Rapid Synthesis

Identifying Evaluative Approaches to Measure the Impact of Healthy Community Programs

14 October 2021

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Rapid Synthesis:
Identifying Evaluative Approaches to Measure the Impact of Healthy Community Programs
30-day response

14 October 2021

McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

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Timeline

Rapid syntheses can be requested in a three-, 10-, 30-, 60- or 90-business-day timeframe. This synthesis was prepared over a 30-business-day timeframe. An overview of what can be provided and what cannot be provided in each of the different timelines is provided on McMaster Health Forum's Rapid Response program webpage (www.mcmasterforum.org/find-evidence/rapid-response).

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the rapid synthesis. The funder played no role in the identification, selection, assessment, synthesis or presentation of the research evidence profiled in the rapid synthesis.

Merit review

The rapid synthesis was reviewed by a small number of policymakers, stakeholders and researchers in order to ensure its scientific rigour and system relevance.

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KEY MESSAGES

Question

- What evaluative approaches exist that measure the impact of Healthy Cities and Communities programs or initiatives to improve health for community members, and that include components related to addressing equity and cultural safety?
- For approaches that exist, what do they measure and how is it measured?

Why the issue is important

- The global recognition of the need to address the social determinants of health that drive health inequity has inspired intersectoral policies, programs and initiatives that aim to bridge the gap between health and social systems.
- The Healthy Cities and Communities approach emerged following the International Conference on Health Promotion in Ottawa in 1986 as a continuous process for creating physical and social environments that promote healthy lifestyles and reduce health inequities through community empowerment, capacity building, and intersectoral collaboration.
- While there are similarities in the implementation of the Healthy Cities and Communities approach globally, there are also contextual differences that lead to variations by jurisdiction in how Healthy Cities and Communities programs or initiatives are implemented and how their impact is assessed.
- This rapid synthesis was requested to identify and synthesize what is known from the available evidence about current evaluative approaches that measure the impact of Healthy Cities and Communities programs and initiatives on the health of community members, and that include components related to addressing equity and cultural safety.

What we found

- We identified one systematic review of medium methodological quality and 23 primary studies that provided additional insight on evaluative approaches for measuring the impact of Healthy Communities programs or initiatives.
- We identified four specific evaluative approaches from these studies: 1) the use of indicators; 2) evaluation frameworks; 3) models; and 4) evaluation tools.
- Three studies, including the medium-quality systematic review, described the use of different indicators, categorized by type (process or impact), function (spatially explicit), or hierarchy, that were used to measure and compare how health determinants in the Healthy City populations changed over time.
- Four types of evaluation frameworks were identified from six primary studies, all of which were informed by questions or questionnaires focused on evaluating Healthy Cities programs and services.
- Models were identified as the most used evaluation approach, with six types of evaluation models being identified from six primary studies that focused on how these models were used to identify barriers and indicators of success in Healthy Communities programs.
- One study incorporated group model building as an evaluative method to determine how parts of the system influenced policy and environmental changes related to healthy eating, while another study identified an evaluation tool that aimed to measure the social determinants of health that impact certain marginalized communities.
- Two Healthy Cities initiatives were identified by several studies for their use of multiple evaluation approaches to assess the impact of their initiatives' activities and services.
- While we did not identify one evaluative approach that could be broadly applied to Healthy Communities assessments, we found one study that offered key lessons for developing evaluative approaches: engage the community in the development process; cultivate diverse partnerships; use a comprehensive approach; balance long-term goals with short-term accomplishments; integrate active-living initiatives into existing policy and planning mandates; and make sustainability a priority.

QUESTIONS

- What evaluative approaches exist that measure the impact of Healthy Communities programs or initiatives to improve health for community members, and that include components related to addressing equity and cultural safety?
- For approaches that exist, what do they measure and how is it measured?

WHY THE ISSUE IS IMPORTANT

The social determinants of health (SDOH) have been well-established as the primary drivers of health inequity. Referred to as underlying structural conditions including social, political and economic factors that result in adverse health outcomes, the effects of these determinants are often distributed unequally amongst marginalized population groups. This recognition has inspired intersectoral policies, programs, and initiatives that aim to bridge the gap between health and social systems to address the social determinants of health inequity. From these efforts, Healthy Cities and Communities programs and initiatives emerged following the International Conference on Health Promotion in Ottawa in 1986.(1)

The Healthy Cities and Communities approach is a continuous process of creating physical and social environments that promote healthy lifestyles. The approach emphasizes key principles such as community empowerment, capacity building, and intersectoral collaboration to improve health and reduce inequities.(2) The approach also draws on the foundations of Health in All Policies (HiAP), where the implications of policy decisions on health outcomes are at the forefront of all public-policy decisions. This often involves collaborative and integrated policymaking processes across sectors.(3) The Healthy Cities and Communities approach also involves a diverse and extensive range of stakeholders and partners. Since its conception, Healthy Cities and Communities has been implemented globally. In the international context, examples include the World Health Organization European Healthy Cities Network, Australia's Healthy Communities Initiative, and the North Karelia project in Finland. In Canada, examples of provincial and municipal Healthy Communities initiatives include the Healthy Alberta Communities, the British Columbia Healthy Communities Society, Vancouver's Healthy City Strategy, and the New Westminster Healthier Community Partnership.

Jurisdictions involved in the Healthy Cities and Communities approach have shared objectives and values (such as addressing the SDOH, reducing inequities, and improving population-health outcomes). While there are similarities in implementation, there are also contextual considerations and differences that vary by jurisdiction to reflect local population needs. As a result of these differences, there are different evaluative approaches to assess the impact of Healthy Cities and Communities.(4) Currently, there is no national

Box 1: Background to the rapid synthesis

This rapid synthesis mobilizes both global and local research evidence about a question submitted to the McMaster Health Forum's Rapid Response program. Whenever possible, the rapid synthesis summarizes research evidence drawn from systematic reviews of the research literature and occasionally from single research studies. A systematic review is a summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select and appraise research studies, and to synthesize data from the included studies. The rapid synthesis does not contain recommendations, which would have required the authors to make judgments based on their personal values and preferences.

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This rapid synthesis was prepared over a 30-business-day timeframe and involved four steps:

1) submission of a question from a policymaker or stakeholder (in this case, the BC Ministry of Health);
2) identifying, selecting, appraising and synthesizing relevant research evidence about the question;
3) drafting the rapid synthesis in such a way as to present concisely and in accessible language the research evidence; and
4) finalizing the rapid synthesis based on the input of at least two merit reviewers.

standardized approach to evaluate Healthy Cities and Communities initiatives. Additionally, developing indicators that can measure outcomes in relation to the SDOH and equity have been found to be challenging.(5) Furthermore, due to the dynamic and complex nature of Healthy Cities and Communities, relevant stakeholders must also be engaged in the evaluation process to ensure their interests and objectives are understood.

This rapid synthesis was requested by the British Columbia Ministry of Health to identify and synthesize what is known from the available evidence about current evaluative approaches that measure the impact of Healthy Cities and Communities programs and initiatives to improve health for community members. The rapid synthesis also aims to identify what evaluative approaches exist, if any, that include components related to addressing equity and cultural safety.

