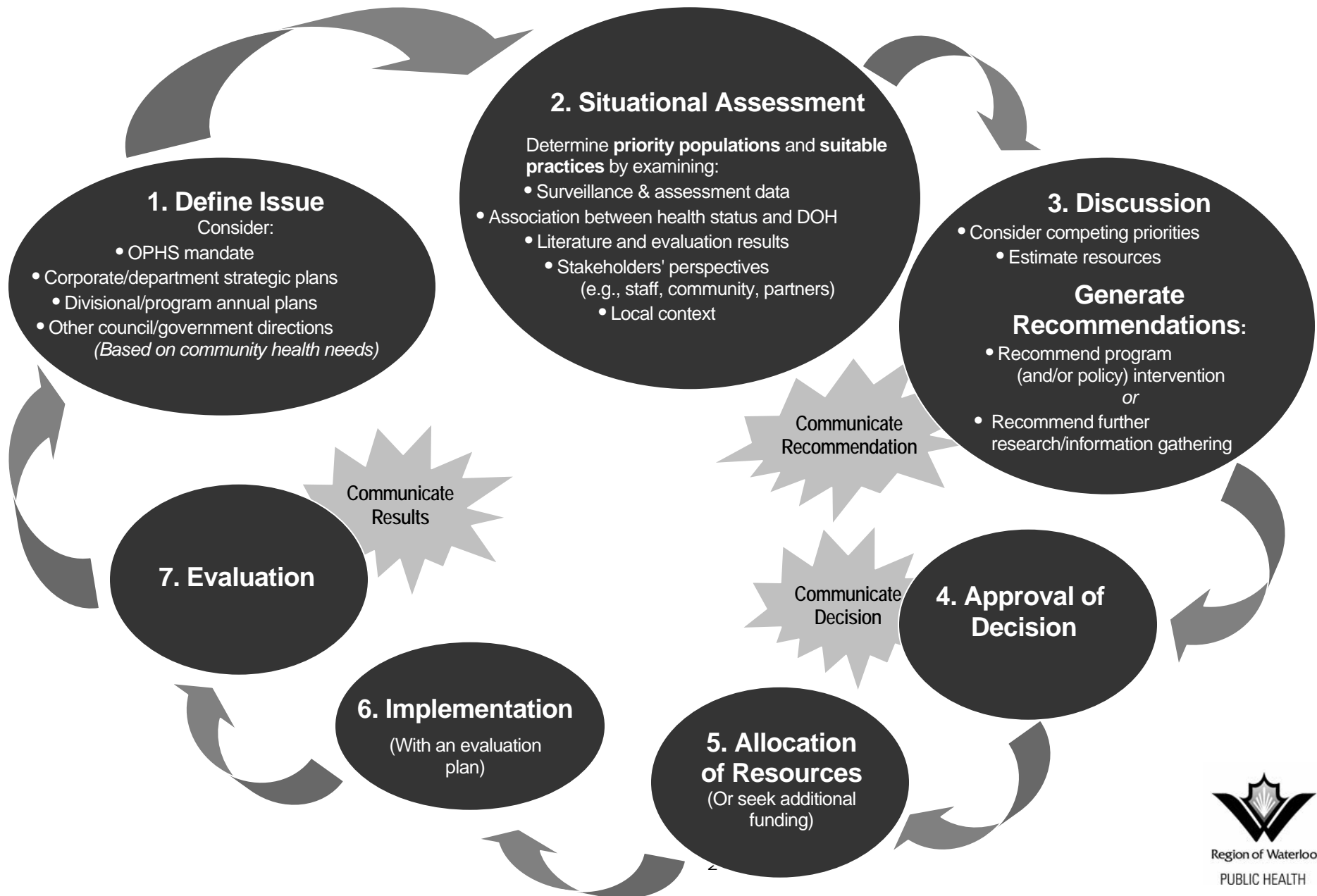
Evidence-based Program Planning Cycle

The model (Figure 1) presents a continuous cycle with seven main steps:

1. Define Issue by Reviewing Mandate/Strategic Directions;
2. Conduct Situational Assessment (including identifying priority populations & suitable practices);
3. Discuss evidence and generate recommendations; either by (a) choosing a program/policy intervention (and communicating recommendations); or (b) seeking further information (and communicating recommendations);
4. Seek Approval of the decision (and communicate decision);
5. Allocate Resources;
6. Implement; and
7. Evaluate (and communicate results).

