Aboriginal Health Transition Fund Evaluation Framework

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1. Introduction

This paper sets out a framework to guide the national evaluation of the Aboriginal Health Transition Fund (AHTF). The framework is also a guide for regional, provincial and project evaluations of AHTF-funded initiatives, since evaluations at these levels will contribute important information to the national evaluation.

The main focus of the framework is assessing progress toward the achievement of the AHTF's expected results. Evaluation at any level may deal with a variety of other subject areas, such as relevance, *sustainability*[1], cost-effectiveness and administrative processes, as outlined in Section 3.

This national framework is designed to be general and flexible enough to capture the results from a diversity of *adaptation* and *integration* initiatives in communities across the country. It was developed from an earlier draft prepared by Health Canada and informed by wide discussions with representatives of Health Canada (national and regional), provincial/ territorial (p/t) governments and five National Aboriginal Organizations (NAOs).

2. Background on AHTF

Objectives

There is growing recognition that closing the gap in health status between Aboriginal and non-Aboriginal Canadians requires coordinated efforts by all those involved in Aboriginal health. The AHTF was created to support:

- First Nations and Inuit communities and organizations to integrate existing federally funded health systems within First Nations and Inuit communities with provincial and territorial health systems; and
- Provinces and territories to adapt their existing health services to better meet the needs of all Aboriginal peoples, including First Nations, Inuit, Métis, and those living off reserve and in urban areas.

The AHTF program objectives are:

- To improve the *integration* of federal and p/t funded health services;
- To improve access to health services;
- To make available health programs and services that are better suited to First Nations and Métis peoples and Inuit; and
- To increase the *participation* of Inuit, First Nations and Métis peoples in the design, delivery and evaluation of health programs.

[1] Note that words in italics throughout the text are defined in Annex A, Glossary of Terms.

The AHTF is expected to contribute to the strategic *outcome* of the First Nations and Inuit Health Branch (FNIHB), Health Canada – better health *outcomes* in First Nations and Inuit communities and reduction of health inequalities between First Nations and Inuit, and other Canadians.

Funding Envelopes

The AHTF provides transitional funding to provincial and territorial governments, First Nations and Inuit communities and National Aboriginal Organizations (NAOs) through three envelopes:

a) *Adaptation*: to support provincial and territorial governments to adapt their existing health programs to the unique needs of all Aboriginal peoples including those living off reserve and in urban areas and Métis settlements and communities.

b) *Integration*: to improve the coordination and *integration* between p/t health systems and federally funded health systems within Inuit and First Nations communities.

c) Pan-Canadian: to support cross-jurisdictional *integration* and *adaptation* initiatives in three streams: First Nations, Inuit, and Métis. Funding is for *capacity building* of NAOs, workshops, evaluation activities and the overall administration of the AHTF.

Examples of possible *adaptation* activities:

- Inclusion of Aboriginal peoples and their representatives in the development of regional health authority plans and priorities, programs and services designed to meet the needs of First Nations, Inuit, and Métis.
- Expansion of existing mental health programs to better address the needs of all Aboriginal peoples including Inuit, First Nations and Métis.
- Development of p/t health and wellness strategies to include specific programs that address the issues and concerns identified by Aboriginal peoples, including those for First Nations, Inuit, and Métis.
- Involvement of Métis, First Nations and Inuit in the design of regional and facility-specific programs and services.
- Design of special palliative care services to better serve Aboriginal populations in need.
- Enhancement of off-reserve and urban Aboriginal, *gender*-based and women's perspectives within existing p/t programs and services.
- Provision of elders' rooms in acute care facilities.

Examples of possible *integration* activities:

- Closer working relationships between clinics on-reserve and regional health authorities.
- Development of consolidated health centres to serve on-reserve and surrounding off-reserve communities.
- Complementary federal/p/t public health protocols to support rapid treatment in the event of a disease outbreak.
- Development of common protocols and procedures for health services on- and off-reserve, such as screening procedures for cancer.
- Review and evaluation of integrated systems within a province/territory, such as gap analyses, *outcome* assessments, and planning for future *integration*.
- Coordinated standards and access rules for sharing patient information between and across jurisdictions.

Examples of possible pan-Canadian activities:

- Increasing the *capacity* for pan-Canadian health leadership and influence in the federal/provincial/territorial/regional jurisdictions for Inuit, First Nations and Métis.
- Identification of common approaches for health promotion across jurisdictions, such as, pan-Inuit alcohol and drug survey methods.
- Development of best practices and standards for specific screening and treatment of Métis, Inuit and First Nations.
- Establishing mechanisms and guidelines for community consultation to shape regional or national policies among Inuit, First Nations, Métis and off-reserve and urban Aboriginal groups.
- Development of national tools and mechanisms for health education, such as, a video on prenatal health.

3. AHTF Evaluation

Objectives

The national AHTF evaluation will serve three objectives:

a) To report on the progress achieved towards the stated *outcomes* of the AHTF;
b) To learn from the experiences of the projects: what worked and why, what didn't work and why, and how lessons can be applied to future work related to Aboriginal health; and
c) To lay the groundwork for any future policy development in *adaptation* and *integration*.

Many of those consulted in preparing this framework wanted emphasis placed on the second objective, learning. They saw the need to create opportunities within the evaluation for sharing experiences and effective practices.

