

SECTION I

The Context of Health Program Development and Evaluation

CHAPTER 1

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CHAPTER 2

Relevance of Diversity and Disparities to Health Programs



CHAPTER 1

Context of Health Program Development and Evaluation

Health is not a state of being that can easily be achieved through isolated, uninformed, individualistic actions. *Health* of individuals, of families, and of populations is a state in which physical, mental, and social wellbeing are integrated so that optimal functioning is possible. From this perspective, achieving and maintaining health across a lifespan is a complex, complicated, intricate affair. For some, health is present irrespective of any special efforts or intention. For most of us, health requires, at a minimum, some level of attention and specific information. It is through health programs that attention is given focus and information is provided or made available, but that does not guarantee that the attention and information are translated into actions or behaviors needed to achieve health. Thus, those providing health programs, however large or small, need to understand not only the processes whereby those in need of attention and information can receive what is needed, but also the processes of learning from their experiences of providing the health program.

The processes and effects of health program planning and evaluation are the subjects of this text. The discussion begins here with a brief overview of the historical context. This background sets the stage for appreciating the growing number of publications on the topic of health program planning and evaluation that have emerged in recent years, and for acknowledging the professionalization of evaluators. The use of the term “processes” to describe the actions involved in health program planning and evaluation is intended to denote action, cycles, and open-endedness. This chapter introduces the planning and evaluation cycle, and the interactions and iterative nature of this cycle are stressed throughout the text. Because health is an individual, aggregate, and population phenomenon, health programs need to be conceptualized across those levels. The public health pyramid, introduced in this chapter, is used

throughout the text as a tool for conceptualizing and actualizing health programs for individuals, aggregates, and populations.

HISTORY AND CONTEXT

An appropriate starting point for this text is reflecting on and understanding what “health” is, along with having a basic appreciation for the genesis of the fields of health program planning and evaluation. A foundation in these elements is key to becoming an evaluation professional.

Concept of Health

It is crucial to begin the health program planning and evaluation cycle by first reflecting on the meaning of health. Both explicit and implicit meanings of health can dramatically influence what is considered the health problem and the subsequent direction of a program. The most widely accepted definition of *health* is that put forth by the World Health Organization (WHO), which for the first time defined health as more than the absence of illness, but also the presence of wellbeing (WHO, 1947).

Since the publication of the WHO definition, health has come to be viewed across the health professions as a holistic concept that encompasses the presence of physical, mental, developmental, social, and financial capabilities, assets, and balance. This idea does not preclude each health profession from having a particular aspect of health to which it primarily contributes. For example, a dentist contributes primarily to a patient’s oral health, knowing that the state of the patient’s teeth and gums has a direct relationship to his or her physical and social health. Thus the dentist might say the health problem is caries. The term “health problem” is used, rather than “illness,” “diagnosis,” or “pathology,” in keeping with the holistic view that there can be problems, deficits, and pathologies in one component of health while the other components remain “healthy.” Using the term “health problem” also makes it easier to think about and plan health programs for aggregates of individuals. A community, a family, and a school can each have a health problem that is the focus of a health program intervention. The extent to which the health program planners have a shared definition of health and have defined the scope of that definition will influence the nature of the health program.

Health is a matter of concern for more than just health professionals. For many Americans, the concept of health is perceived as a right, along with civil rights and liberties. The right to health is often translated by the public and politicians into the

perceived right to have or to access health care. This political aspect of health is the genesis of health policy at the local, federal, and international levels. The extent to which the political nature of health underlies the health problem of concern and is programmatically addressed will also influence the final nature of the health program.

History of Health Program Planning

The history of planning health programs has a different lineage than that of program evaluation. Only relatively recently, in historical terms, have these lineages begun to overlap, with resulting synergies. Planning for health programs has the older history, if public health is considered. Rosen (1993) argued that public health planning began approximately 4000 years ago with planned cities in the Indus Valley that had covered sewers. Particularly since the Industrial Revolution, planning for the health of populations has progressed, and it is now considered a key characteristic of the discipline of public health.

Blum (1981) related *planning* to efforts undertaken on behalf of the public well-being to achieve deliberate or intended social change as well as providing a sense of direction and alternative modes of proceeding to influence social attitudes and actions. Others (Dever, 1980; Rohrer, 1996; Turnock, 2004) have similarly defined planning as an intentional effort to create something that has not occurred previously for the betterment of others and for the purpose of meeting desired goals. The purpose of planning is to ensure that a program has the best possible likelihood of being successful, defined in terms of being effective with the least possible resources. Planning encompasses a variety of activities undertaken to meet this purpose.

The quintessential example of planning is the development and use of the *Healthy People* goals. In 1979, *Healthy People* (U.S. Department of Health, Education, and Welfare [DHEW], 1979) was published as an outgrowth of the need to establish an illness prevention agenda for the United States. The companion publication, *Promoting Health/Preventing Disease* (U.S. Department of Health and Human Services [DHHS], 1980), marked the first time that goals and objectives regarding specific areas of the nation's health were made explicit, with the expectation that these goals would be met by the year 1990. *Healthy People* became the framework for the development of state and local health promotion and disease prevention agendas. Since its publication, the U.S. goals for national health have been revised and published as *Healthy People 2000* (DHHS, 1991), *Healthy Communities 2000* (American Public Health Association [APHA], 1991), *Healthy People 2010* (DHHS, 2000), and, most recently, *Healthy People 2020* (DHHS, 2011). It is worth noting that other nations also set health status goals

and that international organizations, such as the World Health Organization (WHO) and Pan American Health Organization (PAHO), develop health goals applicable across nations.

The evolution of *Healthy People* goals also reflects the accelerating rate of emphasis on nationwide coordination of health promotion and disease prevention efforts and a reliance on systematic planning to achieve this coordination. The development of the *Healthy People* publications also reflects the underlying assumption of most planners that planning is a rational activity that can lead to results. However, with regard to many health problems, the United States has not yet achieved the objectives set for 1990; this fact reflects the colossal potential for planning to fail. Given this potential, the emphasis in this text is on techniques to help future planners of health programs be more realistic in the goals set and less dependent upon a linear, rational approach to planning.

The *Healthy People 1990* objectives were developed by academics and clinician experts in illness prevention and health promotion. In contrast, the goals and health problems listed in *Healthy People 2010* and *Healthy People 2020* were based on and incorporated ideas generated at public forums and through Internet commentary; these ideas were revised by expert panels before their final publication. The shift to a greater participation of the public in the planning stage of health programs is a major change that is now considered the norm. In keeping with the emphasis on participation, the role and involvement of stakeholders are stressed at each stage of the planning and evaluation cycle.

The history of evaluation, from which the evaluation of health programs grew, is far shorter than the history of planning, beginning roughly in the early 1900s, but it is equally rich in important lessons for future health program evaluators. The first evaluations were done in the field of education, particularly as student assessment and evaluation of teaching strategies gained interest (Patton, 2008). Assessment of student scholastic achievement is a comparatively circumscribed outcome of an educational intervention. For this reason, early program evaluators came from the discipline of education, and it was from the fields of education and educational psychology that many methodological advances were made and statistics developed.

Guba and Lincoln (1987) summarized the history of evaluations by proposing generational milestones or characteristics that typify distinct generations. Later, Swenson (1991) built on their concept of generations by acknowledging that subsequent generations will occur. Each generation incorporates the knowledge of early evaluations and extends that knowledge based on current broad cultural and political trends.

Guba and Lincoln (1987) called the first generation of evaluations in the early 1900s “the technical generation.” During this time, nascent scientific management, statistics, and research methodologies were used to test interventions. Currently, evaluations continue to incorporate the rationality of this generation by using activities that are systematic, science based, logical, and sequential. Rational approaches to evaluations focus on identifying the best-known intervention or strategy given the current knowledge, measuring quantifiable outcomes experienced by program participants, and deducing the degree of effect from the program.