² Ontario Public Health Standards, p. 12-14.

Evidence and Practice-based Planning Framework



Steps, Sources of Evidence, Tools, and Supporting Documents

Progress through the framework should be documented in the [EPPF Documentation Checklist](#), capturing who is responsible for each step and linking to supporting documentation

The remaining pages present a description of each step, sources of evidence, and tools that may be used to complete this process.

1. Defining the Issue by Reviewing Mandates and Strategic Directions

This step refers to identifying issues or needs by reviewing the mandates and strategic directions.

There are four key sources to consider:

- a. Ontario Public Health Standards and their specific requirements;
- b. Organizational vision, mission, values, focus areas, strategic objectives, actions/goals;
- c. Program vision, mission, values, focus areas, goals, objectives, annual plans and priorities; and
- d. Ad hoc Council or Board of Health or other governmental directions.

Other sources that may be relevant are: related legislation, regulations, policies and guidelines (e.g., federal, provincial, regional, municipal, organizational); professional standards and ethical guidelines; mandates of potential partners in the community.

This step assumes that consultations related to needs and gap analyses preceded the creation of these strategic documents. Appendix A outlines a sample of a process that may be used to understand and prioritize needs as new plans are developed.

Choices may need to be made as to which unmet needs (i.e., service gaps) should be addressed at the present time. This step may have already been done and incorporated into strategic plans. If not, then gaps may be ranked according to an agreed-upon method or set of criteria which is, ideally, based on consensus. Those gaps which are ranked as highest priority would then be recommended for a more detailed situational assessment. If more gaps are identified as high priorities that can be addressed in the current year, then the list would need to be narrowed further before proceeding to the next stage. A variety of methods are available for prioritizing service gaps. See Appendix B.

2. Situational Assessment

Program and policy planning need to be grounded in a variety of evidence. Combining and analyzing information from a variety of sources is referred to in the new Population Health Assessment and Surveillance Protocol as a “situational assessment.” While situational assessments are explicitly requested in only some of the new standards, they are generally seen as helpful for developing or modifying programs and interventions, and therefore are a key component of this model.³ An outline for documenting a situational assessment and the definitions of “situational assessment” and “priority populations” from the OPHS are in Appendix C.

Determining the scope of the situational assessment is important. It may be useful to plan a situational assessment by documenting the answers to some [preparatory questions](#).

³For some programs, OHPS give specific guidelines in Protocols that detail how an assessment or a program/activity is to be conducted/implemented

The essential components of a situational assessment involve examining and documenting all of the following:

A. Surveillance and population health assessment activities

This step includes examination of data obtained from surveillance and/or population health assessment activities.

Sources of data to consider:

- Public health and other information systems (e.g., RRFSS, PHPDB, IPHIS, CCHS, Census), typically obtained through data requests;
- Administrative databases;
- Surveys or other primary data collection methods (quantitative and qualitative); and
- Data and reports from other local, regional, provincial, and national sources.

Types of population health data and information to consider (as applicable): Socio-economic and demographic factors; mortality; morbidity; reproductive outcomes; growth and development outcomes; risk factors and health behaviours; preventive health practices; physical environment factors; attitudes, awareness and knowledge regarding health practices; health status/outcomes.

B. Association between health status and determinants of health in order to identify priority populations

This step refers to **identification of priority populations**. Almost all of the new standards in the OPHS state the need for identification of priority populations. This process is both overlapping and parallel to some of the other components of the situational assessment. (See Appendix C for definitions from the OPHS.) Identifying priority populations also relies on multiple sources of information and requires an examination of the interplay between the findings from different sources. Those sources include:

- Analysis of the unique population characteristics for the geographic area covered by the health unit.
- Issue-based analysis, which looks at the relationship between the determinants of health and health outcomes or other specific program requirements (e.g. relationship between age and/or education and reproductive outcomes; immigration status and tobacco use; socio-demographic factors and cardiovascular disease, etc.).
- Reviewing local data or, if data are not available at the community level, by combining literature findings with provincial data and some data collection via surveys, key informant interviews, focus groups, etc. in order to systematically collect information on the unique issues/needs.
- Program evaluation information (including formalized staff observations such as trends in attendance of clinics; success of certain methods in reaching out to particular populations; observed/documentated barriers to participation of some populations in program delivery).
- May be completed by developing focused questions within a more comprehensive evaluation or through an ad hoc inquiry to look at the inclusion and exclusion issues in programming as well as assessing the program benefits and outcomes for certain populations.