Box 2: Identification, selection and synthesis of research evidence

We identified research evidence (systematic reviews and primary studies) by searching HealthEvidence, Health Systems Evidence, Social Systems Evidence and PubMed on 6 June 2021. In the first three databases we searched for the terms "healthy communities" OR "healthy community" OR "healthy cities". In PubMed, we searched for primary studies published since 1986 using the following combination of search terms: ("healthy communities" OR "healthy community" OR "healthy cities") AND evaluat*.

The results from the searches were assessed by one reviewer for inclusion. A document was included if it fit within the scope of the question posed for the rapid synthesis, and if the study focused on evaluating the impact of Healthy Communities programs.

For each systematic review we included in the synthesis, we documented the focus of the review, key findings, last year the literature was searched (as an indicator of how recently it was conducted), methodological quality using the AMSTAR quality appraisal tool (see the Appendix for more detail), and the proportion of the included studies that were conducted in Canada. For each included primary study, we documented the focus of the study, methods used, a description of the sample, the jurisdiction(s) studied, key features of the intervention, and key findings. We then used this extracted information to develop a synthesis of the key findings from the included reviews and primary studies.

WHAT WE FOUND

We conducted a synthesis of the evidence identified from the searches described in Box 2. When reviewing the evidence, we sought to include documents that specifically focused on healthy city or healthy community programs and provided an evaluative approach or framework for measuring the impact of these programs.

We identified one systematic review of medium methodological quality and 23 primary studies. An overview of the evaluative approaches that we identified from these studies for measuring the impact of Healthy Cities and Communities programs or initiatives is provided in Table 1 below. These approaches consisted of the use of indicators, evaluation frameworks, models and evaluation tools. Four of the studies identified the use of multiple evaluation approaches to assess two of the Health Community initiatives reviewed.

Development of indicators

We identified three studies that described the use of different types of indicators to evaluate Healthy Cities programs.(6-8) Indicators were categorized according to type (process or impact), function (spatially explicit), or hierarchy, and were used to measure program activities, processes, and impact at the local and national level. Details of how data collected was categorized by the indicators described in these three studies are included in Table 1. The use of process and impact indicators were evaluated in the medium-quality systematic review we identified. In all studies, indicators were used to measure and compare how health determinants in the Healthy City populations changed over time.

Evaluation framework

Four types of evaluation frameworks for Healthy Communities initiatives were identified:

1) the Monitoring Accountability Reporting Impact (MARI) assessment framework was used to evaluate the level of implementation of Healthy Cities' principles and strategies, and assessed six dimensions (equity

policy and political support, management, health promotion programs and activities, community participation, intersectoral partnerships, environmental-protection activities) using questionnaire-derived dimensions data and follow-up interviews;(9)
2) a common analysis framework was used to evaluate an adolescent-health program using components (context, reach, dose delivered, dose received, and fidelity), indicators (e.g., health policies, access to services), questions, and data-collection methods;(10)
3) an evaluation framework organized by levels was used to measure individual, civic participation, organizational, interorganizational, and community levels of impact within the California Healthy Cities project, using indicator data derived from interviews with coordinators and community leaders and from documentation of new policies, practices and partnerships;(11-13) and
4) the Community Health Centre (CHC) Evaluation Framework was identified as a conceptual framework used to evaluate all programs and services in Ontario's community health centres by using evaluation questions, indicators and a Results-Based Logic Model (RBLM) that were developed to measure four main outcomes (see Table 1).(14)

The latter three frameworks in the list above incorporated the use of indicators in the evaluation,(10; 13; 14) and all frameworks were informed by questions or questionnaires focused on evaluating the Healthy Cities programs and services.

Models

Models were identified as the most used evaluation approach from the studies reviewed. Six types of evaluation models were identified from six primary studies:
1) the Emergence Model uses concepts of human and social capital and is grounded in the five health-promotion actions included in the Ottawa Charter;(15)
2) the U.S. Centers for Disease Control and Prevention (CDC) model of evaluation focuses on barriers, facilitators and future action plans, and utilizes a cross-sectional plus longitudinal survey that assesses mediators of change (self-efficacy, perceived environment, attitude, and subjective norms or target behaviours) using data derived from routine surveillance surveys, community health profiles, medical and surveillance data, and newspaper content;(16)
3) a process-evaluation model utilizes indicators based on participation, relationships, capacity building, empowerment, products, policy/procedure change, and community work to evaluate community-based primary prevention programs using semi-structured interviews;(17)
4) the Community Health Governance model was used to organize and analyze partnerships, leadership, and management processes of Washington Healthy Communities, and focused on evaluating partnership functioning, committee advisory and program-planning processes, and use of technical assistance by using data derived from a social capital index and stakeholder questionnaires;(18)
5) the Participatory Evaluation Model involved using a baseline assessment and follow-up assessments of population health, collaborations and leadership programs changes, systems or policy changes, and economic and social-welfare indicators for the ongoing evaluation of all communities in New Mexico's Healthy Communities program;(19) and
6) The Healthy Communities Initiative (HCI) evaluation model used by the David Thompson Health Region Healthy Communities involved using indicators of success and a three-level evaluation design to assess individual sites, sites as a group or cluster, and the HCI as an intervention.(20)

Group model building was also identified in one study where a systems-thinking approach was used to determine how parts of the system influenced policy and environmental changes related to healthy eating.(21) The group model-building exercise asked participants to identify determinants that affected policy systems or environmental change related to healthy eating, physical activity and obesity.

Evaluation tool

The Health Community Assessment Tool (HCAT) was identified in one study as an evaluation tool that aims to measure the SDOH that impact Indigenous and non-Indigenous peoples in rural and remote communities in Australia.(22) It assesses 13 domains and uses a scoring system which allows for ongoing monitoring and evaluation.

Mixed evaluation approaches

Two Healthy Cities programs were identified by several studies for their use of multiple evaluation approaches to assess the impact of the programs' activities and services. The World Health Organization Europe Healthy Cities Network (WHO-EHCN) has undergone several phases of evaluations of the network using a realist evaluation, a 'hybrid theory' that used a realist synthesis approach, the Davidsons' wheel of participation, and a case study (structured and free form) approach.(23; 24) The mixed methods evaluation of the Robert Wood Johnson Foundation's Healthy Kids, Healthy Communities (HKHC) national program took four years to complete and consisted of a performance-monitoring dashboard, a quantitative cross-site impact evaluation, and a qualitative cross-site process and impact evaluation.(25) Evaluation indicators assessed the complexity and impacts of HKHC partnerships, and the progression of community partnership workplans, community engagement, revenue generation, and changes to the local and organizational policies and environments.