The second generation, which lasted until the 1960s, focused on using goals and objectives as the basis for evaluation, in keeping with the managerial trend of management by objectives. Second-generation evaluations were predominantly descriptive. With the introduction in the 1960s of broad innovation and initiation of federal social service programs, including Medicare, Medicaid, and Head Start, the focus of evaluations shifted to establishing the merit and value of the programs. Because of the political issues surrounding these and similar federal programs, there was a growing awareness of the need to determine whether the social policies were having any effect on people. Programs needed to be judged on their merits and effectiveness. The U.S. General Accounting Office (GAO; now called the Government Accountability Office) had been established in 1921 for the purpose of studying the utilization of public finances, assisting Congress in decision making with regard to policy and funding, and evaluating government programs. The second-generation evaluation emphasis on quantifying effects was spurred, in part, by reports from the GAO that were based on the evaluations of federal programs.

Typically, the results of evaluations were not used in the “early” days of evaluating education and social programs. That is, federal health policy was not driven by whether evaluations showed the programs to be successful. Although the scientific rigor of evaluations improved, their usefulness remained minimal. Beginning in the 1980s, however, the third generation of evaluations—termed “the negotiation generation” or “the responsiveness generation”—began. During this generation, evaluators began to acknowledge that they were not autonomous and that their work needed to respond to the needs of those being evaluated. As a result of this awareness, several lineages have emerged. These lineages within the responsiveness generation account for the current diversity in types, emphases, and philosophies related to program evaluation.

One lineage is utilization-focused evaluation (Patton, 2008), in which the evaluator’s primary concern is with developing an evaluation that will be used by the stakeholders. Utilization-focused evaluations are built on the following premises

(Patton, 1987): concern for use of the evaluation pervades the evaluation from beginning to end, evaluations are aimed at the interests and needs of the users, users of the evaluation must be invested in the decisions regarding the evaluation, and a variety of community, organizational, political, resource, and scientific factors affect the utilization of evaluations. Utilization-focused evaluation differs from evaluations that are focused on outcomes (Table 1-1).

Another lineage is participatory evaluation (Whitmore, 1998), in which the evaluation is merely guided by the expert and is actually generated by and conducted by those invested in the health problem. A participatory or empowerment approach invites a wide range of stakeholders into the activity of planning and evaluation, providing those participants with the skills and knowledge to contribute substantively to the activities and fostering their sense of ownership of the product.

The fourth generation of evaluation, which emerged in the mid-1990s, seems to be meta-evaluation: that is, the evaluation of evaluations done across similar programs. This trend in program evaluation is consistent with the trend in social science toward the use of meta-analysis of existing studies to better understand theorized relationships. It is also consistent with the trend across the health professions toward the use of meta-analysis of existing research for the development of evidence-based practice.

This new generation became possible because a culture of evaluation now pervades the health services, and huge data sets are available for use in the meta-evaluations. One indicator of the evaluation culture is the mandate from United Way, a major funder of community-based health programs, for grantees to conduct outcome evaluations. To help grantees meet this mandate, United Way has published a user-friendly

TABLE 1-1 Comparison of Outcome-Focused and Utilization-Focused Evaluations

	Outcome-Focused Evaluations	Utilization-Focused Evaluations
Purpose	Show program effect	Get stakeholders to use evaluation findings for decisions regarding program improvements and future program development
Audience	Funders, researchers, other external audience	Program people (internal audience), funders
Method	Research methods, external evaluators (usually)	Research methods, participatory

manual (United Way of America, 1996) that could be used by nonprofessionals in the development of basic program evaluations. The culture of evaluation is most evident in the explicit requirement of federal agencies that fund community-based health programs that such programs include evaluations conducted by local evaluators.

Despite the complexities involved in this latest stage of evaluation, most people have an intuitive sense of what evaluation is. The purpose of evaluation can be to measure the effects of a program against the goals set for it, in order to contribute to subsequent decision making about the program (Weiss, 1972). Alternatively, evaluation can be defined as “the use of social research methods to systematically investigate the effectiveness of social intervention programs in ways that are adapted to their political and organizational environments and are designed to inform social action to improve social conditions” (Rossi, Lipsey, & Freeman, 2004, p.16). Others (Herman, Morris, & Fitz-Gibbon, 1987) have defined evaluation as judging how well policies and procedures are working or as assessing the quality of a program. These definitions of evaluation remain relevant.

Inherent in these definitions of evaluation is an element of being judged against some criteria. This implicit understanding of evaluation leads those involved with the health program to feel as though they will be judged or found not to meet those criteria and will subsequently experience some form of repercussions. They may fear that they as individuals or as a program will be labeled a failure, unsuccessful, or inadequate. Such feelings must be acknowledged and addressed early in the planning cycle. Throughout the planning and evaluation cycle, the program planners have numerous opportunities to engage and involve program staff and stakeholders in the evaluation process. Taking advantage of these opportunities goes a long way in alleviating the concerns of program staff and stakeholders about the judgmental quality of the program evaluation.

EVALUATION AS A PROFESSION

A major development in the field of evaluation has been the professionalization of evaluators. Founded in 1986, the American Evaluation Association (AEA) serves evaluators primarily in the United States. Several counterparts to the AEA exist, such as the Society for Evaluation in the United Kingdom and the Australian Evaluation Society. The establishment of these professional organizations, whose members are evaluators, and the presence of health-related sections within these organizations demonstrate the existence of a field of expertise and of specialized knowledge regarding the evaluation of health-related programs.

As the field of evaluation has evolved, so have the number and diversity of approaches that can guide the development of evaluations. Currently, 26 different approaches to evaluation have been identified, falling into 3 major groups (Stufflebeam & Shinkfield, 2007). One group of evaluations is oriented toward questions and methods such as objectives-based studies and experimental evaluations. The second group of evaluations is oriented toward improvements and accountability and includes consumer-oriented and accreditation approaches. The third group of evaluations is those that have a social agenda or advocacy approach, such as responsive evaluations, democratic evaluations, and utilization-focused evaluation.

Several concepts are common across the types of evaluations—namely, pluralism of values, stakeholder constructions, fairness and equity regarding stakeholders, the merit and worth of the evaluation, a negotiated process and outcomes, and full collaboration. These concepts have been formalized into the standards for evaluations that were established by the Joint Commission on Standards for Educational Evaluation in 1975 (American Evaluation Association, 2011). Currently, this Joint Commission includes many organizations in its membership, such as the American Evaluation Association and the American Educational Research Association.

The five standards of evaluation established by the American Evaluation Association are utility, feasibility, propriety, accuracy, and evaluation accountability (Table 1-2; American Evaluation Association, 2011).

TABLE 1-2 Evaluation Standards Established by the Joint Commission on Standards for Educational Evaluation

Standard	Description
Utility	To increase the extent to which program stakeholders find evaluation processes and products valuable in meeting their needs.
Feasibility	To increase evaluation effectiveness and efficiency.
Propriety	To support what is proper, fair, legal, right, and just in evaluations.
Accuracy	To increase the dependability and truthfulness of evaluation representations, propositions, and findings, especially those that support interpretations and judgments about quality.
Evaluation Accountability	To encourage adequate documentation of evaluations and a meta-evaluative perspective focused on improvement and accountability for evaluation processes and products.

Source: Data from American Evaluation Association (2011).