A step-by-step process to help determine [*priority populations*](#)⁴ and/or to determine [*priority neighbourhoods*](#) have been provided to help with this task.

⁴ For more information about using a health equity lens, see; Patychuk D. and Seskar-Hencic D. (November 2008). [*First Steps to Equity: Ideas and Strategies for Health Equity in Ontario*](#), 2008-2010. Toronto.

C. Literature and Evaluation Findings

- There are a wide range of tools and well-defined instructions on how to perform and document effective literature reviews. To begin, you can use the [Literature Review Quick Guide](#) that has been developed by Region of Waterloo Public Health. In addition to instructions and suggested references for literature review, this guide provides a template for recording the findings of a literature review.
- The OPHS General Resources website offers pre-defined searches in selected databases and tools for critical appraisal of evidence and research that have been developed by the Ontario Public Health Libraries Association.

D. Stakeholder Perspectives

- Stakeholder perspectives include any additional (i.e. beyond program evaluation) systematically gathered and documented information from staff, community partners, community at large, other Health Units, professional partners, participants, clients, etc.

E. Context

- For this step, consider factors that may affect the initiative, such as political, economic, environmental, social and technological and other factors. Include strengths (capacities, resources), limitations, opportunities and threats/barriers.
- [A Brainstorming Worksheet](#) may be used to document the local context.

3. Discussion and Recommendations to Proceed

This step considers all of the available sources of information and takes into account their interplay; it involves weighing, comparing, and contrasting the evidence. At this stage, both priority populations and suitable practices should emerge and the rationale for pursuing a certain path will be well documented, both by the sources of information and by the process used for decision making. The process for decision making, depending on the unique characteristics of the issue or setting may involve use of a working group, committee, team meetings, or some other form of internal or combined internal and external consultation.

In some cases, a clear and logical program/policy intervention will not emerge and further information gathering, research, or other forms of revisiting the issue would have to be used. It is important to note that further research and information is commonly recommended in planning processes, and could also be a by-product of this process even if a decision for an intervention emerges.

Since this planning model acknowledges not only academic evidence but also examines community, organizational, and other realities, it acknowledges the need to develop realistic, well grounded plans. If a plan of action is not emerging and more research/information is needed, it is important to document the rationale for such a decision.

See **Appendix D** for some tools for decision making.

Estimation of Resources

Estimating resources involves a look at the overall financial and other costs of the implementation of a new or a modified program/policy. **Appendix E** offers a guide to the costs to be considered.

Guidelines for writing Project Summaries

In the EPPF process, it is critical to document the steps taken to complete the situational assessment and summarize the recommendations. A [report outline for project summaries](#) has been developed to help guide this step of the process.

4. Approval of the Decision to Proceed

This step ensures that decisions and recommendations as well as estimated resources are offered with supporting documentation for approval by the internal (or internal and external) governing bodies.

5. Allocation of Resources

Following the approval, resources are allocated to ensure implementation of the decision. Again, Appendix E helps with explaining the steps and sources of information for this step.

6. Implementation

Develop logic model/program theory and evaluation plan. See Appendix F.

7. Evaluation

Evaluation of programs or services is a process completed by individual staff, committees, working groups, or external consultants. Program evaluation is the systematic gathering, analysis, and reporting of data about a program to assist in decision making.⁵

The Ontario Public Health Standards state that “*program evaluation includes quantitative, qualitative, and mixed-method approaches...and it “produces the information needed to support the establishment of new programs and services (needs assessment); assess whether evidence-informed programs are carried out with the necessary reach, intensity, and duration (process evaluation), or document the effectiveness and efficiency of programs and services (outcome evaluation)”*⁶

See Appendix G for more information about relating the logic model to evaluation.

Communicate results and begin a new cycle.

⁵ Porteous, Nancy L. (1997). Program Evaluation Tool Kit: A blueprint for public health management. Ottawa-Carleton Health Department: Introduction, p. 1. (Available to order from Ottawa Public Health).

⁶ Ontario Public Health Standards.