Treasury Board Requirements

Treasury Board guidelines outline three issues that need to be addressed in federal program evaluations.

- Relevance: Is the program consistent with departmental and government-wide priorities and does it realistically address an actual need?

- Results: Is the program effective in meeting its objectives, within budget and without unwanted *outcomes*?

- Cost-effectiveness: Was the program cost-effective relative to other ways of achieving the same *outcomes*?

Scope and Focus

Section 6 (page 9) provides results and indicators at the national level for AHTF. The national evaluation will assess the extent to which these results have been achieved. The national-level results and indicators also serve as a guide to individual projects, provinces, territories, regions and NAOs and their affiliates in designing their results frameworks. Evaluations at all levels may, however, deal with additional issues depending on what is most important and relevant at the time of the evaluation. A comprehensive list of standard evaluation topics and questions appears in Annex B.

The following questions will help focus the national evaluation. They were the questions mentioned most frequently during discussions with NAOs, Health Canada and provincial/ territorial governments.

Results

- To what extent are *gender* equality considerations fully integrated in project design and implementation and reflected in the results?
- To what extent has the AHTF increased the *capacity* of Inuit, Métis, and First Nations communities and organizations to develop vision, strategies and leadership to address jurisdictional issues?

Relevance

- Are *adaptation* and *integration* the solutions to poor health status of First Nations, Inuit and Métis and their inequitable access to services?

Effectiveness

- To what extent has the AHTF allowed sufficient time to build the relationships that lead to the *adaptation* and *integration* of programs and services over the longer term?

Management

- How effective was the implementation phase of the AHTF and what improvements could be made?
- How effective have the oversight and approval processes been for program implementation?

While these are some of the issues currently identified by *partners* and *affected parties*[2], other issues and topic areas may arise toward the end of the program when the national evaluation is carried out.

4. Evaluation Principles

Below are some guiding principles for evaluation, including a number that touch on cultural competency and the evaluation of systems change. The national evaluation will adhere to these principles and evaluations at other levels are encouraged to do the same.

1. Evaluation is about learning, and creating and sharing knowledge. Evaluations need to be designed to ensure maximum opportunities to engage *partners* and *affected parties* in discussions around lessons and their implications.

2. There is no single best way to undertake evaluation, or any one best plan or methodology. It is, however, considered good practice to use multiple methods and data sources. This is consistent with the recognition that there are many perspectives, and that individual effects ripple through the family, community and nation.

[2] Partners and affected parties of *integration projects* include: First Nations and Inuit populations; regional and national First Nations and Inuit organizations; the provinces and territories and their associated structures and FNIHB of Health Canada and the broader federal health portfolio. For *adaptation projects* and the AHTF as a whole, the definition expands to include First Nations, Inuit, and Métis in all regions and communities regardless of their relationship to the *Indian Act* and regardless of their place of residence (urban, rural, remote, arctic regions on-reserve or off-reserve); regional and NAOs (AFN, ITK, MNC, Congress of Aboriginal Peoples, and Native Women's Association of Canada).

3. Context is critical in undertaking evaluation, and a holistic framing of the issues and questions, along with a sense of the interrelationship of the different actors and components – services, systems, communities, and so on – is required. In this regard, evaluation must take into account traditional ways of knowing and varying worldviews.

4. Flexibility is required when implementing the evaluation framework in light of the diversity of the communities and nations.

5. All evaluations should adhere to Canadian ethical standards for social research and evaluation.

6. The design and implementation of each evaluation should involve the active *participation* of Aboriginal peoples including First Nations, Inuit, Métis and p/t partners.

7. With regard to results, evaluations conducted toward the end of a program should focus on assessing progress towards the achievement of the *immediate* and, in particular, the *intermediate outcomes*.

8. Evaluations should always assess the extent to which *gender* equality has been integrated in the project design and implementation. All projects should have a *gender-based analysis* as part of the design.

9. The evaluation process should be used to build evaluation *capacity* with Aboriginal communities and organizations, including First Nations, Inuit and Métis. For this reason, the AHTF Secretariat, the provinces/territories and funding recipients should engage evaluation specialists early in the project cycle rather than at the end.

10. Evaluation design and implementation should be consistent with this national evaluation framework and based on project logic models, as illustrated in Section 5 and Annex C.

11. Evaluations should be useful and relevant to communities.

12. Evaluation should respect the significance of relationship building as an outcome, and the processes and investments required to build relationships in different contexts.

13. Evaluation must recognize that systems and structural changes are rarely linear or sequential. They often occur in spurts after periods of preparation or apparent stagnation.

14. Evaluations should be situated in the larger context of *sustainability* and other over-arching factors affecting Aboriginal health (holistic worldview).

15. Evaluation activities should be proportionate to the size of the project initiative.

5. AHTF Logic Model

This section provides a program logic model for AHTF, followed in the next section by expected AHTF *outcomes* and indicators. The AHTF Secretariat will monitor implementation against these results and indicators. Funding recipients are encouraged to gather, wherever possible, information in relation to these results and indicators at the project level, since these data will be helpful to the national evaluation. A logic model for each of the three AHTF funding envelopes appears in Annex C.