The utility standard specifies that an evaluation must be useful to those who requested the evaluation. An evaluation is useful when it shows ways to make improvements to the intervention, increase the efficiency of the program, or enhance the possibility of garnering financial support for the program. The feasibility standard denotes that the ideal may not be practical. Evaluations that are highly complex or costly will not be done by small programs with limited capabilities and resources. Propriety is the ethical and politically correct component of the standards. Evaluations can invade privacy or be harmful to either program participants or program staff. The propriety standard also holds evaluators accountable for upholding all of the other standards. Accuracy is essential and is achieved through the elements that constitute scientific rigor. These established and accepted standards for evaluations reflect current norms and values held by professional evaluators and deserve attention in health program evaluations. The existence and acceptance of standards is truly an indication of the professionalism of evaluators.

Achieving these standards requires that those involved in the program planning and evaluation have experience in at least one aspect of planning or evaluation, whether that be experience with the health problem; experience with epidemiological, social, or behavioral science research methods; or skill in facilitating processes that involve diverse constituents, capabilities, and interests. Program planning and evaluation can be done in innumerable ways: there is no single “right way.” This degree of freedom and flexibility can feel uncomfortable for some people. As with any skill or activity, until experience is acquired, program planners and evaluators may feel intimidated by the size of the task or by the experience of others involved. To become a professional evaluator, therefore, requires a degree of willingness to learn, to grow, and to be flexible.

Who Does Planning and Evaluations?

Many different types of health professionals and social scientists can be involved in health program planning and evaluation. At the outset of program planning and evaluation, some trepidation revolves around who ought to be the planners and evaluators. In a sense, virtually anyone with an interest and a willingness to be an active participant in the planning or evaluation process could be involved, including health professionals, businesspersons, paraprofessionals, and advocates or activists.

Planners and evaluators may be employees of the organization about to undertake the activity, or they may be external consultants hired to assist in all phases or just a specific phase of the planning and evaluation cycle. Internal and external planners and evaluators each have their advantages and disadvantages. Regardless of whether an

internal or external evaluator is used, professional stakes and allegiances ought to be acknowledged and understood as factors that can affect the decision making.

Planners and evaluators from within the organization are susceptible to biases, consciously or not, in favor of the program or some aspect of the program, particularly if their involvement can positively affect their work. On the positive side, internal planners and evaluators are more likely to have insider knowledge of organizational factors that can be utilized or may have a positive effect on the delivery and success of the health program. Internal evaluators may experience divided loyalties, such as between the program and their job, between the program staff and other staff, or between the proposed program or evaluation and their view of what would be better.

A source of internal evaluators can be members of quality improvement teams, particularly if they have received any training in program development or evaluation as they relate to quality improvement. The use of total quality management (TQM), continuous quality improvement (CQI), and other quality improvement methodologies by healthcare organizations and public health agencies can be integral to achieving well-functioning programs. The quality improvement impetus of health care has been fueled by the use of standard measures of performance, such as the National Council on Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS). The wide use of HEDIS is not only a source of data for health program planners and evaluators, but also demonstrates the social value that is currently placed on data and on the evaluation of services, albeit for competitive purposes.

External evaluators can bring a fresh perspective and a way of thinking that generates alternatives not currently in the agencies' repertoire of approaches to the health problem and program evaluation. Compared to internal evaluators, external evaluators are less likely to be biased in favor of one approach—unless, of course, they were chosen for their expertise in a particular area, which would naturally bias their perspective to some extent. External program planners and evaluators can, however, be expensive consultants. Some organizations that specialize in health program evaluations serve as one category of external evaluator. These for-profit research firms, such as Mathematica and the Alpha Center, receive contracts to evaluate health program initiatives and conduct national evaluations that require sophisticated methodology and considerable resources.

The question of who does evaluations also can be answered by looking at who funds health program evaluations. From this perspective, organizations that do evaluations as a component of their business is the answer to who does evaluations. Although most funding agencies prefer to fund health programs rather than stand-alone program evaluations, there are some exceptions. For example, the Agency for Healthcare Research and Quality (AHRQ) funds health services research about

the quality of medical care, which is essentially effect evaluation research. Other federal agencies, such as the National Institutes of Health and the bureaus within the Department of Health and Human Services, fund evaluation research of pilot health programs. However, the funding priorities of these federal agencies change to be consistent with federal health policy. This is a reminder that organizations funding and conducting health program evaluations evolve over time.

Roles of Evaluators

Evaluators may be required to take on various roles, given that they are professionals involved in a process that very likely involves others. For example, as the evaluation takes on a sociopolitical process, the evaluators become mediators and change agents. If the evaluation is a learning–teaching process, evaluators become both teacher and student of the stakeholders. To the extent that the evaluation is a process that creates a new reality for stakeholders, program staff, and program participants, evaluators are reality shapers. Sometimes the evaluation may have an unpredictable outcome; at such times, evaluators are human instruments that gauge what is occurring and analyze events. Ideally, evaluations are a collaborative process, and evaluators act as collaborators with the stakeholders, program staff, and program participants. If the evaluation takes the form of a case study, the evaluators may become illustrators, historians, and storytellers.

These are but a few examples of how the roles of the professional program evaluator evolve and emerge from the situation at hand. The individual’s role in the planning and evaluation activities may not be clear at the time that the project is started. Roles will develop and evolve as the planning and evaluation activities progress.

PLANNING AND EVALUATION CYCLE

Although planning and evaluation are commonly described in a linear sequential manner, they constitute a cyclical process. In this section, the cycle is described along with an emphasis on factors that enhance and detract from that process being effective.

Interdependent and Cyclic Nature of Planning and Evaluation

A major premise running through the current thinking about programs and evaluation is that the activities constituting program planning and program evaluation are cyclical and interdependent (**Figure 1-1**) and that the activities occur more or less in stages or sets of activities. The stages are cyclical to the extent that the end of one

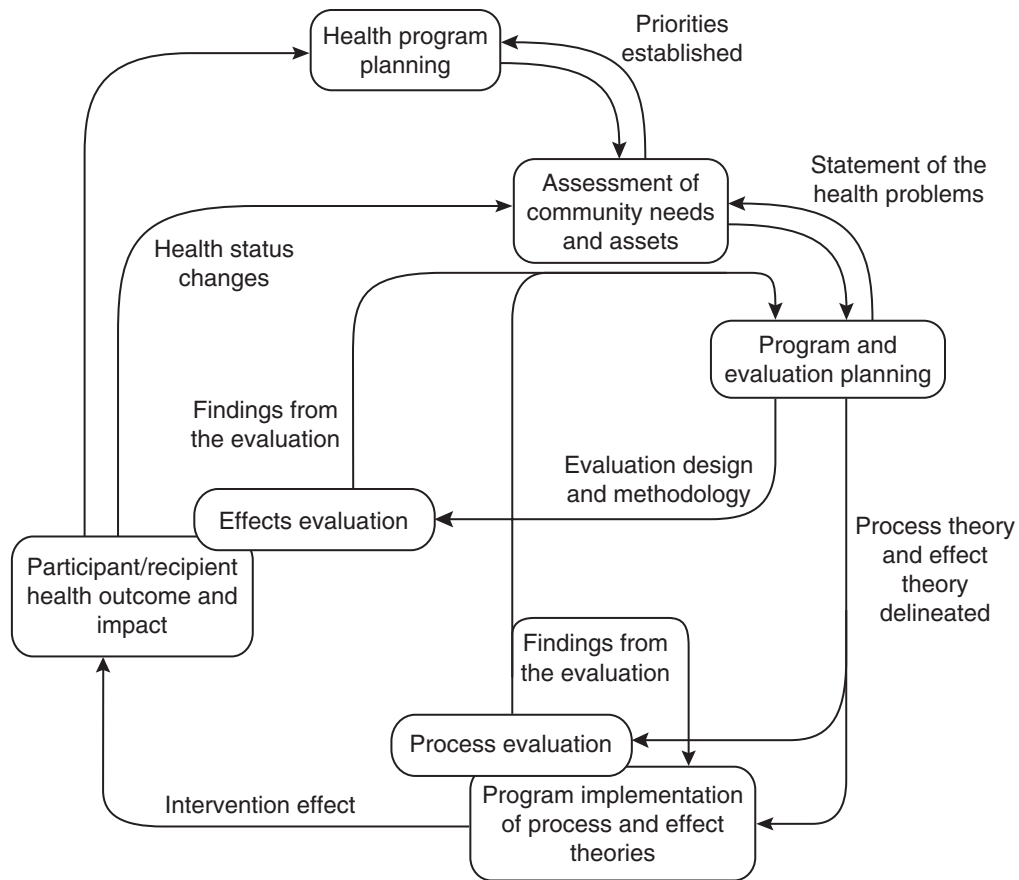


FIGURE 1-1 The Planning and Evaluation Cycle

program or stage flows almost seamlessly into the next program or planning activity. The activities are interdependent to the extent that the learning, insights, and ideas that result at one stage are likely to influence the available information and thus the decision making and actions of another stage. Interdependence of activities and stages is ideally a result of information and data feedback loops that connect the stages.