Appendix A:

Determining Needs and Capacities and Prioritizing Gaps

A variety of strategies can be used to determine needs and capacities, including, but not limited to:

- Maintaining a running list of needs and capacities brought forward at committee or working group meetings and discussing needs and capacities on the list on a defined schedule (i.e., quarterly, annually). The sources of need and capacity identification might include:
 - Staff
 - Partner agencies
 - Clients
 - Other programs (in the division or department)
 - Other Regional departments or programs
 - The media
- Scanning relevant electronic mailing lists and literature on a routine basis as part of committee member duties

Identifying Service Gaps

Identifying service gaps is a multi-step process. The initial investigation used to identify gaps should be based primarily on consultation or readily available written information. More in-depth investigation may take place as part of a situational assessment for service gaps that are prioritized.

Steps in gap identification include:

1. Review the section “Health Needs Assessment Choices: Concepts and Theories” below to become familiar with the basic concepts.
2. Classify each item listed as a *want*, *demand* or *need*.
3. Using committee member knowledge of current local services, classify each listed need as *met*, *unmet* or *unknown status*. A need may be met in one population, but remain unmet in another. These are referred to as *comparative needs* and are classified as *unmet* with the population(s) specified.
4. Seek information from colleagues, managers and other divisions to determine if needs classified as *unknown status* are currently *met* or *unmet* in the community. Check committee lists or other sources of potential key informants. Reclassify *unknown status* needs as *met* or *unmet*, based on the feedback gathered.
5. Once all needs have been classified as *met* or *unmet*, create a final list of *unmet* needs (including *comparative needs*). This is a list of service *gaps*.

What is a “Need”?

If health resources are to be distributed according to need, a way of defining “health need” must be found. But “need” is an ambiguous concept, defined in many ways. Figure 1 may help distinguish between some types of needs.

Felt need (wants/attitudes) is the subjective experience of need; a need seen as important to the person concerned. Felt need is the basis of, but may or may not translate into, expressed need.

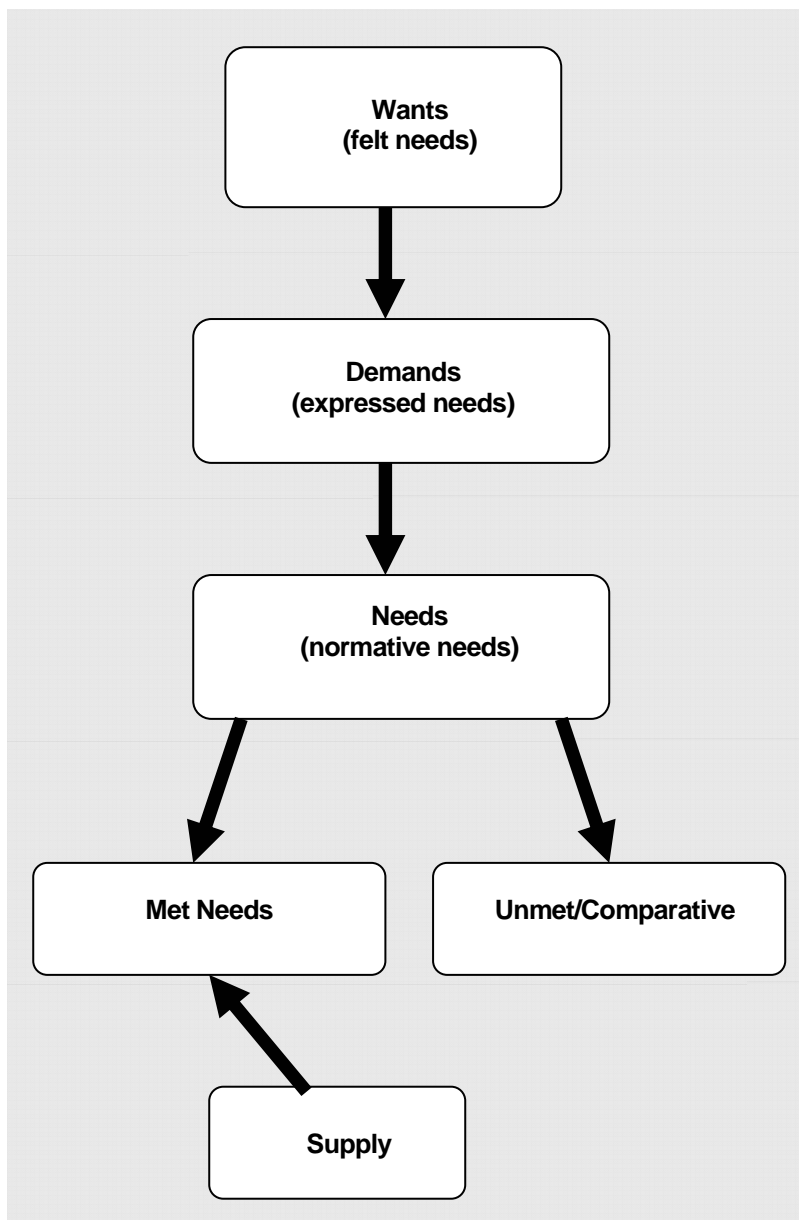
Expressed need (demands/actions) is a vocalized need, often referred to as demand for (or utilization of) service. Expressed needs may or may not be demonstrated through research to be normative needs.