AHTF Logic Model

Long term Outcomes

- Improved health programs & services for Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas
- Improved access to quality health programs & services by Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas

Intermediate Outcomes

- Improved *integration* of federal & p/t health systems, programs & services for First Nations & Inuit
- Improved *adaptation* of p/t health systems, programs & services to the needs of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas

Immediate Outcomes

- Increased *capacity* for integrating federal, p/t health systems, programs & services to the needs of First Nations & Inuit
- Increased *capacity* for adapting p/t health systems, programs & services to the needs of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas
- Increased awareness among *partners* & *affected parties* of the concepts, barriers & enablers to *adaptation* & *integration*
- Increased *participation* of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas in the design, delivery & evaluation of services
- Increased *collaboration* & strengthened *partnerships* among federal, p/t governments & Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas

Outputs

- Minutes of Adaptation and Integration Committee meetings; funding guides & toolkits, project proposals; plans; signed contribution agreements; progress reports; financial reports; monitoring & evaluation reports; applied research

Activities

- *Communication* & collaboration with *partners* & *affected parties*; preparation of a funding guide & toolkit; funding processes (submission, review, approval); oversight & monitoring; workshops

Inputs

- $200 million in contribution funds, O & M funds, consultants and experts, FTEs

6. Outcomes and Indicators

This section provides indicators that will be used to measure the *outcomes* or results of the AHTF at the national level for all envelopes. The indicators relate only to the AHTF's expected results, not to other issues, such as cost-effectiveness, relevance and *sustainability,* which may also be examined as part of the national evaluation.

The matrix below outlines *immediate outcomes, intermediate outcomes and long-term outcomes.* The national evaluation will assess the achievement of *outcomes* at the immediate and intermediate levels only. *Long-term outcomes* are much more difficult to assess because there are many factors that could influence them beyond the program itself. As well, *long-term outcomes* are usually assessed long after a program ends.

AHTF Outcomes and Indicators

Long-term Outcomes	**Indicators**
1. Improved health programs & services for Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas	1.1 # and % of programs & services where one or more improvements have been made that are better suited to the needs of Aboriginal peoples, including First Nations, Inuit, Métis & those living off-reserve & in urban areas (female & male) 1.1 Quality of programs & services as perceived by Aboriginal peoples, including First Nations, Inuit, Métis & those living off reserve & in urban areas (f & m)
2. Improved access to quality health programs & services by Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas	2. 1 # and % of health programs & services that are more accessible to Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas 2.2 % of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas (f & m) involved in AHTF who perceive that access to quality health programs & services has been improved as a result of the program
Intermediate Outcomes	
1. Improved *integration* of federal & p/t health systems, programs & services for First Nations & Inuit	1.1 # and % of projects/initiatives & spin offs that demonstrate improved *integration* 1.1 *Level, scale & reach* of *integration* 1.2 # and % of *successful integration* initiatives that are likely to be *sustained* 1.3 Extent to which systems, programs & services have been *successfully integrated* as perceived by *partners* & *affected parties* (f & m)
2. Improved *adaptation* of p/t health systems, programs & services to the needs of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas	2.1 # and % of projects/initiatives & spin offs that demonstrate *improved adaptation* 2.2 *Level, scale, & reach* of *adaptation* 2.3 # and % of improved *adaptation*s that are likely to be *sustained* 2.4 Extent to which systems, programs & services have been successfully adapted as perceived by *partners* & *affected parties* (f & m)

Immediate Outcomes	**Indicators**
1. Increased *capacity* for integrating federal & p/t health systems, programs & services to the needs of First Nations & Inuit	1.1 # of *capacity gaps* that have been filled as a result of AHTF interventions 1.2 Extent to which *capacity* developments are likely to be *institutionalized* & *sustained* 1.3 Depth & quality of *capacity* development activities as perceived by *partners* & *affected parties* (f & m)
2. Increased *capacity* for adapting p/t health systems, programs & services to the needs of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas	2.1 # of *capacity* gaps that have been filled as a result of AHTF interventions 2.2 Extent to which *capacity* developments are likely to be *institutionalized* & *sustained* 2.3 Depth & quality of *capacity* development activities as perceived by *partners & affected parties* (f & m)
3. Increased awareness among *partners* & *affected parties* of the concepts, barriers & enablers to *adaptation* & *integration*	3.1 # of projects/initiatives that contribute to increased awareness of the concepts, barriers & enablers to *adaptation* & *integration* 3.2 Extent to which *partners* & *affected parties* perceive that their awareness has been increased in relation the concepts, barriers & enablers to *adaptation* & *integration*
4. Increased *participation* of Aboriginal peoples, including First Nations, Inuit, Métis & those living off-reserve & in urban areas, in the design, delivery, management & evaluation of health services	4.1 # of Aboriginal peoples including First Nations, Inuit, Métis & those living off reserve & in urban areas (f & m) who *participate* directly in AHTF-funded activities in relation to the design, delivery, management & evaluation of initiatives to improve the *integration* & *adaptation* 4.2 Quality & depth of *participation* as perceived by *partners* & *affected parties* (f & m) 4.3 % of AHTF *partners* & *affected parties* (f & m) who perceive that *participation* has improved in the design, delivery, management & evaluation of services as a result of AHTF
5. Increased *collaboration* & strengthened *partnerships* among federal, p/t governments & Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas	5.1 # of projects/initiatives that demonstrate increased *collaboration* & strengthened *partnerships* 5.2 Quality & depth of *collaboration* & *partnerships* as perceived by *partners* & *affected parties* (f & m) 5.3 Quality of communication as perceived by *partners* & *affected parties*

7. Roles and Responsibilities

This section examines how the different players at various levels fit into the national evaluation framework.