One study did not identify a specific evaluation approach for measuring the impact of Healthy Cities initiatives, but rather offered key lessons for developing an evaluative approach, specifically the critical need to engage neighbourhood residents in the beginning of the development process, cultivate diverse partnerships, use a comprehensive approach, balance long-term goals with short-term accomplishments, integrate active-living initiatives into existing policy and planning mandates, and make sustainability a priority.(26)

Table 1: Overview of evaluative approaches to measure the impact of Healthy Cities and Communities programs or initiatives

Type of evaluative approach	Key features of evaluative approaches to measure the impact of Healthy Cities and Communities programs or initiatives		
	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
Development of indicators	Healthy Municipalities, Cities and Communities (HMCS) Strategy (6) *Jurisdiction*: Multiple – Latin America and Caribbean Region	• To assess how countries used indicators to evaluate the performance of the HMCS	*What was measured?* • Process indicators were reported at five levels: 1) local projects; 2) local activities; 3) provincial; 4) national; and 5) international networks • Local project and activity indicators referred to the execution and completion of projects, the allocated budget for projects, an intersectoral committee, and active community organizations and community participation • Provincial indicators included the presence of guidelines or rules for the functioning of an intersectoral committee • National indicators included the presence of a Health Situation Analysis and a Health Plan • Impact indicators included measures for decreases in disease prevalence, the implementation of public policies and adherence to bylaws, and changes in school curriculum to include health education *How was it measured?* • Process and impact indicators data were derived from the conduct of community needs assessment and document review with consultation of an intersectoral evaluation committee and community organizations
	China's Healthy Cities (8) *Jurisdiction:* Shenzhen, China	• To assess the spatial relation between health determinants and the Healthy City population Using Shenzhen in South China as the case study • Spatial distance among facilities, people and residential buildings was calculated and each sub-district or district was ranked	*What was measured?* • Four health determinants (green infrastructure, transportation, utilities and services, and leisure and recreation) were assessed using both spatially explicit indicators and indicators commonly included in Healthy City indicator systems *How was it measured?* • Spatial indicators data were derived from census data and social media data as proxies of high-resolution population distribution data

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		and then compared by indicator values	
	China's Healthy Cities (7) *Jurisdiction:* Shenzhen, China	• To develop an indicator system and evaluate a Healthy City in Chongqing, China consisting of first-level, second-level, third-level, and characteristic indicators	*What was measured?* • First-level indicators included healthy environment, healthy society, health services, healthy people, health literacy, and health behaviours • Second-level indicators included determinants such as air quality, education and health resources • Examples of third-level indicators included incidence of myopia, regional ambient noise, and trends in the incidence of cardio-cerebral vascular events • Lastly, characteristic indicators included the number of large-scale national fitness activities held each year, health sciences popularization, and construction of health venues *How was it measured?* • Not reported
Framework	Israel Healthy Cities Network (9) *Jurisdiction*: Israel	• To evaluate the level of implementation of the Healthy Cities' principles and strategies by each of the cities in Israel's Healthy Cities network using the Monitoring Accountability Reporting Impact (MARI) assessment framework	*What was measured?* • The MARI framework assessed six dimensions: 1) equity policy and political support; 2) management; 3) health-promotion programs and activities; 4) community participation; 5) intersectoral partnerships; and 6) environmental-protection activities consensual process • Some measures also referred to the impact of the network and assessment of its contribution to the city's health-promotion activities *How was it measured?* • Dimensions data were derived from a questionnaire (open-ended and closed), statistically analyzed and the Donabedian's model for assessing quality of healthcare was used • Follow-up interviews were conducted with individuals who completed the survey for in-depth probing

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	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
	Healthy Communities adolescent health program (10) *Jurisdiction*: Uganda	• To use a common analysis framework and evaluate a Healthy Communities adolescent health program that aims to reduce HIV infections, mortality, malnutrition, malaria and tuberculosis in Uganda • The framework includes components (context, reach, dose delivered, dose received, and fidelity), indicators (e.g., health policies, access to services), questions, and data-collection methods	*What was measured?* • Indicators included program coverage, reach and factors influencing implementation such as existing health policies, access to services, exposure to health messages, stakeholder engagement, percentage of intended participants, and number of changes made during program implementation *How was it measured?* • Indicator data were derived from mixed-methods evaluation such as direct observation during site-monitoring activities, consultations with program staff, review of program documents
	California Healthy Cities Project (11-13) *Jurisdiction:* California, United States	• To evaluate the California Healthy Cities Project based on an evaluation framework that is organized by levels: 1) individual (e.g., skills acquisition); 2) civic participation (e.g., participatory governance, resident involvement, leadership opportunities); 3) organizational (e.g., assessment of new and existing policies, access to resources); 4) interorganizational (e.g., partnerships, collaborations, community engagement); and 5) community (e.g.,	*What was measured?* • Indicators included changes in individual, civic, participation, organizational, interorganizational, and community every six months through the California Healthy Cities Project reporting system *How was it measured?* • Indicator data were derived from semi-structured interviews with coordinators and community leaders, focus groups with coalition members, a self-administered mail questionnaire, and a document review • Individual-level changes were measured by asking city representatives to indicate the skills they acquired, strengthened or applied during the reporting period as a result of participation in the Healthy Cities Project • Civic participation changes were measured by how many residents were involved in various aspects of the Healthy Cities Project (e.g., < 10 residents, 10-25 residents, >25 residents), if there were any new leadership roles created

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	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
		assessment of physical and social environments such as green space)	that were taken on by any residents, and if there were more opportunities created for resident input • Organizational and community-level changes were measured by the number of new policies and practices, policy adoptions and acquired resources (e.g., grants, city budget allocations) due to the Healthy Cities Project • Interorganizational-level changes were measured by documenting if any new partnerships were formed, involvement of communities in the project, and steering committee performance
	Community Health Centres in Ontario (14) *Jurisdiction*: Ontario, Canada	• Community Health Centre (CHC) Evaluation Framework was designed around the three values and eight attributes of the Model of Health and Wellbeing (MHWB) • Values and attributes focus on the social determinants of health, community vitality and belonging, and health equity and social justice • Evaluation questions, indicators, and the Results-Based Logic Model (RBLM) were developed to measure health centre activities and their outcomes	*What was measured?* • Indicators were developed based on four main outcomes: 1) reduced risk, incidence, duration and effects of acute, episodic, and/or chronic physical, social and psychological conditions at individual and community level; 2) increased access to healthcare for people who are experiencing barriers; 3) increased integration and coordination; and 4) increased community capacity to address the social determinants of health *How was it measured?* • Individual client information was collected such as registration data (e.g., identifiers, socio-demographic data, etc.), individual service data (e.g., procedures), and personal development group (PDG) data (e.g., group life span) • Community initiative data was collected separately
Model	Healthy Municipalities Project (15) *Jurisdiction*: Brazil	• The Emergence Model was developed for designing infrastructure for Healthy Municipalities and Cities using concepts of human and social capital	*Not reported*