Naturally, not all of the possible interactions among program planning, implementation, and evaluation are shown in Figure 1-1. In reality, the cyclical or interactive nature of health program planning and evaluation exists in varying degrees. In the ideal, interactions, feedback loops, and reiterations of process would be reflected throughout this text. For the sake of clarity, however, the cycle is presented in a linear

fashion in the text, with steps and sequences covered in an orderly fashion across the progression of chapters. This pedagogical approach belies the true messiness of health program planning and program evaluation. Because the planning and evaluation cycle is susceptible to and affected by external influences, to be successful as a program planner or evaluator requires a substantial degree of flexibility and creativity in recovering from these influences. The cycle begins with a trigger event, such as awareness of a health problem, a periodic strategic planning effort, or newly available funds for a health program. This trigger event or situation leads to the collection of data about the health problem, the characteristics of the people affected, and their perceptions of the health problem. These data, along with additional data on available resources, constitute a community needs and assets assessment.

Based on the data from the needs assessment, program development begins. Problems and their solutions are prioritized. The planning phase includes developing the program theory, which explicates the connection between what is done and the intended effects of the program. Assessment of organizational and infrastructure resources for implementing the program, such as garnering resources to implement and sustain the program, is another component of the planning phase. Yet another major component of program planning is setting goals and objectives that are derived from the program theory.

After the resources necessary to implement the program have been secured and the activities that make up the program intervention have been explicated, the program can be implemented. The logistics of implementation include marketing the program to the target audience, training and managing program personnel, and delivering or providing the intervention as planned. During implementation of the program, it is critical to conduct an evaluation of the extent to which the program is provided as planned; this is the process evaluation. The data and findings from the process evaluation are key feedback items in the planning and evaluation cycle, and they can and ought to lead to revisions in the program delivery.

Ultimately, the health program ought to have an effect on the health of the individual program participants or on the recipients of the program intervention if provided to the community or a population. The evaluation can be an outcome evaluation of immediate and closely causally linked programmatic effects or an impact evaluation of more temporally and causally distal programmatic effects. Both types of evaluations provide information to the health program planners for use in subsequent program planning. Evaluation of the effects of the program provides data and information that can be used to alter the program intervention. These findings also can be used in subsequent assessments of the need for future or other health programs.

The model used throughout this text as a framework (Figure 1-1) is intended to be a generic representation of the steps and processes. It is one of many possible ways to characterize the planning and evaluation cycle. For example, along with the *Healthy People 2020* objects, the MAPIT model was introduced. MAPIT is the acronym for: **M**obilize the community, **A**ssess the health status, **P**lan the program, **I**mplement the program, and then **T**rack the outcomes. The model used for this text has a great deal of similarity with MAPIT. As a generic representation, the planning and evaluation cycle model used in this text includes the essential elements, but cannot provide detailed instructions on the “whens” and “hows,” as each situation will be slightly different.

Use of Evaluation Results as the Cyclical Link

Before embarking on either a process or an effect evaluation, it is important to consider who will use the results because, in being used, evaluation results are perpetuating the program planning and evaluation cycle. The usefulness of an evaluation depends on the extent to which questions that need to be answered are, in fact, answered. Naturally, different stakeholder groups that are likely to use evaluation findings will be concerned with different questions.

One stakeholder group is the funding organizations, whether federal agencies or private foundations. Funders may use process evaluations for program accountability and effect evaluations for determining the success of broad initiatives and individual program effectiveness. Another stakeholder group is the project directors and managers, who will use both process and effect evaluation findings as a basis for seeking further funding as well as for making improvements to the health program. The program staff is another stakeholder group that is likely to use both the process and the effect evaluation as a validation of their efforts and as a justification for their feelings about their success with program participants or recipients. Scholars and health professionals constitute another stakeholder group that accesses the findings of effect evaluations through the professional literature. Members of this group are likely to use effect evaluations as the basis for generating new theories about what is effective in addressing a particular health problem, and why it is effective.

Policy makers are yet another stakeholder group that uses both published literature and final program reports regarding process and effect evaluation findings when formulating health policy and making decisions about program resource allocation. Finally, community action groups, community members, and program participants and recipients form another group of stakeholders. This stakeholder group is most

likely to advocate for a community health assessment and to use process evaluation results as a basis for seeking additional resources or to hold the program accountable.

Thus far, this discussion has assumed the positive perspective that the evaluations will be used in productive ways. Of course, it is equally possible that the stakeholder groups may suppress, ignore, or discredit evaluations that are not favorable. This reality gains the most visibility in the health policy arena. An example will illustrate this point.

Mathematica, a private research firm, was hired by the Federal Maternal and Child Health Bureau (MCHB) of the Health Resources Services Administration to evaluate the effect of the Healthy Start Initiative programs funded by the MCHB (Howell et al., 1997). The Healthy Start Initiative funded local programs designed to reduce infant mortality and the rate of low birthweight births; each local Healthy Start program had a local evaluation. Mathematica evaluated a range of programmatic interventions in more than 20 locations, using much of the data from the local evaluations in addition to other data sources. The Mathematica meta-evaluation revealed a lack of evidence that the Healthy Start programs had an effect on the rates of infant mortality or low birth weight. These findings, however, were not used by the MCHB in subsequent requests to Congress for funds for the Healthy Start Initiative.

This story illustrates the tension that exists between health policy, which may be driven by contradictions between beliefs about what will work, and the “cold, hard facts” of both poorly and well-done evaluations. Political considerations involved in situations like these can be problematic. Regardless of the source of the political issues, planners and evaluators will encounter the occasional unexpected “landmine.”

Program Life Cycle

Feedback loops contribute to the overall development and evolution of a health program, giving it a life cycle from pilot to institutionalized. In the early stages of an idea for a health program, the program may begin as a pilot. That is, the program does not rely on any existing format or theory, so simple trial and error is used to determine whether it is feasible and might produce an effect. This is a *pilot program*. It is likely to be small and somewhat experimental because a similar type of program has not been developed or previously attempted.

If the pilot program appears to be successful and doable, as documented by both the process and effect evaluations, it may evolve into a model program. A *model program*

has interventions that are formalized, or explicit, with protocols that standardize the intervention, and the program is delivered under conditions that are controlled by the program staff and developers. The model program, because it is provided under ideal rather than realistic conditions, is difficult to sustain over time. Evaluating the effects of this type of program is easier than in a pilot program, however, because more stringent procedures have been developed for enrollment and follow-up of program participants.

If the model program shows promise for addressing the health problem, it can be copied and implemented as a prototype program. A *prototype program* is implemented under realistic conditions and, therefore, is easily replicated and tailored to the organization and the specifics of the local target audience. Finally, if the prototype health program is successful and stable, it may become *institutionalized* within the organization as an ongoing part of the services provided. It is possible for successful programs that are institutionalized across a number of organizations in a community to gain wide acceptance as standard practice, with the establishment of an expectation that a “good” agency will provide the program. At this last stage, the health program has become institutionalized within health services.