The evaluation of the AHTF is complicated by several factors:

a) Projects and activities are taking place at several levels: community, regional, and national.
b) The three envelopes (*adaptation*, *integration*, pan-Canadian) fund projects that are undertaken by project proponents in different jurisdictions and spheres of activity.
c) There are three streams in the pan-Canadian envelope, which take account of the distinct needs and context of First Nations, Inuit and Métis peoples.

The national framework guides evaluation for each envelope. The quality of the national program evaluation will depend on the quality of evaluations at the project, regional and organizational level.

With respect to *integration*, each project will be responsible for undertaking some form of evaluation of its integration activities and *outcomes*, commensurate with the size and scope of the project, including development of an evaluation plan.

Each FNIHB Region will be responsible for taking steps to ensure project evaluations are completed in its region. Some Regions have expressed interest in undertaking an assessment of all regional *integration* activities while other Regions may choose to provide input into the national evaluation in other ways.

In the *adaptation* envelope, provinces and territories will be responsible for undertaking and reporting on the evaluation of their respective activities towards the achievement of their stated *outcomes*. Discussions with provinces and territories are recommended to secure agreement about common guidelines for evaluation, using the information in this framework as a starting point. It is anticipated that some provincial and territorial evaluation reports may include individual project evaluations. In other cases, where there are province-wide or territory-wide initiatives, a single provincial or territorial evaluation may be conducted. In all cases, evaluation plans should show how progress towards expected *adaptation* results will be assessed.

The pan-Canadian envelope provides support for cross-jurisdictional integration and adaptation initiatives by the three national Aboriginal organizations dealing with First Nations, Inuit and Métis peoples and their affiliates. Projects may be undertaken in a single region or in more than one. The funding recipients, which may be a NAO or regional affiliate, will be responsible for evaluating their

respective initiatives. AHTF will hold discussions with the funding recipients to come to agreement on evaluation requirements and common approaches.

The national evaluation may be comprised of three main elements:

1) A roll-up and summary of the evaluation reports received from Regions, provinces and territories, and from NAOs/PTOs, including project evaluations and summaries of evaluations;
2) “Cluster evaluations” of groups of individual projects that share several key characteristics and that lend themselves to more in-depth analysis in order to gather richer information on good practices and lessons; and
3) An implementation or process evaluation which would assess such elements as the quality of engagement of the *partners* and *affected parties* in AHTF envelopes, funding allocations, how the *capacity* funding was used by NAOs, governance of the AHTF, regional processes and others, as identified. This would also include assessments of the *outcomes* of national and regional workshops or conferences funded under the pan-Canadian envelope.

In summary, the key roles and responsibilities in evaluation will be as follows:

a) Role of project funding recipients:

- Develop an evaluation plan to assess project results in line with the national framework as well as relevant project-specific issues
- Hire an independent evaluator to conduct the evaluation
- Set up an evaluation steering committee if possible
- Submit evaluation results and reports to the funding source
- Share findings and lessons

b) Role of regions:

- Ensure *integration* project evaluations are undertaken, and that plans align with the national framework
- Receive and comment on project evaluations and forward them to AHTF Secretariat
- Co-ordinate project monitoring and reporting
- Possibly undertake and manage a regional-level assessment of the implementation of the AHTF
- Possibly host *capacity*-building opportunities for projects

c) Role of provinces and territories:

- Ensure *adaptation* project evaluations are undertaken, and that plans align with the national framework
- Receive and comment on project evaluations and forward them to AHTF Secretariat
- Co-ordinate project monitoring and reporting
- Undertake provincial or territorial evaluation of *adaptation* initiatives, which may be project-based or global and align with the national framework

- Possibly host *capacity*-building opportunities for projects

d) Role of AHTF Secretariat:

- Complete the national evaluation framework with discussions involving all concerned *partners* and *affected parties*
- Develop monitoring and reporting tools for use by Regions and P/Ts and national use
- Ensure evaluation of pan-Canadian envelope activities
- Undertake a national evaluation, including roll-up of *integration* project evaluations, and roll-up of *adaptation* evaluations
- Provide tools to support evaluation activities at all levels and encourage *capacity* building and skills transfer in evaluation
- Share evaluation findings and encourage learning

8. Implementation Plan

There are four phases to an evaluation, which apply both to individual projects and the national evaluation. These phases are outlined in general terms as follows. The AHTF Secretariat will develop a more detailed work plan for the national evaluation, which elaborates on these four phases.

Design

Once the national evaluation framework is completed, the next step in the design phase is to prepare terms of reference for the evaluation. When this is done, the AHTF Secretariat can hire an evaluator. The evaluator is usually responsible for preparing a detailed work plan based on the Secretariat's specifications. The Secretariat may wish to form a steering committee to oversee the evaluation.

Data Gathering

Data gathering involves collecting the information for the evaluation, including baseline data, from a variety of sources using appropriate evaluation methods and tools. The data gathered for the national evaluation will be both quantitative and qualitative, based on project evaluation reports and other sources such as surveys, key informant interviews, etc.