Type of evaluative approach	Key features of evaluative approaches to measure the impact of Healthy Cities and Communities programs or initiatives		
	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
		• The model is grounded in the five health-promotion actions included in the Ottawa Charter:1) build healthy public policy; 2) create supportive environments; 3) strengthen community action; 4) develop personal skills; and 5) reorient health services	
	Healthy Kids, Healthy Cuba Initiative (21) *Jurisdiction*: Cuba	• To evaluate how behaviours of children in the Healthy Kids, Healthy Cuba initiative changed over time • The approach was used to assess cause-effect relationships, using information from a group model building session with partners in the initiative to create system feedback loops	*What was measured?* • Five indicators emerged from the study: 1) healthy-eating policies and environments; 2) active-living policies and environments; 3) health and health behaviours; 4) partnerships and community capacity; and 5) social determinants *How was it measured?* • The indicators were derived from a systems-thinking approach through a group model building session • Additional details on how these indicators were measured were not reported
	Healthy Hawaii Initiative (16) *Jurisdiction:* Hawaii	• To evaluate the Healthy Hawaii Initiative with the U.S. Centers for Disease Control and Prevention (CDC) model of evaluation, which focuses on barriers, facilitators and future action plans • The HHI focused on disease-prevention programs that promote healthy lifestyles in tobacco use, nutrition and physical activity	*What was measured?* • A cross-sectional longitudinal survey which assessed mediators of change (self-efficacy, perceived environment, attitude, and subjective norms for target behaviours) was conducted and repeated every six months during the first years of the HHI and continued yearly afterwards *How was it measured?* • The data is derived from existing indicators from the Behavioural Risk Factor and Surveillance Survey, the Youth Risk Behaviour Survey, and community health profiles developed by the Hawaii Outcome Institute, which includes over 100 health indicators from 18 different data sources

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	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
			• A newspaper content analysis was conducted yearly to derive data on the content covering behaviours related to tobacco use, nutrition and physical activity • Chronic disease rates were tracked through hospital-discharge data, the Hawaii Tumor Registry, and the Surveillance, Epidemiology, and End Results sites • Environmental attributes related to each health behaviour were incorporated into the longitudinal survey • Yearly stakeholder assessments were provided to HHI management and coordinators
	Healthy communities in Seattle (17) *Jurisdiction*: Washington, United States	• Seattle Partners for Healthy Communities is responsible for the design and evaluation of community-based primary prevention programs for urban and underserved communities in the greater Seattle area • The process evaluation model was developed by anthropologists, epidemiologists, and a social scientist based on a literature review of evidence on community organization characteristics, participation, relationships, capacity building, empowerment, products, policy and procedure change, and community organizing	*What was measured?* • Indicators to evaluate community-based primary prevention programs included: 1) participation (e.g., meeting attendance, committee service, involvement in activities); 2) relationships (e.g., network of interpersonal and interinstitutional links); 3) capacity building (e.g., training and skill acquisition); 4) empowerment (e.g., group's belief in the capability to succeed in future actions); 5) products (e.g., number of publications, programs, evaluations, grants); 6) policy/procedure change (e.g., stories of activities to exert influence on policy makers); and 7) community work (e.g., clear designations of communities, activities to involve members, sustainability plan) *How was it measured?* • Indicator data were derived from semi-structured interviews and content analysis that used standard ethnographic data-gathering techniques (i.e., interviews, observations, participant observations, grant proposals, meeting notes, publications, workshop descriptions, budgets, staff rolls, and mailing lists) • Semi-structured interviews were used to gather participants' views on the Seattle Partners for Healthy

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	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
			Communities (the Center) activities and progress, as well as information relevant to the model • Participants were chosen by convenience and included advisory group members and staff of the centre
	Washington State's Healthy Communities projects (18) *Jurisdiction*: Washington, United States	• The Community Health Governance model was used to organize and analyze partnerships, leadership and management processes of Washington State's Healthy Communities projects • The model focuses on partnership functioning, committee advisory processes (e.g., structure and function, leadership facilitation), processes of program planning and implementation, and use of technical assistance	*What was measured?* • This evaluation measured individual empowerment, bridging social ties, synergy, critical characteristics of who was involved and how they were involved, the scope of the process, and leadership and management parameters such as participation and facilitation *How was it measured?* • Data was derived from the use of a social capital index and community partnership stakeholder questionnaires
	New Mexico's Healthier Communities program (19) *Jurisdiction:* New Mexico, United States	• The Participatory Evaluation Model was used to evaluate the process, structure and systems related to the implementation of New Mexico's Healthier Communities program • The evaluation involves a baseline assessment and a one-year follow-up with four communities first, and then a three-year follow-up for all 12 communities	*What was measured?* • The evaluation assessed population health, collaborations and leadership program changes, systems or policy changes, and economic and social-welfare indicators • The main research questions included "how does a community express the characteristics and principles of a healthier community?" and "what are the barriers to and facilitators of change?" *How was it measured?* • Indicator data were derived from interviews with both informal and formal community leaders, direct observations, and population-based data

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	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
		• The core values of the evaluation team were: 1) engaging community coalitions to identify key indicators; 2) continual feedback; and 3) using process and short- and long-term outcome measures	
	David Thompson Health Region Healthy Communities (20) *Jurisdiction*: Alberta, Canada	• The evaluation of the Healthy Communities Initiative (HCI) involved questions focusing on processes and outcomes of the initiative • Through surveys, interviews and success stories of community partners, indicators of success and a three-level evaluation design were developed. The three-level evaluation design focused on individual sites, sites as a group or cluster, and the HCI as an intervention	*Not reported*
Evaluation tool	Healthy Community Assessment Tool (HCAT) (22) *Jurisdiction*: Australia	• The Health Community Assessment Tool (HCAT) aims to measure, monitor and evaluate the social determinants of health that impact Indigenous and non-Indigenous peoples in rural and remote communities	*What was measured?* • The tool assesses the following domains: 1) electricity supply; 2) pest control and animal management; 3) air quality; 4) drainage, roads and footpaths; 5) public toilets; 6) healthy housing; 7) reducing environmental tobacco smoke; 8) solid waste disposal; 9) water supply; 10) community vibrancy, pride and safety; 11) promoting physical activity; 12) food supply; and 13) sewerage system *How was it measured?*

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	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
		• HCAT was piloted and validated in four remote communities in Australia	• The tool uses a scoring system which allows for ongoing monitoring and evaluation and includes age and gender considerations
Other – mixed approaches	WHO European Healthy Cities Network (4; 23; 24; 27) *Jurisdiction:* Multiple – Europe	• Since its conception, the WHO European Healthy Cities Network (WHO-EHCN) has undergone numerous evaluations to determine its effectiveness • Evaluations have been categorized in five phases, with all included studies focusing on Phase IV evaluations • Additional types of evaluative approaches that are described for potential use include the 'Fourth Generation' (4GE) or 'naturalistic' inquiry for Healthy Cities evaluations, in which stakeholder perspectives are incorporated into the development process for evaluation parameters	*What was measured?* • Four categories of indicators were collected: 1) health indicators; 2) health-service indicators; 3) environmental indicators; and 4) socio-economic indicators • Specific indicators related to the four main categories (health indicators, health service, environmental, socio-economic) include: mortality; atmospheric pollution; percentage of water pollutants removed from total sewage produced; household waste collection quality index; relative surface area of green spaces in the city; public access to green space; cycling in city; public transport; public transport network cover; unemployment rate and percentage of disabled persons employed • Recommended key questions to be asked during impact evaluations include: 1) to what extent can a specific net impact be attributed to an intervention?; 2) did the intervention make a difference?; 3) how has the intervention made a difference?; and 4) will the evaluation work elsewhere? *How was it measured?* • Data for phase IV evaluations consisted of a realist evaluation, a 'hybrid theory' that used a realist synthesis approach, the Davidsons' wheel of participation, a case study (structured and free form) approach, the use of a General Evaluative Questionnaire (GEQ), and the use of existing information from project management support exercises, city health profiles containing local level health indicators (social, environment, other), initial documentation of city commitment and plans, and other datasets