Normative Need is typically defined by experts and professionals. Regarding health, this is usually expressed in terms of acceptable minimum and maximum population health status and/or levels of service provision.

Comparative need is determined by comparing populations based on certain indicators; it is underpinned by the concept of equal allocation of resources. If nothing else is known about the optimum level of health, there is at least reason for investigation if levels of health or service differ markedly among different populations.

Supply is the health resources provided. Their size and range depend on the definition of need and the interests of health professionals, the priorities of government and communities, and the amount of money available.

Figure A1: Wants and Needs



⁷ From *Assessing Need: The Health Planner's Toolkit*. Health System Intelligence Project - 2006. Ontario MOHLTC. Section 2.1:9-10.

Appendix B:

Prioritizing Needs/Gaps

It is recommended that you use a priority setting checklist for prioritizing gaps. An example has been provided here that has been modified from the Region of Waterloo Priority Setting Checklist.

Primary Considerations

1. To what degree is it legislated/mandated by the province that we have to address this gap?
2. a) To what degree is there evidence demonstrating this gap?
b) How much impact can we make on addressing this gap?
3. To what degree is this gap identified by the community?
4. To what degree does this gap fit within Regional/Departmental/Divisional program goals?
5. Are we the right agency to address this gap?

Further Considerations:

6. To what degree is the community ready to address this gap?
7. To what degree does addressing this gap “round out” a multiple-strategy approach to the issue?
8. Would it be innovative to address this gap?
9. To what degree will addressing this gap promote synergies and linkages with other cross-departmental or corporate initiatives?
10. To what degree will addressing this gap build community/citizen capacity (which can be applied beyond the initiative)?
11. To what degree is internal capacity present for addressing this gap?
12. Can we bring “value added” to the partners already involved in addressing this gap?

Other methods for prioritizing include:

- A. Preference Survey Method
 - Committee members can indicate their preferences by individually comparing each gap against the others and identifying the highest ranking one.
- B. Simplex Method
 - Structured questions are used to analyze and rank alternatives.
- C. Dotmocracy or Advanced Dotmocracy
 - Participants use dots to indicate their preference or rating of each gap.

If one method provides an inconclusive answer, the group should try a different method.

These methods may also be used later (during “Decide to Proceed”) to prioritize possible strategies for addressing the gaps.

Appendix C:

Documenting a Situational Assessment

This outline may be used to complete the situational assessment. The purpose of a situational assessment is to ground significant program/policy planning decisions in a variety of evidence. Through reviewing the evidence gathered during the situational assessment, priority populations and suitable practices are identified. The results of the situational assessment are used to generate recommendations for action.

Begin by creating a focused, answerable question (i.e., clarify what you need to find out). Then, examine and document the following information in a way that helps to answer the question.

1. Surveillance and population health assessment data

Types of population health data/information to consider (as applicable):

- Socio-economic & demographic
- Mortality & morbidity
- Reproductive outcomes
- Growth & development outcomes
- Risk factors & health behaviours; preventive health practices
- Physical environment
- Attitudes, awareness & knowledge regarding health practices
- Health status/outcomes

Sources of data to consider:

- Information systems
- Administrative databases
- Surveys
- Other primary data collection
- Data/reports from other sources

2. Association between health status and determinants of health

In order to identify priority populations, examine:

- Analysis of unique local population characteristics
- Issue-based analysis of relationship between determinants of health and health outcomes or other specific program requirements
- Program evaluation information (re; inclusion/exclusion issues & benefits/outcomes for specific populations)

3. Literature and evaluation findings

- Current literature
- Evaluation results

4. Stakeholder perspectives

Systematically gather and document information from stakeholders in the decision, which may include:

- Clients/participants
- Community/public
- Staff
- Professional and community partners
- Others (as applicable), e.g., other health units

5. Context

Consider factors that may affect the initiative:

- Political, economic, environmental, social, technological, and other factors
- Strengths (capacities, resources); weaknesses (limitations); opportunities; threats (barriers); potential risks & benefits

Definitions of Situational Assessment and Priority Populations from the OPHS

The Population Health Assessment and Surveillance (PHAS) Protocol glossary defines situational assessment in this way:

“A situational assessment influences planning in significant ways by examining the legal and political environment, stakeholders, the health needs of the population, the literature and previous evaluations, as well as the overall vision for the project. The phrase ‘situational assessment’ is now used rather than the previous term ‘needs assessment.’ This is intentional. The new terminology is used as a way to avoid the common pitfall of only looking at problems and difficulties. Instead it encourages considering the strengths of and opportunities for individuals and communities. In a health promotion context, this also means looking at socio-environmental conditions and broader determinants of health.”

The PHAS Protocol (“data analysis and interpretation” section) describes our responsibility for conducting situational assessments and lists data sources:

- “g) The board of health shall synthesize data and information into a situational assessment as required. A situational assessment includes, but is not limited to, the use of the following types and sources of information:
- i) Key facts, findings, trends, and recommendations from the literature;
 - ii) Data and analyses obtained from population health assessment and surveillance;
 - iii) Legal and political environments;
 - iv) Stakeholder perspectives; and
 - v) Recommendations based on past experiences, including program evaluation information.”

The OPHS Foundational Standard (“population health assessment” section) gives the definition of, and states the requirement for identifying, priority populations:

“3. The board of health shall use population health, determinants of health and health inequities information to assess the needs of the local population, including the identification of populations at risk, to determine those groups that would benefit most from public health programs and services (i.e. priority populations). Priority populations are identified by surveillance, epidemiological, or other research studies. They are those populations that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level.”

The PHAS Protocol (“data analysis and interpretation” section) describes our responsibility for identifying priority populations and lists data sources:

“h) The board of health shall identify priority populations to address the determinants of health, by considering those with health inequities including: increased burden of illness; or increased risk for adverse health outcome(s); and/or those who may experience barriers in accessing public health or other health services or who would benefit from public health action.

The board of health shall use the following to identify priority populations:

- i) Socio-demographic and geographic characteristics of the health unit;
- ii) Interpretation of existing and/or acquired data and information that describe the relationship between the barriers and specific program requirements (e.g., relationship between age or education and reproductive outcomes; immigration status and tobacco use, etc.); and,
- iii) Program evaluation data and information which identifies program benefits and gaps for diverse populations.”

Appendix D:

Decide to Proceed

Wherever possible, the decision making process will include:

- a) **Decision Making/Recommendation Team** - This could be representation from management, committees or working groups. The team needs to have delegated authority to make the decision, or have been directed to generate recommendations for consideration by the party responsible for making the decision.
- b) **Advisory Group/Individuals** – This could be representation from community agencies, staff, or the public. These people provide input and advice to assist the decision making/recommendation team in completing their assigned tasks.

It should be noted that the ideal process outlined above cannot always be followed. For example, time lines, resource constraints and/or changes to mandates that are revised mid-process may require that a modified approach to decision making be used.

A decision making aid uses all relevant knowledge available, is logically sound and understandable. It should also look at:

1. **Short term outcomes** – which “are the direct result of the program on its participants. They show why the program activities will lead to long-term outcomes”; and
2. **Long term outcomes** – which “reflect the consequences of your program in the broader community”. These tend to be the ultimate goals of the program.⁸