Data Analysis

Once all of the information is gathered, the evaluator must analyze the data in order to answer the key questions of the evaluation. Statistical software packages can be used when there is a great deal of quantitative data to be analyzed. This may apply to the national evaluation, but is less likely to apply to evaluations at other levels. It is envisaged that for all evaluations much of the information gathered is likely to be of a qualitative nature.

Dissemination

Once the evaluation report is drafted, the usual practice is to circulate it to the various *partners* and *affected parties* for comment. On the basis of the responses received, the evaluator will revise the report and the AHTF Secretariat will circulate it widely. The AHTF Secretariat should share important lessons and stories from all evaluations in ways that encourage learning.

9. Challenges and Constraints

Any evaluation process brings with it a series of challenges. This section outlines some of the main challenges associated with the AHTF evaluation along with proposed mitigation strategies.

1. Managing and integrating evaluation data from the several layers (community, province/territory, region, national) in a meaningful way; and gathering data from projects which vary dramatically in size and focus.
   Mitigation: AHTF Secretariat should have ongoing access to evaluation expertise to assist it with program monitoring, baselines and other preparatory work for the national evaluation.

2. Lack of baseline data against which to measure the degree of change achieved.
   Mitigation: AHTF Secretariat should encourage projects to establish baselines against results and indicators. It should conduct research to establish national level baselines wherever feasible.

3. Weak evaluation *capacity.*
   Mitigation: AHTF Secretariat should provide evaluation advice, tools and resources, and it should support *capacity-building* activities at the regional, provincial/territorial and project level.

4. Challenges in interpreting evaluation results across a wide range of cultures.
   Mitigation: Evaluations should involve First Nations, Inuit or Métis evaluators, whenever possible, and should be led by qualified individuals with advanced evaluation skills and experience in cross-cultural settings.

5. Analyzing data and drawing conclusions when provinces and territories are at different levels of *integration* and *adaptation.*
   Mitigation: Evaluators should be aware of such variances and not underestimate the significance of incremental progress towards the

achievement of results, particularly where new, collaborative relationships are involved.

6. Relatively short time frame for projects (2-3 years maximum), and national evaluation taking place before all projects are completed.
   Mitigation: Expectations regarding progress toward the achievement of some results must be realistic given the short time frames for implementation. Those providing funding for projects, including provinces and territories, NAOs, Regions and the AHTF Secretariat should monitor projects and ensure that funding recipients produce high quality reports on time.

7. Evaluators may not be familiar with *gender-based analysis.*
   Mitigation: AHTF Secretariat will provide information and links to resources on *gender-based analysis*.

Constraints

The ability to evaluate results and cost-effectiveness may be constrained by the experimental nature of AHTF projects. Many projects are trying to do new things or do things differently, making it difficult to predict the *outcomes*. This means that there could be as many unexpected as expected results, some positive and some negative. The experimental nature of the program makes cost-effectiveness both less relevant and more difficult to measure as it is only by experimenting with new approaches that the most appropriate and cost-effective methods can be identified.

In some provinces, territories and communities there has been initial progress in *integration* or *adaptation*, but in other cases, the work that will be carried out under the AHTF will be among the first steps in what could be a long process. This will affect the rate of progress achieved under the AHTF. The national evaluation must recognize that the process of change is largely focused on building relationships and *capacity*, which are, over time, expected to lead to improvements in services.

Evaluations at all levels will have to bear in mind that [the program has had a slow start and that] the time frame for project implementation is short. This too may have a bearing on the extent to which results are achieved.

Glossary of Terms

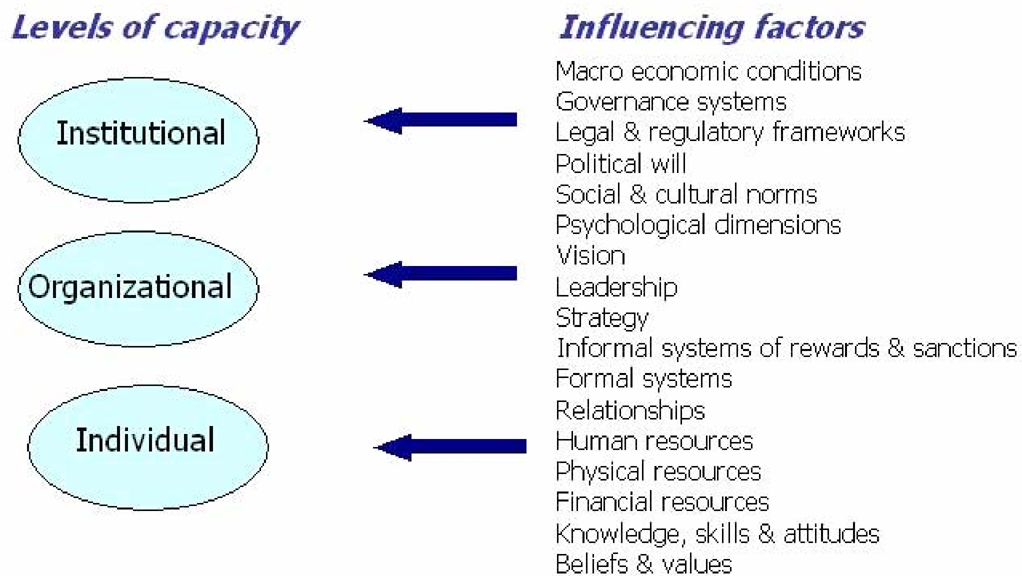
Adaptation

(Under development by FNIHB)

Capacity and capacity development

There are no universally accepted definitions of capacity. Capacity is about empowerment and identity, properties that allow people, organizations and systems to survive, grow, diversify and perform. Various kinds of capacity are needed and at different levels in order to have vibrant, adaptable organizations. Examples of capacity include management skills, management systems, organizational procedures, human and financial resources, facilities and equipment. But, as Figure 1 illustrates, capacity also includes such things as vision, leadership, values, strategy and political will.