Type of evaluative approach	Key features of evaluative approaches to measure the impact of Healthy Cities and Communities programs or initiatives		
	Name of program or initiative	**Description of evaluative approach**	**Methods used to evaluate program or initiative**
	Healthy Kids, Healthy Communities program (25; 28; 29) *Jurisdiction*: United States	• The evaluation of the Robert Wood Johnson Foundation's Healthy Kids, Healthy Communities (HKHC) national program involved one year of evaluation planning and four years of a mixed-methods evaluation conducted across the 49 communities involved in the program	*What was measured?* • Indicators assessed the complexity and impacts of HKHC partnerships and the progression of community partnership workplans, community engagement, revenue generation, and changes to the local and organizational policies and environments *How was it measured?* • Indicator data were derived from a performance monitoring dashboard and quantitative and qualitative cross-site impact evaluations consisting of environmental audits, direct observations, group interviews, an 82-item partnership and community capacity survey, and secondary surveillance data
Other – lessons learned	Buffalo's Healthy Communities Initiative (26) *Jurisdiction:* Buffalo, United States	• The evaluation reports key lessons when developing an evaluative approach that considers equity such as: 1) the critical need to engage neighbourhood residents from the beginning; 2) cultivating a diverse partnership; 3) using a comprehensive approach; 4) balancing long-term goals with short-term accomplishments; 5) integrating active-living initiatives into existing policy and planning mandates; 6) and making sustainability a priority	*Not reported*

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APPENDICES

The following tables provide detailed information about the systematic reviews and primary studies identified in the rapid synthesis. The ensuing information was extracted from the following sources:

- systematic reviews - the focus of the review, key findings, last year the literature was searched, and the proportion of studies conducted in Canada; and
- primary studies - the focus of the study, methods used, study sample, jurisdiction studied, key features of the intervention and the study findings (based on the outcomes reported in the study).

For the appendix table providing details about the systematic reviews, the fourth column presents a rating of the overall quality of each review. The quality of each review has been assessed using AMSTAR (A MeaSurement Tool to Assess Reviews), which rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. It is important to note that the AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to systematic reviews pertaining to delivery, financial or governance arrangements within health systems. Where the denominator is not 11, an aspect of the tool was considered not relevant by the raters. In comparing ratings, it is therefore important to keep both parts of the score (i.e., the numerator and denominator) in mind. For example, a review that scores 8/8 is generally of comparable quality to a review scoring 11/11; both ratings are considered "high scores." A high score signals that readers of the review can have a high level of confidence in its findings. A low score, on the other hand, does not mean that the review should be discarded, merely that less confidence can be placed in its findings and that the review needs to be examined closely to identify its limitations. (Lewin S, Oxman AD, Lavis JN, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP): 8. Deciding how much confidence to place in a systematic review. *Health Research Policy and Systems* 2009; 7 (Suppl1):S8).

All of the information provided in the appendix tables was taken into account by the authors in describing the findings in the rapid synthesis.

Appendix 1: Summary of findings from systematic reviews about evaluative approaches to measure the impact of healthy community programs or initiatives

Focus of systematic review	Key findings	Year of last search/ publication date	AMSTAR (quality) rating	Proportion of studies that were conducted in Canada
Assessment indicators used by Healthy Municipalities and Communities Program in Latin America and the Caribbean region (6)	The Healthy Municipalities, Cities and Communities Strategy (HMCS) was created in 1990 by the Pan American Health Organization based on the principles of health promotion found in the Ottawa Charter. HMCS provides a guide for addressing underlying determinants of health through collaborative and integrated action and has been widely adopted throughout North and South America in 18 countries. A systematic review was conducted to determine how countries are using indicators to evaluate the performance of the HMCS. Indicators identified in the literature were classified into two categories. Process indicators were reported at five levels: 1) local projects; 2) local activities; 3) provincial; 4) national; and 5) international networks. Local project and activity indicators referred to the execution and completion of projects, the allocated budget for projects, an intersectoral committee, and active community organizations and community participation. Provincial indicators included the presence of guidelines or rules for the functioning of an intersectoral committee. National indicators included the presence of a Health Situation Analysis and a Health Plan. The second category of indicators was impact indicators. These included indicators such as decreases in disease prevalence, the implementation of public policies and adherence to bylaws, and changes in school curriculum to include health education. The study found that each country took a different approach to developing and implementing the strategy. The majority of indicators were found at the local level. Strong national networks were found to support initiatives at the local level, however, in some countries the absence of a reporting structure made it challenging to evaluate and monitor progress of HMCS. Very few countries reported on impact indicators. The authors recommend that each country monitor their implementation strategies and evaluation tools to promote knowledge sharing and flexible information systems.	2019	5/9 (AMSTAR rating from McMaster Health Forum)	Not reported

Appendix 2: Summary of findings from primary studies about evaluative approaches to measure the impact of healthy community programs or initiatives

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
Developing and trialling of a tool to support a systems approach to improve social determinants of health in rural and remote Australian communities (22)	*Publication date:* 2013 *Jurisdiction studied:* Australia *Methods used:* Mixed-methods approach for the development and piloting of an evaluation tool	Stakeholders from local and territorial government and non-government agencies, community partners (including public-health officers, clinicians, and allied health workers), and stakeholders from Indigenous communities contributed to the development of the tool. The tool was piloted with Indigenous (Aboriginal and Torres Strait Islander) peoples living in four rural and remote communities in the Northern Territory of Australia.	Addressing the social determinants of health (SDOH) has been a key focus for the Australian government, particularly those which affect Indigenous populations. The Indigenous primary-care sector has developed quality-improvement tools to evaluate service delivery and health outcomes. These tools have yet to be tested to determine their effectiveness in evaluating programs and policies targeting the SDOH. This study developed and tested a Health Community Assessment Tool (HCAT) to measure, monitor, and evaluate the SDOH that impact Indigenous and non-Indigenous peoples in rural and remote communities.	The HCAT is driven by social ecological theory. The tool was developed using the Driving Force, Pressure, State, Exposure, Effect framework and the Multiple Exposure Multiple Effect Model to inform how environmental health indicators would be included in the framework. The domains of focus and their respective health indicators to be included in HCAT were determined based on epidemiological evidence, infrastructure and programs considered integral to the promotion of good health and preventing chronic disease, and areas where known inequities currently exist at the community level and where changes were feasible. These domains include: 1) electricity supply; 2) pest control and animal management; 3) air quality; 4) drainage, roads and footpaths; 5) public toilets; 6) healthy housing; 7) reducing environmental tobacco smoke; 8) solid waste disposal; 9) water supply; 10) community vibrancy, pride and safety; 11) promoting physical activity; 12) food supply; and 13) sewerage system. The tool uses a scoring system which allows for ongoing monitoring and evaluation and includes age and gender considerations. HCAT was piloted in four remote communities and face validity was confirmed. The use of a facilitated small group process while scoring the indicators was found to reduce bias. The tool was deemed to be useful in promoting improvements in the SDOH through a systems approach. Testing of formal validity and reliability was planned in a subsequent study. Limitations of the research included a lack of evidence to support the selected indicators and the small sample size of participants during the pilot testing.
Evaluating WHO Healthy Cities in Europe (4)	*Publication date:* 2013 *Jurisdiction studied:* Europe *Methods used:* Descriptive study	Not reported	The WHO European Healthy Cities Network (WHO-EHCN) was implemented by the European regional office of the World Health Organization in the 1980s. Since its conception, the initiative has undergone numerous evaluations to determine its effectiveness. The authors categorize these evaluation efforts into four phases and discuss the	Several approaches to evaluation of Phase IV of the Healthy Cities Network were identified. The first was a descriptive responsive realist evaluation, which focused on intersectoral action and health-promotion partnerships to address health determinants. A second group of researchers focused on the development and continuous updating of city health profiles. These profiles were viewed as a tool to suit local data needs and support implementation of the initiative. Another approach taken was the use of a 'hybrid theory' which utilized a realist synthesis approach to estimate the impacts of distal determinants on city health. Another notable evaluation approach was using Davidsons' wheel of participation to qualitatively evaluate community participation and empowerment during Healthy Cities