Regardless of the stage in a program’s life cycle, the major planning and evaluation stages of community assessment and evaluation are carried out. The precise nature and purpose of each activity vary slightly as the program matures (**Table 1-3**). Being aware of the stage of the program being implemented can help tailor the community assessment and evaluation.

This life cycle of a health program is reflected in the evolution of hospice care. Hospice—care for the dying in a home and family setting—began in London in 1967 as a grassroots service that entailed trial and error (pilot) about how to manage dying patients (Kaur, 2000). As its advocates saw the need for reimbursement for the service, they began to systematically control what was done and who was “admitted” to hospice. Once evaluations of these hospice programs began to yield findings that demonstrated their positive benefits, they become the model for more widespread programs that were implemented in local agencies or by new hospice organizations (prototypes). As the prototype hospice programs became accepted as a standard of care for the dying, the hospice programs became standard, institutionalized services for the organization. Today the availability and use of hospice services for terminally ill patients are accepted as standard practice, and most larger healthcare organizations or systems have established a hospice program. The evolution of hospice is but one example of how an idea for a “better” or “needed” program can gradually become widely available as routine care.

TABLE 1-3 Assessment, Implementation, and Evaluation Across the Program Life Cycle

Stage of Program	Community Assessment	Program Implementation	Program Evaluation
Pilot	Greater information about the target audience	Small number of participants; strict guidelines and protocols for intervention	Rigorous impact evaluation; rigorous process monitoring
Model	Greater information about the target audience	Realistic number of participants; use of previously set procedures	Outcome and impact assessment; rigorous process monitoring
Prototype	Very specific information about the local target audience and local variations on the health problem	Some flexibility and adaptation to local needs; realistic enrollment	Outcome and impact assessment; routine process monitoring
Organizationally institutionalized	More attention on assessment of organizational resources for program sustainability	Use standard operating procedures, organization specific	Outcome and impact assessment based on objectives; routine process monitoring
Professionally institutionalized	Rarely any detailed community assessment; more assessment of competitors and professional norms	Standard for professional practice, certification may be involved	Use professionally set standards as benchmarks of outcome and impact assessment

TYPES OF EVALUATION

Several major types of activities are classified as evaluations. Each type of activity requires a specific focus, purpose, and set of skills. The types of evaluations are introduced here as an overview of the field of planning and evaluation.

Community needs assessment (also known as community health assessment) is a type of evaluation that is performed to collect data about the health problems of a particular group. The data collected for this purpose are then used to tailor the health program to the needs and distinctive characteristics of that group. A community needs

assessment is a major component of program planning, being done at an early stage in the program planning and evaluation cycle. In addition, community assessments may be required to be completed on a regular basis. For example, many states do 5-year planning of programs based on state needs assessments.

Another type of evaluation begins at the same time that the program starts. *Process evaluations* focus on the degree to which the program has been implemented as planned and on the quality of the program implementation. Process evaluations are known by a variety of terms, such as monitoring evaluations, depending on their focus and characteristics. The underlying framework for designing a process evaluation comes from the process theory component of the overall program theory developed during the planning stage. The *process theory* delineates the logistical activities, resources, and interventions needed to achieve the health change in program participants or recipients. Information from the process evaluation is used to plan, revise, or improve the program.

The third type of evaluation seeks to determine the effect of the program—in other words, to demonstrate or identify the program’s effect on those who participated in the program. *Effect evaluations* answer a key question: Did the program make a difference? The effect theory component of the program theory is used as the basis for designing this evaluation. For the most part, evaluators seek to use the most rigorous and robust designs, methods, and statistics possible and feasible when conducting an effect evaluation. Thus, chapters of this text are devoted to various aspects of conducting effect evaluations with particular attention to the methods, designs, and samples needed to achieve scientific rigor, giving practical suggestions for maximizing rigor. Findings from effect evaluations are used to revise the program and may be used in subsequent initial program planning activities.

Effect evaluations are more commonly known as outcome or impact evaluations. *Outcome evaluations* focus on the more immediate effects of the program, whereas *impact evaluations* may have a more long-term focus. This language is not used consistently in the evaluation literature; indeed, the terms “impact evaluation” and “outcome evaluation” seem to be used interchangeably. Program planners and evaluators must be vigilant with regard to how they and others are using terms and should not hesitate to clarify meanings and address any underlying misconceptions or misunderstandings.

A fourth type of evaluation focuses on efficiency and the costs associated with the program. *Cost evaluations* encompass a variety of more specific cost-related evaluations—namely, cost-effectiveness evaluations, cost-benefit evaluations, and cost-utility evaluations. For the most part, cost evaluations are done by researchers because cost-benefit and cost-utility evaluations, in particular, require expertise in

economics. Nonetheless, small-scale and simplified cost-effectiveness evaluations can be done if good cost accounting has been maintained by the program and a more sophisticated outcome or impact evaluation has been conducted. The similarities and differences among these three types of cost studies are reviewed in greater detail in the text so that program planners can be, at minimum, savvy consumers of published reports of cost evaluations. Because cost evaluations are performed late in the planning and evaluation cycle, their results are not likely to be available in time to make program improvements or revisions. Instead, such evaluations are generally used during subsequent planning stages to gather information for prioritizing program options.

Comprehensive evaluations, the fifth type of evaluation, involve analyzing needs assessment data, process evaluation data, effect evaluation data, and cost evaluation data as a set of data. It is not uncommon for program staff to have each of these types of data available for further analyses; it is relatively uncommon, however, for the program to use all of these data to draw more sweeping conclusions about the effectiveness and efficiency of the program. In addition, for larger, more complex health programs, a comprehensive evaluation can be quite costly and challenging and, therefore, is less likely to be planned as an evaluation activity. It is possible to create a comprehensive evaluation from existing process and effect evaluations done over time, if the data can be collated and interpreted as a complete set of information. Comprehensive evaluations are more likely to be done for model or prototype programs, as a point of reference and to document the value of the program.

A sixth type of evaluation is a *meta-evaluation*. A meta-evaluation is done by combining the findings from previous outcome evaluations of various programs for the same health problem. The purpose of a meta-evaluation is to gain insights into which of the various programmatic approaches has had the most effect and to determine the maximum effect that a particular programmatic approach has had on the health problem. This type of evaluation relies on the availability of existing information about evaluations and on the use of a specific set of methodological and statistical procedures. For these reasons, meta-evaluations are less likely to be done by program personnel; instead, they are generally carried out by evaluation researchers. Meta-evaluations that are published are extremely useful in program planning because they indicate which programmatic interventions are more likely to succeed in having an effect on the participants. Published meta-evaluations can also be valuable in influencing health policy and health funding decisions.

Summative evaluations, in the strictest sense, are done at the conclusion of a program to provide a conclusive statement regarding program effects. Unfortunately, the

term “summative evaluation” is sometimes used to refer to either an outcome or impact evaluation, adding even more confusion to the evaluation terminology and vernacular language. Summative evaluations are usually contrasted with *formative evaluations*. The term *formative evaluation* is used to refer to program assessments that are performed early in the implementation of the program and used to make changes to the program. Formative evaluations might include elements of process evaluation and preliminary effect evaluations.