Figure 1:



Capacity development is a complex process. Research has shown that to develop capacity successfully, one needs to pay close attention to the informal factors that influence capacity, such as relationships, incentives and organizational culture. Successful capacity development involves working at individual, organizational and institutional levels. Developing the skills of individuals through training is unlikely to lead to successful change in most circumstances if there is not capacity developed at organizational and institutional levels.

Capacity gap

A capacity gap is the difference between actual capacity and desired capacity. It is determined through an analysis of existing capacity in relation to desired capacity.

Collaboration

Collaboration is a structured, ongoing process where two or more people work together toward a common goal by sharing knowledge, learning and building consensus. As illustrated in Figure 3 (p. 20), there is an element of egalitarianism in collaboration in that those involved participate equally in decisions, including the development of alternatives and the identification of preferred solutions to problems.

Communication

Communication can be interpersonal or via various media. Effective communication is interactive, two-way or multi-directional communication that involves feedback, respect for cultural and linguistic differences and mutual attentiveness. Effective communication does not necessarily mean more communication. Attentive listening is the key to good interpersonal communication. Improved communication is a first step in building relationships and collaboration.

Gender equality and gender-based analysis

Gender equality acknowledges that women and men, girls and boys are equal and should benefit from the same rights and social status. Gender equality is the process of being fair to women and men. It recognizes that women and men must have equal conditions for realizing their full human rights and potential to contribute to and benefit from political, economic, social and cultural development. The federal government has a government-wide policy of gender equality.

Health Canada supports gender equality in the health system through gender-based analysis (GBA). Health Canada's GBA is a tool for examining and assessing the links between gender[3] and health, and between gender and the determinants of health. It uses sex and gender as an organizing principle or a way of conceptualizing information. It helps to bring forth and clarify the differences between women and men, the nature of their social relationships, and their different social realities, life expectations and economic circumstances. It identifies how these conditions affect women's and men's

[3] Gender refers to the socially constructed roles and responsibilities of women and men. The concept of gender also includes the expectations society holds of women and men, including expectations with respect to femininity and masculinity.

health status and their access to, and interaction with, the health care system. Health Canada's web site contains helpful information and guides for gender-based analysis.

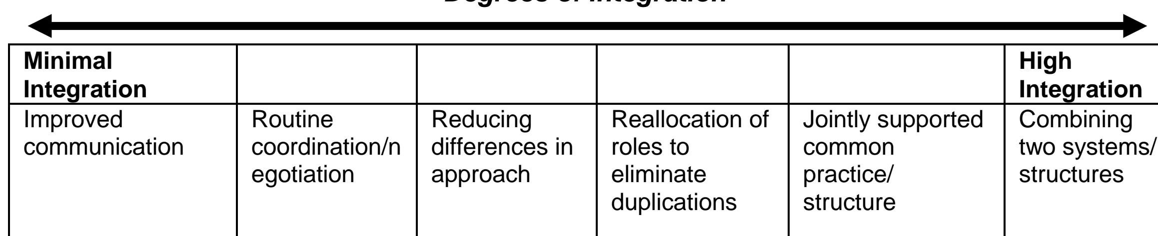
Institutionalize

A practice or innovation becomes institutionalized when it becomes part of the standard rules of business, or standard procedures, of an organization and is followed widely.

Integration

Integration is a progress along a continuum from initial communication to joint governance and shared funding, as illustrated in Figure 2.

Figure 2:
Degrees of Integration



Minimal Integration					**High Integration**
Improved communication	Routine coordination/negotiation	Reducing differences in approach	Reallocation of roles to eliminate duplications	Jointly supported common practice/ structure	Combining two systems/ structures

Level, scale and reach

Level examines where integration and/or adaptation is occurring, for example, at a community, tribal council, regional, provincial/territorial or institutional level.

Scale looks at whether a particular initiative is occurring in a community, region, or throughout a province, territory, nation or country, and whether there are plans and opportunities to expand the intervention so that it moves to a higher level, thus spreading the benefits to more people.

Reach assesses the proportion of the target group that is benefiting from a particular intervention.

Outcomes: Immediate, intermediate and long-term

An outcome, which is synonymous with a result, means a describable change in condition, resulting from a cause and effect relationship, and which is attributable to an organization, policy, program or initiative. Outcomes are usually qualified as immediate, intermediate or long-term.

Immediate Outcome: an outcome that is directly attributable to a policy, program or initiative's outputs. These are short-term results and most often apply to changes at the individual level, such as increased awareness of healthy lifestyles by a particular group. Ideally, immediate outcomes should be achieved by the mid-point of a project.

Intermediate Outcome: an outcome that is expected to logically occur once one or more immediate outcomes have been achieved. These are medium-term

results that show a change in a target population, an organization or institution. Ideally, intermediate outcomes should be achieved by the end of a project.