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
			approaches taken under phase IV. They conclude with recommendations for the types of evaluative questions that should be posed in the fifth phase of evaluation.	initiatives. This mixed-methods approach utilized qualitative content analysis of questionnaires, annual reports and case studies. The common assumptions underlying the varying evaluation approaches identified included the recognition of health as determined by structural factors, and the recognition that local actors have the most significant impact on protecting and promoting health. The authors concluded that key questions to be asked during evaluations to determine impact include: 1) to what extent can a specific net impact be attributed to an intervention? 2) did the intervention make a difference? 3) how has the intervention made a difference? 4) will the evaluation work elsewhere? Further, they recommend that a realist conceptual framework should be adopted in future evaluations.
Assessing impact and outcome of healthy cities (27)	*Publication date:* 2012 *Jurisdiction studied:* European Region of the World Health Organization *Methods used:* Descriptive study	Not reported	This study discusses the evaluations undertaken during phase IV of the WHO European Healthy Cities Network and assesses how the adoption of the value system promoted by the Healthy Cities initiative generated new options for the implementation of interventions.	The author discusses approaches undertaken by a group of 14 senior researchers during Phase IV of the European Healthy Cities Project. None of the approaches looked directly at health impacts or outcomes, but instead focused on process indicators. The author recommends that a realist evaluation approach should be utilized to develop a context-mechanism-outcome theory underlying the Healthy Cities intervention. Lastly, it is recommended that the focus should be shifted from evaluating the effectiveness of interventions towards the adoption and consequences of Healthy Cities values where a realist evaluation would be the appropriate methodology to be utilized.
Describing European Healthy Cities evaluation conceptual framework and methodology (23)	*Publication date:* 2015 *Jurisdiction studied:* Europe *Methods used:* Descriptive study	Not reported	This study describes the evaluation approaches undertaken during Phase V of the WHO European Healthy Cities Network.	The evaluation approach undertaken during Phase V included a mixed-methods realist synthesis using both structured case studies and free-form case studies. Cities were sent fillable PDF case study templates and coded using qualitative software. This approach was selected to allow evaluators to determine what works for whom under which contexts when implementing a Healthy Cities initiative by uncovering underlying causalities. The case-study approach was also selected for its ability to capture experiences of implementation in the local context. A General Evaluative Questionnaire (GEQ) was also sent out to local and national networks of Healthy Cities. Four categories of indicators were collected: 1) health indicators; 2) health-service indicators; 3) environmental indicators; and 4) socio-economic indicators. Specific indicators related to the four main categories (health indicators, health service, environmental, socio-economic) included: mortality; atmospheric pollution; percentage of water pollutants removed from total sewage produced; household waste collection quality index; relative surface area of green spaces in

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				the city; public access to green space; cycling in city; public transport; public transport network cover; unemployment rate; and percentage of disabled persons employed. The case studies and the GEQ were supplemented with existing information from project management support exercises, city health profiles containing local-level health indicators (social, environment, other), initial documentation of city commitment and plans, and accessing other databanks such as Eurostat. Challenges to this evaluative approach included differences between Health Cities due to the local context that influenced implementation approaches taken, limited ability to account for confounding factors, and non-response from the questionnaire.
Comparing the Use of Spatially Explicit Indicators and Conventional Indicators in the Evaluation of Healthy Cities (8)	*Publication date:* 2020 *Jurisdiction studied:* Shenzhen, China *Methods used* Case Study	Shenzhen in South China was selected for the case study. It contains 11 districts and 74 sub-districts. As of 2018, the resident population reached 13.03 million. Major causes of death included heart disease, cerebrovascular disease, and malignant tumours.	Utilizing case study methodology, four health determinants (green infrastructure, transportation, utilities and services, and leisure and recreation) were assessed using both spatially explicit indicators and indicators commonly included in Healthy Cities indicator systems. Evaluation results were compared between conventional indicators and spatially explicit indicators in Shenzhen, China. Conventional indicators were first collected and then the spatially explicit indicators were estimated. Spatially explicit indicators were estimated by calculating the spatial distance among facilities, people and residential buildings using ArcGIS. Each district or sub-district was ranked by indicator values, and rankings were then compared.	Spatially explicit indicators can be used to assess and measure the spatial relation between health determinants and the affected population. This study aimed to determine whether spatially explicit indicators are worthwhile to include in Healthy Cities indicators. The study used the urban health-indicator framework developed by Pineo and colleagues. They evaluated green infrastructure, transportation, utilities and services, and leisure and recreation. This was measured by collecting census data and social media data as proxy of high-resolution population distribution data. The study found that including spatial information into Healthy Cities indicators for these specific health determinants can alter evaluation results significantly. For green infrastructure, the evaluation results based on the two types of indicators agreed with each other. For health-service provision the evaluation results based on the conventional indicator had little relevance with the evaluation results based on the spatially explicit indicators. This suggests that both sets of indicators are necessary and they each measure different aspects of the determinant. For example, spatial indicators that measured the accessibility of community health centres are essential. For transportation, the conventional indicator evaluation results were negatively associated with the results of the spatially explicit indicators, suggesting that more transit stops and stations did not support better access to transportation. The authors concluded that spatially explicit indicators are necessary for the evaluation of Healthy Cities. This is due to the additional insights they can bring to understanding and addressing the spatial relation between health