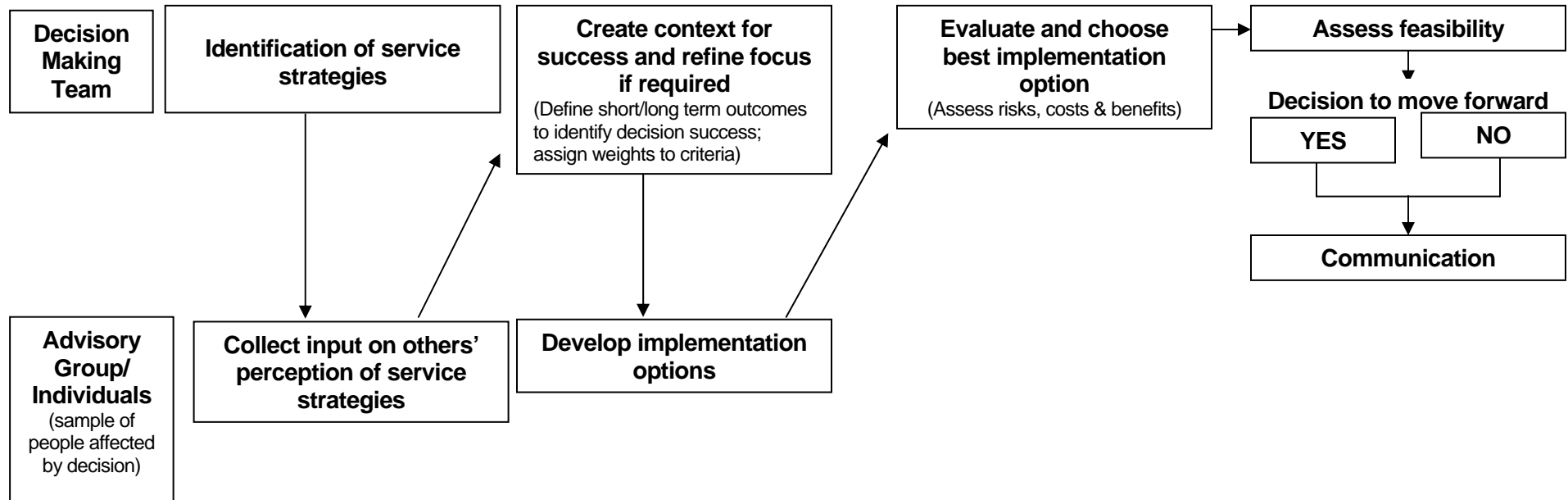
Figure 3 depicts a decision making process that outlines the tasks of the decision making team, the advisory group/individuals and the linkages and interplay between these groups in working toward a decision to proceed or not. The process is not linear and may flow back and forth between steps before a decision is made. Although the final decision or recommendation resides with the team, the back and forth process will allow all parties to voice concerns, develop implementation options and evaluate options presented. As all parties are involved and see the decision process as fair, it will lead to increased advocacy for the decision by all. This back and forth process will also help to justify the outcomes to superiors, community agencies and peers when there was input at multiple levels.

The tools in Appendix B may also be used to prioritize which recommended strategies or initiatives to move forward.

After determining the feasibility of the decision, a communication plan is put into place to convey the decision to all parties affected (i.e., staff, community agencies, public, management leads, management teams). The communication will outline the thinking behind the decision and expected outcomes of the decision.

⁸ Porteous, Nancy L. (1997). Program Evaluation Tool Kit: A blueprint for public health management. Ottawa-Carleton Health Department, p. 8.

Figure D3: Decision Making Process



Adapted from: David Matheson and Jim Matheson, *The Smart Organization* (Boston: Harvard Business School Press, 1998), 178

Appendix E: *Estimate and Allocate Resources*

Before embarking on a project, it must first be determined that the resources to complete the project are available. Resources include financial, material, and human. Examples of resources to consider:

Financial

- Funding from any or all involved agencies
- Funding from grants
- In-kind contributions of personnel time or materials that would otherwise need to be purchased

Material

- Office space
- Office furniture
- Office services (e.g. telephone charges, Internet services)
- Office supplies (e.g. paper, desk supplies)
- Equipment (e.g. telephone, fax, photocopier, computer or audio-visual)
- Educational supplies (e.g. books, DVDs)

Human (consider positions, distribution and amount of FTEs)

- Administrative support (e.g. photocopying, minute taking)
- Planning support (e.g. Public Health Planner, consultant)
- Client contact support (staff working directly with clients such as Public Health Nurses)
- Management
- Data analysis support (e.g. epidemiology and data support staff or staff knowledgeable in planning and evaluation)
- Client – It is important to consider the total burden of any research that involves clients on the clients themselves. Remember that there may be other research in the community that is accessing the same group of clients. It is critical to determine this before attempting to involve clients.

There is typically some level of resource support required from all agencies involved in a project, even if the only requirement is time from one person to attend planning meetings.