Long-term Outcome or Impact: the highest-level outcome that can be reasonably attributed to a policy, program or initiative in causal manner, and that is the consequence of one or more intermediate outcomes having been achieved. These high-level results usually signify a change of state of a society, nation, province, territory or country. The long-term outcomes of a federal program would reflect the high-level outcomes of department from which it is funded. Long-term outcomes are usually assessed well after a program ends. They are difficult to measure because change at such high level can be influenced by many factors in addition to the policy, program or initiative being evaluated.

Participation

As shown in Figure 3, participation can be seen as a continuum. At the lowest level, people have access to information and then progress to involvement and collaboration toward taking on an active role in the decision-making, or in the case of the AHTF direct involvement in the design, management, delivery and evaluation of health care systems, programs and services.

Figure 3:

IAP2 Public Participation Spectrum

Developed by the International Association for Public Participation

INCREASING LEVEL OF PUBLIC IMPACT

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Public Participation Goal:	**Public Participation Goal:**	**Public Participation Goal:**	**Public Participation Goal:**	**Public Participation Goal:**
To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
Promise to the Public:	**Promise to the Public:**	**Promise to the Public:**	**Promise to the Public:**	**Promise to the Public:**
We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.
Example Techniques to Consider:	**Example Techniques to Consider:**	**Example Techniques to Consider:**	**Example Techniques to Consider:**	**Example Techniques to Consider:**
• Fact sheets • Web sites • Open houses	• Public comment • Focus groups • Surveys • Public meetings	• Workshops • Deliberate polling	• Citizen Advisory Committees • Consensus-building • Participatory decision-making	• Citizen juries • Ballots • Delegated decisions

Partners and affected parties

Partners and affected parties of integration projects include: First Nations and Inuit populations; regional and national First Nations and Inuit organizations; the provinces and territories and their associated structures and FNIHB of Health Canada and the broader federal health portfolio.

For adaptation projects and the AHTF as a whole, the definition expands to include First Nations, Inuit, and Métis in all regions and communities regardless of their relationship to the *Indian Act* and regardless of their place of residence (urban, rural, remote, arctic regions on-reserve or off-reserve); regional and NAOs (AFN, ITK, MNC, Congress of Aboriginal Peoples, and Native Women's Association of Canada).

Success

In results-based management (RBM), successful projects, programs and initiatives are those that achieve their expected outcomes.

Sustainability

To be sustainable, the benefits of an intervention must carry on beyond the life of a program. Evaluators look to see if changes have been *institutionalized*. Lasting partnerships, local "ownership" and support and a commitment by partners to carry forward the changes brought about by the project are indicators of sustainability for the AHTF.

Potential Subject Areas and Questions for Program Evaluation

The mix of subject areas and specific questions will be different for each evaluation with the exception of the results category and possibly the lessons category below. The appropriate mix is best determined at the time the evaluation is conducted. It is important that each evaluation focus on a few key questions—those that are most important to the program stakeholders—particularly when resources for evaluation are limited.

Results

- What results have been achieved, expected and unexpected, positive and negative?
- To what extent are *gender* equality considerations fully integrated in project design and implementation, and reflected in the results?

Relevance

- Is the program meeting needs that its participants/beneficiaries have expressed and to which they have agreed?
- Does the program make sense in relation to the conditions, needs or problems to which it is intended to respond?
- Is the program consistent with Health Canada's mandate and priorities?
- Is the program complementary to other federal/p/t government programs?

Cost effectiveness

- Is the relationship between cost and results reasonable?
- How do the costs compare with similar programs?
- Are the variances between planned and actual expenditures justified?
- What are the program implications of any significant variances?
- Are resources and services delivered in an efficient, effective and timely manner?

Sustainability

- What is the likelihood that program benefits will continue after its completion without over-burdening local organizations and partners?
- Is institutional *capacity* being developed at the individual, organizational and systems levels, and if so, is it adequate to ensure that local, p/t, federal institutions/organizations will take over and sustain the benefits envisaged?
- To what extent do local program partners and beneficiaries participate in the program and "own" the program's results?

Appropriateness of the program

- Are the management and oversight structures appropriate?
- Are the program resources, capacities and selected strategies sensible and are they sufficient to achieve the intended results?
- Do the program components complement each other?
- Does the program use proven, successful practices?
- Is the program innovative, yet not high risk?

Partnerships

- How strong and effective are the partnerships?
- Are the partners aware of their roles and responsibilities?
- Does each partner contribute resources to the program in a manner that is fair and reasonable?
- Is there shared responsibility and accountability for program results by all partners?
- How effective is the *communication*, coordination and cooperation among the program partners?

Challenges, constraints, risks and opportunities

- What have been the key challenges, constraints and risks facing the program?
- How did the program deal with them and with what degree of success?
- To what extent has the program successfully adapted to changing circumstances?
- To what extent has the program taken advantage of opportunities?