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				determinants and populations that are not captured in conventional indicators.
Assessing community change at multiple levels with an evaluation framework (11)	*Publication date:* 2000 *Jurisdiction studied:* California *Methods used* Descriptive study	The California Healthy Cities project was implemented in 1988. Since that time, 40 cities have participated in the initiative.	The framework for the California Healthy Cities project was organized by levels which include individual, civic participation, organizational, interorganizational, and community. Progress reports on specific indicators for each level were submitted by each participating city at the six-month and 12-month mark through a reporting system.	This article described the evaluation framework developed for the California Healthy Cities project and its implications for research and practice. The framework was developed in 1997 through the combination of input from 35 city representatives and three theoretical/conceptual orientations, which included social ecology, community capacity/competence, and civic infrastructure. Social ecology focuses on change at multiple analytic levels for intervention and outcomes, where determining the interplay between individual behaviour, environment and well-being is a key principle. Community capacity refers to defining characteristics of a community, including capacity for participation and leadership, skills, resources, power and values. Civic infrastructure includes informal and formal networks and processes. The framework was organized by levels which include individual, civic participation, organizational, interorganizational, and community. At the individual level, determining whether the acquisition of new skills has occurred is paramount to community change. Skills in assessing, facilitating, problem solving, planning, and policy advocacy are assessed. The evaluation framework measured change by levels, namely individual, civic participation, organizational, interorganizational, and community changes. The California Healthy Cities Project reporting system was used to collect data on changes and to document how the concepts in the framework are measured. The city representative coordinating each Health City completed a written progress report every six months on specific indicators related to each level of change. To measure individual-level changes, city representatives were asked to indicate the skills they acquired or strengthened during the reporting period as a result of participation in the Healthy Cities Project, as well as the skills that were applied or transferred to an organization or situation outside of the Project. Civic participation-level change includes assessing participatory governance, resident involvement, opportunities for new leadership, emergence of new leadership, involvement of informal community leadership, and formation of social capital. Civic participation changes were measured by documenting how many residents were involved in various aspects of the Healthy Cities Project (e.g., < 10 residents, 10-25 residents, >25 residents), if there were any new leadership roles

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				created that were taken on by any residents, and if there were more opportunities created for resident input. Organization-level change includes assessing adoption of new policies and practices, improved enforcement of existing policies, development of health-enhancing programs, institutionalization of health-enhancing programs, and increased resources for health. This level is focused on the mediating structures between individuals and the communities. New policies and practices due to the Healthy Cities effort are reported as organizational-level change, as well as their adoption into cities and communities. Resources acquired were also assessed by providing details about the types of resources (e.g., grants, city budget allocations). Community-level changes were measured using the same questions as the organization-level indicators. Interorganizational change refers to the linkages between organizations and includes assessing new partnerships, mature collaborations, and bridging of community sectors. Interorganizational-level changes were measured by documenting if any new partnerships were formed, how involved community sectors are in the project, and how the steering committee is performing. Lastly, community-level change includes assessing changes to the physical and social environment, such as more green spaces, community gardens, and changes in community norms such as a reduction in smoking. Data on these changes were collected through a reporting system where participating cities were required to submit progress reports at the six- and 12-month mark on specific indicators related to each level of change. The authors highlight that potential bias from staff in completing these reporting forms could be a limitation. It is recommended that valid and reliable measures are needed to assess the concepts presented in the framework.
Describing the Emergence Model of social and human capital and its application to the Healthy Municipalities project in Northeast Brazil (15)	*Publication date:* 2007 *Jurisdiction studied:* Northeast Brazil *Methods used* Descriptive study	The Emergence Model was applied to the designing of Healthy Municipalities in rural areas in Northeast Brazil	In this model, social and human capital at the state, municipality and community levels are the target points for intervention to ensure formation of adequate infrastructure for health promotion.	In 2003, the federal government of Brazil implemented the Healthy Municipalities project in Northern Brazil over five years. The goal of this initiative was to foster infrastructure and environments that supported health and well-being. The Emergence Model of a Health Promotion Setting was developed for designing infrastructure for Healthy Municipalities and Cities using concepts of human and social capital. The model is grounded in

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				the five health-promotion actions included in the Ottawa Charter: 1) build healthy public policy; 2) create supportive environments; 3) strengthen community action; 4) develop personal skills; and 5) reorient health services. Application of the Emergence Model of a Health Promotion Setting initially involves carrying out the five health-promotion actions listed in the Ottawa Charter in the Healthy Cities setting. The interventions that are implemented would enhance and strengthen the five forms of capital – physical, financial, natural, human, and social – that exist within and/or outside the setting, but when social and human capital becomes considerably enhanced, the collective action of those within the setting would influence environmental, human, and/or social determinants of health and quality of life. Once these actions have been adopted in the Healthy Municipalities project, the authors posit that social and human capital will become enhanced. These forms of capital will then enable individuals to draw on financial, physical, and/or natural capital, which would in turn influence environmental, human, and/or social determinants of health and quality of life. Application of the Emergence Model in the Healthy Municipalities project in Northeast Brazil involved enhancing social and human capital at the state, municipality and community levels. There was no explicit description included in the study of how the outcomes of the Healthy Municipalities project were measured.
Developing an Indicator System for a Healthy City (7)	*Publication date:* 2020 *Jurisdiction studied:* Chongqing, China *Methods used* Mixed methods including focus groups and in-depth interviews	The first round of focus groups included eight experts and opinion leaders from the Patriotic Health Campaign Committee Office, the Health Commission, CDC, the Education Commission, the Sports Bureau, and other health departments. The second round of focus groups included a clinician and university professor. In-depth interviews were conducted with 15 chiefs or senior staff members from the Health Commission, Sports Bureau, the Environmental	Seventy-six indicators were identified and divided into first-level, second-level, third-level, and characteristic indicators. This indicator system was used to assess the Healthy City.	This study aimed to develop an indicator system for the evaluation of a Healthy City in Chongqing, China using government documents, a literature review, interviews and focus groups. Seventy-six indicators were selected and divided into first-level, second-level, third-level, and characteristic indicators. The domains in which indicators were classified were referred to as first-level indicators, which included healthy environment, healthy society, health services, healthy people, health literacy, and health behaviours. Second-level indicators included determinants such as air quality, education and health resources. Examples of third-level indicators included incidence of myopia, regional ambient noise, and trends in the incidence of cardio-cerebral vascular events. Lastly, characteristic indicators included the number of large-scale national fitness activities held each year, health sciences popularization, and construction of health venues.

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
		Protection Bureau, the Social Security Bureau, the Civil Affairs Bureau, the Food and Drug Administration, the Primary and Secondary Health Care Center, and the CDC. Length of employment experience for each participant ranged from six to greater than 20 years.		This indicator system was found to include more indicators than the European Urban Health Indicators System Project Part 1, which only included 39 indicators. It also did not include environmental indicators, which this study included. The new indicator system also revealed new public-health challenges emerging in China such as increased prevalence of myopia in children and adolescents. As the indicator system also collected information on health behaviours like smoking, daily salt intake and exercise, it could contribute to the monitoring of chronic-disease risk factors. Limitations of this study were that only qualitative data was used, and the indicator system was not verified or generalizable to other areas.
Assessing the Healthy Hawaii initiative (16)	*Publication date:* 2005 *Jurisdiction studied:* Hawaii *Methods used* Descriptive study	n/a	Tthe Healthy Hawaii Initiative (HHI) was designed based on the U.S. Centers for Disease Control and Prevention (CDC) model of evaluation. Quarterly or biannual progress reports are required, and a cross-sectional plus longitudinal survey is completed within specific timeframes.	This study describes the Healthy Hawaii Initiative (HHI) and the initial process evaluation that was undertaken. The HHI focused on disease-prevention programs that promote healthy lifestyles in tobacco use, nutrition and physical activity. A group of international experts was convened through a workshop to design the evaluation for the HHI. The U.S. CDC model of evaluation was selected. This model requires quarterly or biannual progress reports highlighting progress, barriers, facilitators and future action plans. A modality of approaches for the collection of data to inform the evaluation was also utilized. A cross-sectional plus longitudinal survey which assessed mediators of change (self-efficacy, perceived environment, attitude and subjective norms for target behaviours) was conducted and repeated every six months during the first years of the HHI and continued yearly afterwards. The primary behaviour-outcome assessments utilized were the Behavioural Risk Factor and Surveillance Survey and the Youth Risk Behaviour Survey. Community health profiles, which included over 100 health indicators from 18 different data sources, were collected through the development of the Hawaii Outcomes Institute at the University of Hawaii. A newspaper content analysis of content covering behaviours related to tobacco use, nutrition and physical activity was conducted yearly. Chronic-disease rates were tracked through hospital discharge data, the Hawaii Tumor Registry, and the Surveillance, Epidemiology, and End Results site. Environmental attributes related to each health behaviour were incorporated into the longitudinal survey. Lastly, yearly stakeholder assessments were provided to HHI management and coordinators.