Mandated and Voluntary Evaluations

Evaluations are not spontaneous events. Rather, they are either mandated or voluntary. A mandate to evaluate a program is always linked in some way to the funding agencies, whether a governmental body or a foundation. If an evaluation is mandated, then the contract for receiving the program funding will include language specifying the parameters and timeline for the mandated evaluation. The mandate for an evaluation may specify whether the evaluation will be done by project staff or external evaluators or both. For example, the State Child Health Insurance Program (SCHIP) was created in 1998 as a federally funded and mandated program to expand insurance coverage to children just above the federal poverty level. Congress has the authority to mandate evaluations of federal programs and did just that with the SCHIP. In 2003, Wooldridge and associates from the Urban Institute published an interim report on the implementation of SCHIP. This is just one example of a federal program having a mandated evaluation.

Other evaluations may be linked to accreditation that is required for reimbursement of services provided, making them *de facto* mandated evaluations. For example, to receive accreditation from the Joint Commission, a health services organization must collect data over time on patient outcomes. These data are then used to develop ongoing quality improvement efforts. A similar process exists for mental health agencies. The Commission on Accreditation of Rehabilitation Facilities (CARF) requires that provider organizations conduct a self-evaluation as an early step in the accreditation process. These accreditation-related evaluations apply predominantly to direct care providers, rather than to specific programs.

Completely voluntary evaluations are initiated, planned, and completed by the project staff in an effort to make improvements. However, given the relatively low reward from, and cost associated with, doing an evaluation when it is not required, these evaluations are likely to be small with low scientific rigor. Programs that engage

voluntarily in evaluations may have good intentions, but they often lack the skills and knowledge required to conduct an appropriate evaluation.

When Not to Evaluate

Situations and circumstances that are not amenable to conducting an evaluation do exist, despite a request or the requirement for having an evaluation. Specifically, it is not advisable to attempt an evaluation under the following four circumstances: when there are no questions about the program, when the program has no clear direction, when stakeholders cannot agree on the program objectives, and when there is not enough money to conduct a sound evaluation (Patton, 2008). In addition to these situations, Weiss (1972) recognized that sometimes evaluations are requested and conducted for less than legitimate purposes, namely: to postpone program or policy decisions, thereby avoiding the responsibility of making the program or policy decision; to make a program look good as a public relations effort; or to fulfill program grant requirements. As these lists suggest, those engaged in program planning and evaluation need to be purposeful in what is done and should be aware that external forces can influence the planning and evaluation processes.

Since Weiss made her observation in 1972, funders have begun to require program process and effect evaluations, and conducting these evaluations to meet that requirement is considered quite legitimate. This change has occurred as techniques for designing and conducting both program process and effect evaluations have improved, and the expectation is that even mandated evaluations will be useful in some way. Nonetheless, it remains critical to consider how to conduct evaluations legitimately, rigorously, inexpensively, and fairly. In addition, if the AEA standards of utility, feasibility, propriety, and accuracy cannot be met, it is not wise to conduct an evaluation (Patton, 2008).

Interests and the degree of influence held by stakeholders can change. Such changes affect not only how the evaluation is conceptualized, but also whether evaluation findings are used. In addition, the priorities and responsibilities of the organizations and agencies providing the program can change during the course of delivering the program, which can then lead to changes in the program implementation that have not been taken into account by the evaluation. For example, if withdrawal of resources leads to a shortened or streamlined evaluation, subsequent findings may indicate a failure of the program intervention. However, it will remain unclear whether the apparently ineffective intervention was due to the design of the program or the design of the evaluation. In addition, unanticipated problems in delivering the

program interventions and the evaluation will always exist. Even rigorously designed evaluations face challenges in the real world stemming from staff turnover, potential participants' noninvolvement in the program, bad weather, or any of a host of other factors that might hamper achieving the original evaluation design. Stakeholders will need to understand that the evaluator attempted to address challenges as they arose, if they are to have confidence in the evaluation findings.

THE PUBLIC HEALTH PYRAMID

As part of the Government Performance and Results Act (GPRA) of 1993, U.S. federal agencies were directed to evaluate their services and effectiveness. One agency, the Maternal and Child Health Bureau of the Health Resources Services Administration, administers several entitlement programs, including Title V, which provides funds to states for maternal and child health improvement programs. One step toward complying with the GPRA was the development of standard performance measures for the Title V programs. To address the range of health issues covered under Title V, a model was developed under the leadership of the director, Pete Van Dyke, in which the range of services could be categorized. The model became known as “the pyramid” among the state and local maternal and child health programs that received Title V funds. Although the pyramid was developed for use with state maternal and child health programs, it has applicability and usefulness as an overarching framework for public health program planning and evaluation.

Pyramids tend to be easy to understand and work well to capture tiered concepts. For these reasons, other agencies in the federal government also have relied on pyramids to depict tiered services. For example, the U.S. Public Health Service used the Health Care Pyramid (U.S. Public Health Service, 1994) to show the tiered nature of primary health care, secondary health care, and tertiary health care. At the base of that pyramid was population services, which has a corresponding level in the public health pyramid.

The public health pyramid is divided into four sections (**Figure 1-2**). The top, first section of the pyramid contains direct healthcare services, such as medical care, psychological counseling, hospital care, and pharmacy services. At this level of the pyramid, programs are delivered to individuals, whether patients, clients, or even students. Generally, programs at the direct services level have a direct, and often relatively immediate, effect on individual participants in the health program. Direct services of these types appear at the tip of the pyramid to reflect that, overall, the smallest proportion of a population receives them.

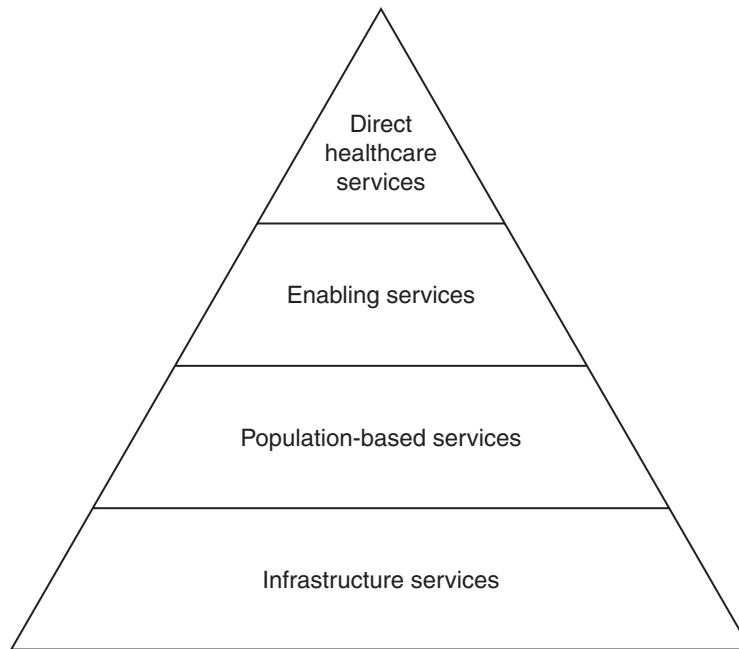


FIGURE 1-2 The Public Health Pyramid

At the second level of the pyramid are enabling services, which are those health and social services that support or supplement the health of aggregates. *Aggregates* are used to distinguish between individuals and populations; they are groups of individuals who share a defining characteristic, such as mental illness or a terminal disease. Examples of enabling services include mental health drop-in centers, hospice programs, financial assistance programs that provide transportation to medical care, community-based case management for AIDS patients, nutrition education programs provided by schools, and workplace child care centers. As this list of programs demonstrates, the services at this level may directly or indirectly contribute to the health of individuals, families, and communities and are provided to aggregates.