Lessons

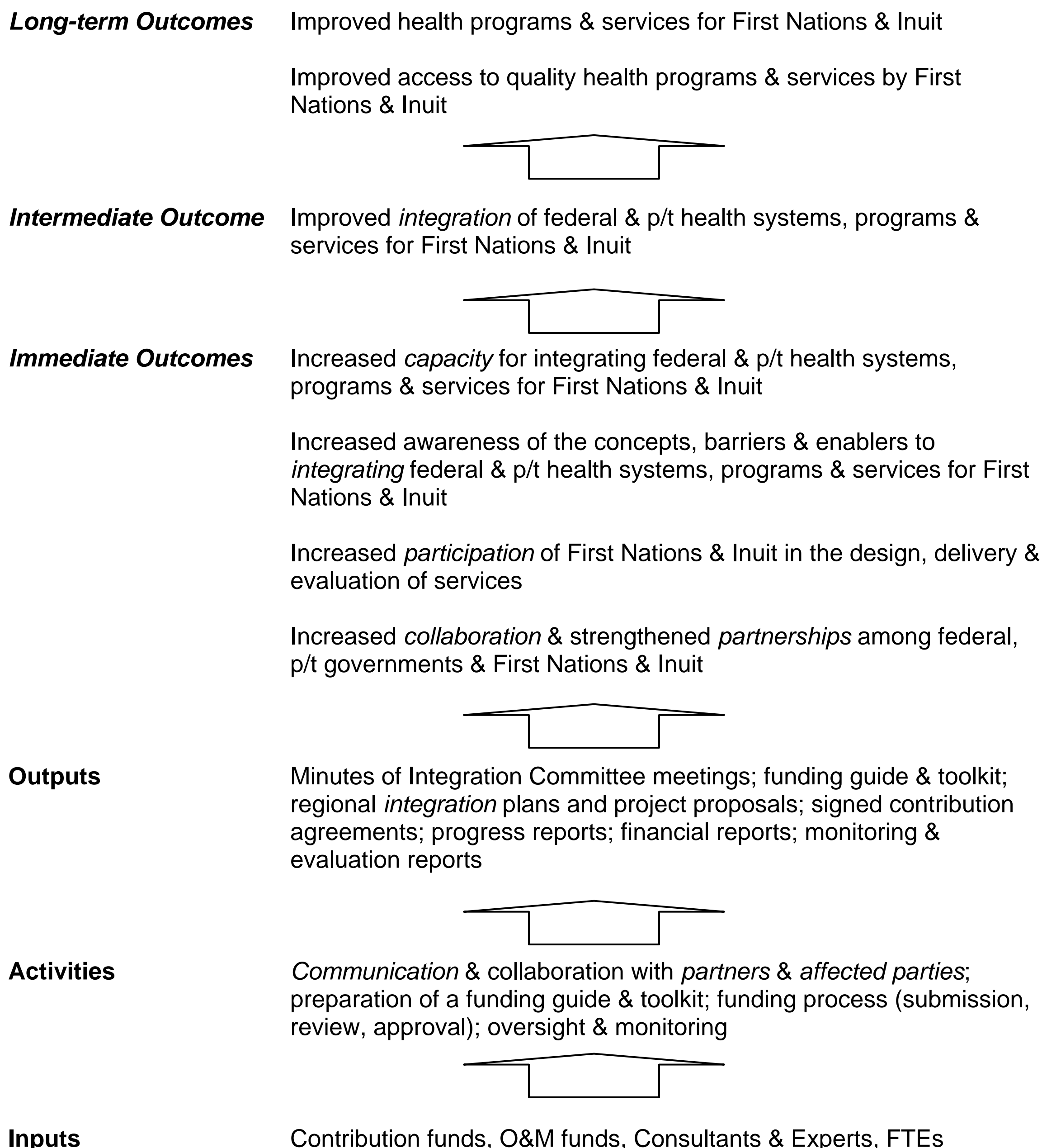
- What lessons can be drawn from the program experience, including those that may be applicable to future programming?
- What were the reasons why some things worked well and others didn't?

(Lessons may be drawn from program management, internal monitoring, programming processes and procedures used to achieve results.)

Future

- Where should the program focus in the future?
- What changes are needed in the program design in order to respond to emerging needs or changing circumstances in the program environment?

Logic Model for the Integration Envelope

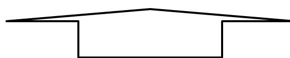


Logic Model for Adaptation Envelope

Long-term Outcomes

Improved health programs & services for Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas

Improved access to quality health programs & services by Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas



Intermediate Outcome

Improved *adaptation* of p/t health systems, programs & services to the needs of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas

Immediate Outcomes

Increased *capacity* for adapting p/t health systems, programs & services to the needs of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas peoples

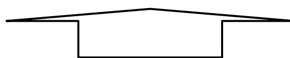
Increased awareness among *partners* & *affected parties* of the concepts, barriers & enablers to the *adaptation* of p/t health systems, programs & services to the needs of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas

Increased *participation* of Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas in the design, delivery & evaluation of services

Increased *collaboration* & strengthened *partnerships* among federal, p/t governments & Aboriginal peoples including First Nations, Inuit, Métis & those living off-reserve & in urban areas

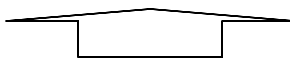
Outputs

Minutes of Adaptation Committee meetings; funding guide & toolkit; *adaptation* plans; signed contribution agreements; progress reports; financial reports; monitoring & evaluation reports



Activities

Communication & collaboration with *partners* & *affected parties*; preparation of a funding guide & toolkit; funding process (submission, review, approval); oversight & monitoring



Inputs

Contribution funds, O&M funds, consultants & experts, FTEs

Annex C

Logic Model for the Pan-Canadian Envelope