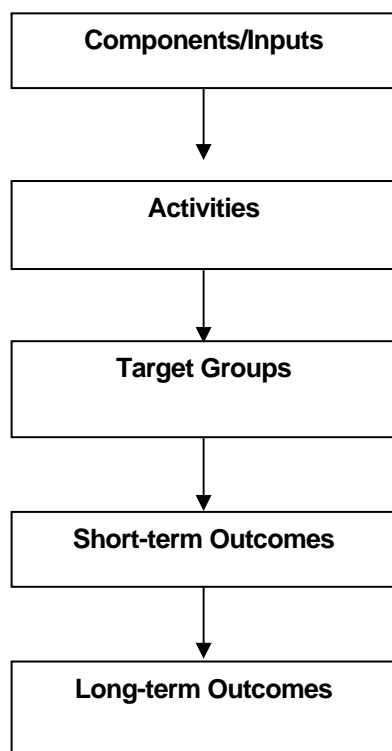
The group carrying out planning is responsible for drafting out the support they believe they will need. However, it is a management decision to determine if, and when, this support can be provided.

Appendix F:

Implement

Implementing a program or service could be done by the committees, working groups, assigned staff, or external consultants. Before beginning implementation of a program or service, the implementation group should develop a logic model or a program theory⁹ to depict what the decision/service intends to do, with whom and for what purpose. For detailed instructions on how to create and apply this logic model, please refer to ***The Program Evaluation Tool Kit: A blueprint for public health management.***¹⁰

Logic Model for Implementation



Components/Inputs are groups of closely-related activities in a program. Concentrate on themes or sets of activities.

Activities are the things the program does to work toward its desired outcomes. Do not include the administrative aspects of the program. Use action verbs.

Target groups are the individuals, groups or communities for whom the program activities are designed. Be as specific as possible by combining several characteristics.

Outcomes are the changes the program hopes to achieve. There are both short-term and long-term outcomes. Be sure to include the direction of change (that is, increase or decrease), and what the program is trying to change.

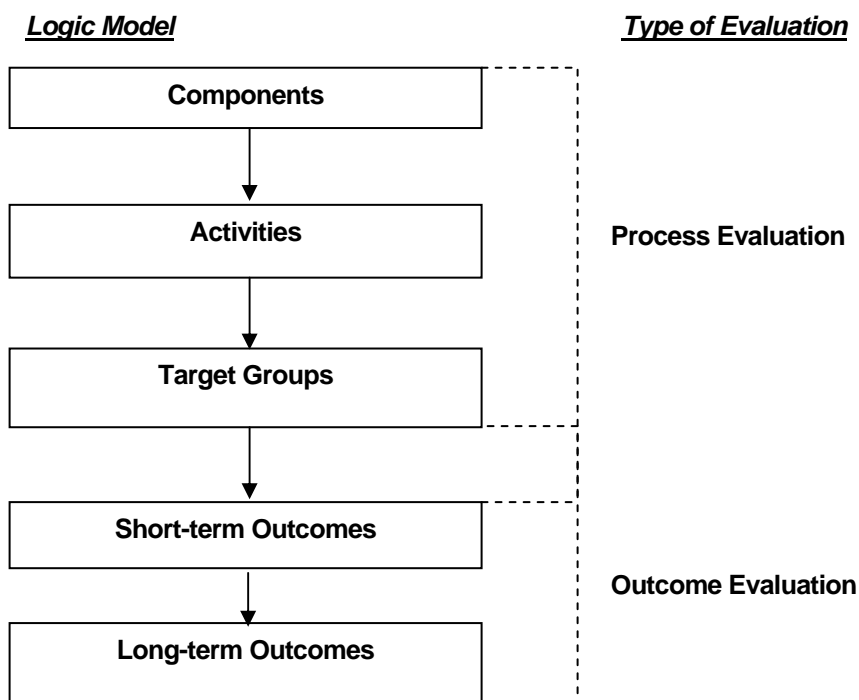
⁹ Region of Waterloo Public Health. (2009). *Program Logic Model Quick Guide*.

¹⁰ Porteous, Nancy L. (1997). *Program Evaluation Tool Kit: A blueprint for public health management*. Ottawa-Carleton Health Department: Introduction, p. 1. (Available to order from Ottawa Public Health).

Appendix G:

Evaluate

Relating the Logic Model to Type of Evaluation



It is imperative that when evaluation takes place it is documented, saved, and shared with relevant stakeholders and other parties who would benefit from the information gathered through the evaluation. The results of evaluations contribute to our body of knowledge and evidence, and may be used for future strategic planning and decision making (feeding into the first step of the model).