The next, more encompassing level of the public health pyramid is population-based services. At the population level of the pyramid, services are delivered to an entire population, such as all persons residing in a city, state, or country. Examples of population services include immunization programs for all children in a county, newborn screening for all infants born in a state, food safety inspections carried out under the auspices of federal regulations, workplace safety programs, nutrition labeling on

food, and the Medicaid program for pregnant women whose incomes fall below the federal poverty guidelines. As this list reflects, the distinction between an aggregate and a population can be blurry. Programs at this level typically are intended to reach an entire population, sometimes without the conscious involvement of individuals. In this sense, individuals receive a population-based health program, such as water fluoridation, rather than participating in the program, as they would in a smoking-cessation class. Within public health and across the health disciplines, social determinants of health have gained greater attention. Interventions and programs aimed at changing the socioeconomic context within which populations live would be included at this population level of the pyramid. Population-level programs contribute to the health of individuals and, cumulatively, to the health status of the population.

Supporting the pyramid at its base is the infrastructure of the healthcare system and the public health system. The health services at the other pyramid levels would not be possible unless there were skilled, knowledgeable health professionals; laws and regulations pertinent to the health of the people; quality assurance and improvement programs; leadership and managerial oversight; health planning and program evaluation; information systems; and technological resources. The planning and evaluation of health programs at the direct, enabling, and population services levels is itself a component of the infrastructure; these are infrastructure activities. In addition, planning programs to address problems of the infrastructure, as well as to evaluate the infrastructure itself, are needed to keep the health and public health system infrastructure strong, stable, and supportive of the myriad of health programs.

Use of the Public Health Pyramid in Program Planning and Evaluation

Health programs exist across the pyramid levels, and evaluations of these programs are needed. However, at each level of the pyramid, certain issues unique to that level must be addressed in developing health programs. Accordingly, the types of health professionals and the types of expertise needed vary by pyramid level, reinforcing the need to match program, participants, and providers appropriately. Similarly, each level of the pyramid is characterized by unique challenges for evaluating programs. For this reason, the public health pyramid is an extremely useful framework to help illuminate those differences, issues, and challenges, as well as to reinforce that health programs are needed across the pyramid levels if the *Healthy People 2020* goals and objectives are to be achieved.

In a more general sense, the public health pyramid provides reminders that various aggregates of potential audiences exist for any health problem and program and that health programs are needed across the pyramid. Depending on the health discipline and the environment in which the planning is being done, direct service programs may

be the natural or only inclination. The pyramid provides a rationale for thinking about only those programs needed to improve the health of the people who are appropriately at the direct services level. It is both difficult and expensive to reach the same number of persons with a direct services program as with a population services program.

The pyramid also serves as a reminder that stakeholder alignments and allegiances may be specific to a level of the pyramid. For example, a school health program (an enabling-level program) will have a different set of constituents and concerned stakeholders than a highway safety program (a population-level program). The savvy program planner considers not only the potential program participants at each level of the pyramid, but also the stakeholders who are likely to make themselves known during the planning process.

The public health pyramid has particular relevance for public health agencies concerned with addressing the three core functions of public health (Institute of Medicine, 1988): assessment, assurance, and policy. These core functions are evident, in varying forms, at each level of the pyramid. Similarly, the pyramid can be applied to the strategic plans of organizations in the private healthcare sector. For optimal health program planning, each health program being developed or implemented ought to be considered in terms of its relationship to services, programs, and health needs at other levels of the pyramid. For all of these reasons, the public health pyramid is used throughout this text as a framework for summarizing specific issues and applications of chapter content to each level of the pyramid and to identify and discuss potential or real issues related to the topic of the chapter.

The public health pyramid has been used in the education and training of public health nutritional personnel (Mixon, 2002), for explaining services provided to children with special healthcare needs (Colorado Department of Public Health and Environment, n.d.), and for education of general health professionals (Rocky Mountain Public Health Education Consortium, 2004). Other health and human service agencies have used pyramids to help explain the organization of services. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) used a pyramid to explain expenditures for mental health services. Its Mental Health Services Pyramid was included in the agency's annual report to Congress (Center for Mental Health Services, 2000).

The Public Health Pyramid as an Ecological Model

Individual behavior and health are now understood to be influenced by the social and physical environment of individuals. This recognition is reflected in the growing use of the ecological approach to health services and public health programs.

The ecological approach, which stemmed from systems theory applied to individuals and families (Bronfenbrenner, 1970, 1989), postulates that individuals can be influenced by factors in their immediate social and physical environment. This perspective has been expanded into the social determinants perspective in public health, which has wide acceptance (Friedan, 2010). The individual is viewed as a member of an intimate social network, usually a family, which is a member of a larger social network, such as a neighborhood or community. The way in which individuals are nested within these social networks has consequences for the health of the individual.

The public health pyramid, by distinguishing and recognizing the importance of enabling and population services, can be integrated with an ecological view of health and health problems. If one were to look down on the pyramid from above, the levels would appear as concentric squares (**Figure 1-3**)—direct services for individuals nested

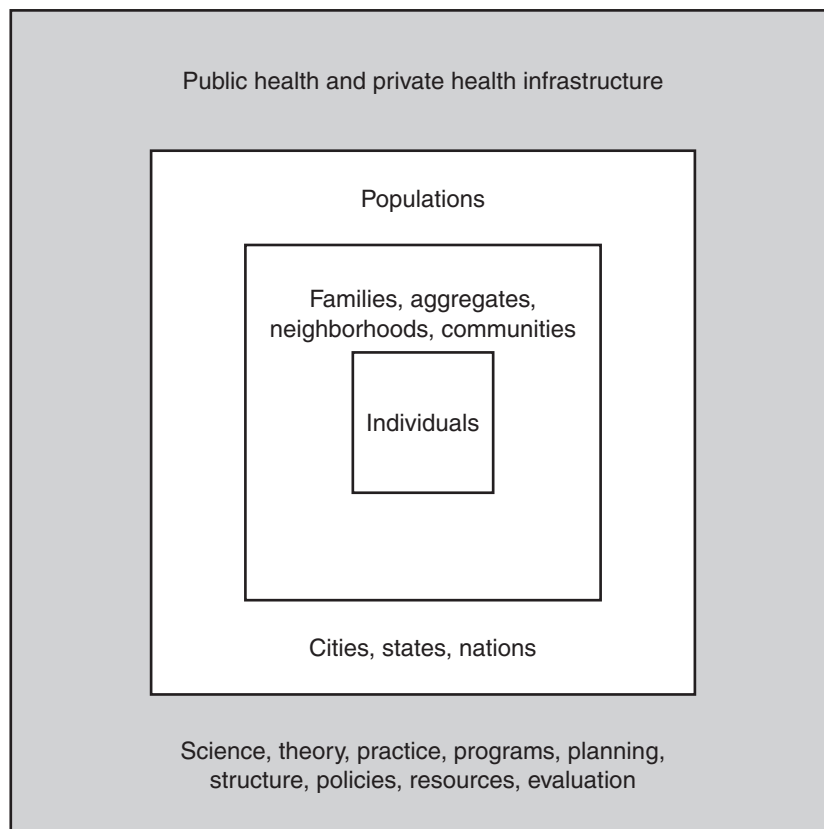


FIGURE 1-3 The Pyramid as an Ecological Model

within enabling services for families, aggregates, and neighborhoods, which are in turn nested within population services for all residents of cities, states, or countries. This is similar to individuals being nested within the enabling environment of their family, workplace setting, or neighborhood, all of which are nested within the population environment of factors such as social norms and economic and political environments. The infrastructure of the healthcare system and public health system is the foundation and supporting environment for promoting health and preventing illnesses and diseases.

At the end of the chapter, a summary of the chapter contents is presented in the form of challenges or issues related to applying the chapter content to each level of the pyramid. This feature is intended to reinforce the message that each level of the pyramid has value and importance to health program planning and evaluation. In addition, certain unique challenges are specific to each level of the pyramid. The chapter summary by levels offers an opportunity to acknowledge and address the issues related to the levels.

Health Programs, Projects, and Services

What distinguishes a program from a project or from a service can be difficult to explain, given the fluidity of language and terms. The term *program* is fairly generic, but generally connotes a structured effort to provide a specific set of services or interventions. In contrast, a *project* often refers to a time-limited or experimental effort to provide a specific set of services or interventions through an organizational structure. In the abstract, a *service* can be difficult to define but generally includes interaction between provider and client, an intangibility aspect to what is provided, and a nonpermanence or transitory nature to what is provided. Using this definition of service, it is easy to see that what is provided in a health program qualifies as a service, although it may not be a health service.

A *health program* is a totality of an organized structure designed for the provision of fairly discrete health-focused intervention, where that intervention is designed for a specific target audience. By comparison, *health services* are the organizational structures through which providers interact with clients or patients so as to meet the needs or address the health problems of the clients or patients. Health programs, particularly in public health, tend to provide educational services, have a prevention focus, and deliver services that are not at the direct services level of the pyramid. In contrast, health services exist exclusively at the direct services level of the public health pyramid. Recognizing the distinction between health programs and health services is important for understanding the corresponding unique planning and evaluation needs of each. The approach used in this text considers those unique differences through the perspective of the public health pyramid.

LAYETTEVILLE AND BOWE COUNTY

As an aid to understanding and assimilating the content covered, examples are given from the literature. In addition, chapters include some application of content to a hypothetical town (Layetteville) in an imaginary county (Bowe County). Based on a fictional community needs assessment, subsequent prioritization leads to the identification of five health problems as foci for health program planning. These health problems are used throughout the text as opportunities to demonstrate application of the chapter content. Also, some discussion questions and activities use Layetteville and Bowe County as opportunities for the reader to practice applying the chapter content. While the town and county are fictitious, the health problems around which the program planning and evaluation occur are very real and relevant.

ACROSS THE PYRAMID

At the direct services level, health program planning and evaluation focus on individual clients or patients—that is, on developing programs that are provided to those individuals and on assessing the extent to which those programs make a difference in the health of the individuals who receive the health program. Health is defined in individual terms, and program effects are measured as individual changes. From this level of the public health pyramid, community is most likely viewed as the context affecting individual health.

At the enabling services level, health program planning and evaluation focus on the needs of aggregates of individuals and on the services that the aggregate needs to maintain health or make health improvements. Enabling services are often social, educational, or human services that have an indirect effect on health, thus warranting their inclusion in planning health programs. Health continues to be defined and measured as an individual characteristic to the extent that enabling services are provided to individual members of the aggregate. However, program planning and evaluation focus not on individuals but rather on the aggregate as a unit. At this level of the pyramid, community can be either the aggregate that is targeted for a health program or the context in which the aggregate functions and lives. How community is viewed will depend on the health problem being addressed.

At the population-based services level, health program planning and evaluation focus on the needs of all members of a population. At this level of the pyramid, health programs are at a minimum population driven, meaning that data collected in regard to the health of the population drive the decisions about the health program. This approach results in programs that are population focused and, ideally (but not necessarily),

population based. It is worth noting that population-focused programs tend to have a health promotion or health maintenance focus, rather than a focus on treatment of illnesses. At a population level, health is defined in terms of population statistics, such as mortality and morbidity rates. In this regard, the *Healthy People 2020* objectives (Table 1-4) are predominantly at the population level of the public health pyramid. Community is more likely to be the population targeted by the health program.

TABLE 1-4 A Summary of the *Healthy People 2020* Priority Areas

- | | |
|--|--|
| 1. Access to quality health services | 20. Hearing and other sensory or communication disorders |
| 2. Adolescent health | 21. Heart disease and stroke |
| 3. Arthritis, osteoporosis, and chronic back conditions | 22. HIV |
| 4. Blood disorders and blood safety | 23. Immunization and infectious diseases |
| 5. Cancer | 24. Injury and violence prevention |
| 6. Chronic kidney disease | 25. Lesbian, gay, bisexual, and transgender health |
| 7. Dementias, including Alzheimer’s disease | 26. Maternal, infant, and child health |
| 8. Diabetes | 27. Medical product safety |
| 9. Disability and secondary conditions | 28. Mental health and mental disorders |
| 10. Early and middle childhood | 29. Nutrition and weight status |
| 11. Educational and community-based programs | 30. Occupational safety and health |
| 12. Environmental health | 31. Older adults |
| 13. Family planning | 32. Oral health |
| 14. Food safety | 33. Physical activity |
| 15. Genomics | 34. Preparedness |
| 16. Global health | 35. Public health infrastructure |
| 17. Health communication and health information technology | 36. Respiratory diseases |
| 18. Healthcare-associated infections | 37. Sexually transmitted diseases |
| 19. Health-related quality of life and wellbeing | 38. Sleep health |
| | 39. Social determinants of health ¹ |
| | 40. Substance abuse |
| | 41. Tobacco use |
| | 42. Vision |

¹Under development

Source: Department of Health and Human Services. Retrieved September 11, 2012, from www.cdc.gov/nchs/healthy_people/hp2020/hp2020_topic_areas.htm.

At the infrastructure level, health program planning and evaluation are infrastructure activities of both the public health system and the healthcare system. Infrastructure includes organizational management, acquisition of resources, and development of health policy. A significant document reflecting health policy is *Healthy People 2020*, which outlines the goals and objectives for the health of the people of the United States. These national objectives are considered when setting priorities and are used by many federal and nongovernmental funding agencies, which often require that a health program identify which *Healthy People 2020* objectives are being addressed. To the extent that health planners and evaluators are familiar with these objectives, they will be better able to design appropriate programs and then to argue in favor of the relevance of each of those programs. At the infrastructure level, health can be defined in terms of the individual workers in the healthcare sector (an aggregate). More to the point, because program planning and evaluation are infrastructure activities, it is actually at the infrastructure level that the decisions are made on the definition of health to be used in the program. Similarly, the way that community is viewed is determined at the infrastructure level.

DISCUSSION QUESTIONS

1. When and under what conditions might it be advisable not to conduct an evaluation?
2. Oral health is a major health problem, especially for children living in poverty. Describe how an oral health program developed at each level of the public health pyramid would differ and how the considerations would differ.
3. Conduct a literature search using words such as “planning,” “evaluation,” “program,” and a health condition of interest to you. Which journals publish articles about health program planning and health program evaluations? What are the current trends in the field as reflected in the published literature that you reviewed?
4. Access and review the material in the following document and compare it with the perspective given in this chapter: Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report*, 48(RR-11): i-41. Retrieved August 31, 2012, from www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm.

INTERNET RESOURCES

American Evaluation Association

This international, professional organization of evaluators is devoted to the application and exploration of program evaluation, personnel evaluation, technology, and many other forms of evaluation. The AEA website (www.eval.org/resources.asp) includes links to professional groups, foundations, online publications, and other resources related to evaluation.

Centers for Disease Control and Prevention

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report*, 48(RR-11): i–41. Retrieved August 31, 2012, from www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm. This online textbook describes the steps involved in conducting an evaluation.

Evaluation Center of Western Michigan University

This organization focuses on advancing the theory and practice of program, personnel, and student/constituent evaluation, as applied primarily to education and human services. Its website (www.wmich.edu/evalctr/home) has links and a set of checklists that can be used to improve the quality of an evaluation project.

The Evaluation Exchange

Harvard Family Research Project's evaluation periodical, *The Evaluation Exchange*, addresses current issues facing program evaluators of all levels, with articles written by the most prominent evaluators in the field. Designed as an ongoing discussion among evaluators, program practitioners, funders, and policy makers, The Evaluation Exchange highlights innovative methods and approaches to evaluation, emerging trends in evaluation practice, and practical applications of evaluation theory. It goes out to its subscribers free of charge four times per year. It can be accessed via the Internet at www.gse.harvard.edu/hfrp/eval.html.

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