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				No discussion related to the effectiveness or limitations of this evaluation approach was included in the study.
Evaluating Healthy Kids, Healthy Cuba (21)	*Publication date:* 2015 *Jurisdiction studied:* Cuba *Methods used* Cross-sectional study design	Twelve participants were included with representatives from the University of New Mexico Prevention Research Center, Nacimiento Community Foundation, Cuba Farmer's Market, Cuba Community Garden, Cuba Public Health office, Cuba Independent Schools, Sandoval Country Fair Board, horticulture and backyard gardening, community residents, and a local health clinic.	The evaluation of the Healthy Kids, Healthy Cuba initiative utilized systems thinking at the community level by determining how parts of the system influence policy and environmental changes related to healthy eating. Partners of the initiative participated in a group model building session and were asked to identify determinants that affected policy systems or environmental change related to healthy eating, physical activity and obesity. A behaviour-over-time graph and a causal loop diagram were developed based on the session outcomes.	The Healthy Kids, Healthy Cuba initiative was implemented to support healthy eating and active-living policy, system and environmental changes to promote healthy communities. The demographic of particular focus was children at high risk of obesity based on race, ethnicity, income or geographic location. This study utilized a systems thinking approach to evaluate how behaviours change over time. The authors aimed to identify and assess cause-effect relationships, also known as system feedback loops. Partners of the Healthy Kids, Healthy Cuba initiative participated in a group model building session. Participants were asked to identify determinants that affected policy systems or environmental change related to healthy eating, physical activity and obesity. Twenty-seven of the healthy-eating and physical-activity influences identified by participants during the behaviour-over-time graph exercise were connected by a feedback loop. Five sub-systems emerged: 1) healthy-eating policies and environments; 2) active-living policies and environments; 3) health and health behaviours; 4) partnerships and community capacity; and 5) social determinants. Feedback loops specific to the goals of the Healthy Kids, Healthy Cuba initiative included farmers' markets, community gardens, healthy vending, after-school activity bus and active transportation, and parks and recreation. This approach to uncovering cause-effect relationships was found to be well received by participants unfamiliar with systems thinking.
Evaluating urban community work (17)	*Publication date:* 2020 *Jurisdiction studied:* Washington, United States *Methods used:* Qualitative study	Seattle Partners for Healthy Communities is responsible for the design and evaluation of community-based primary prevention programs for urban and underserved communities in the greater Seattle area	The process evaluation model was developed by anthropologists, epidemiologists and a social scientist based on a literature review of evidence on community organization characteristics, participation, relationships, capacity building, empowerment, products, policy and procedure change, and community organizing.	This study described the use of the process evaluation model by the Seattle Partners for Healthy Communities. The process evaluation model used key components derived from the literature with respective indicators: 1) participation (e.g., meeting attendance, committee service, involvement in activities); 2) relationships (e.g., network of interpersonal and inter-institutional links); 3) capacity building (e.g., training and skill acquisition); 4) empowerment (e.g., group's belief in the capability to succeed in future actions); 5) products (e.g., number of publications, programs, evaluations, grants); 6) policy/procedure change (e.g., stories of activities to exert influence on policymakers); and 7) community work (e.g., clear designations of communities, activities to involve members, and sustainability plan.

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				Semi-structured interviews and content analysis were undertaken using standard ethnographic data-gathering techniques. This included interviews, observations, participant observations, grant proposals, meeting notes, publications, workshop descriptions, budgets, staff rolls, and mailing lists. Semi-structured interviews were used to gather participants' views on the Seattle Partners for Health Communities (the Center) activities and progress, as well as information relevant to the model. Participants were chosen by convenience and included advisory group members and staff of the Center. Overall, the authors recommend the use of ethnographic methods, theories related to community organizing, and participatory action research guided by shared power, open communication, and community outcomes to guide future evaluations for these types of programs.
Developing evaluation tools used in Washington State's Healthy Communities projects (18)	*Publication date:* 2006 *Jurisdiction studied:* Washington, United States *Methods used:* Descriptive study	Washington State's Healthy Communities projects	The Community Health Governance (CHG) model was applied to data collected from telephone and interview surveys of committee and project team members of the Washington State's Healthy Communities projects.	In this study, the CHG model is used to organize and analyze partnerships, leadership and management processes of Washington State's Healthy Communities projects. These projects involve efforts to prevent obesity in the state with projects focused on trails and paths, breastfeeding and community garden. The CHG model was used as an evaluation tool of the Healthy Communities pilot project. This model was used to measure critical characteristics and proximal outcomes. Critical characteristics take into account who participates in a project and how they participate in the collaborative process. Proximal outcomes are the empowerment of individuals and groups to create and enhance social ties, and work to solve community health problems. Leadership and management are important to ensuring that these processes can occur in a collaborative manner. Specifically, the CHG model analyzed and measured individual empowerment, bridging social ties, synergy, critical characteristics of who was involved and how they were involved, the scope of the process, and leadership and management parameters such as participation and facilitation. The following resources were used to design the survey tool to evaluate community partnerships for health-promotion projects: a social capital index (measuring trust, involvement and reciprocity); evaluating partnerships (a criteria of perceived costs and benefits to partnership management); measuring perceptions of multiple levels of control (statements applied to index individual and community

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				empowerment); assessing principles of partnership (questions based on principles of community-campus partnership); partnership synergy self-assessment tool (tool on the elements of a community healthy governance model); community partnership stakeholders questionnaires (addressing stakeholder views of participation and outcomes based on community partnership for healthy personnel education); and community coalition action (elements of coalition membership and process that create synergy for community capacity and change outcomes). Survey results were compared with objective observations of the project, including community involvement, attendance and participation at meetings, and progress towards project goals. The authors concluded that the CHG model was useful as it involved community engagement and identified most of the required elements for working with communities to facilitate policy and environmental changes.
Evaluating healthy communities process in central Alberta (20)	*Publication date:* 2000 *Jurisdiction studied:* Alberta, Canada *Methods used:* Qualitative study	David Thompson Health Region is one of 17 health authorities which serves 170,000 people	The Healthy Communities Initiative (HCI) included the development of a committee at the community level that involved key community perspectives (e.g., agriculture, higher education, business and industry, social services, children's services, criminal justice and elected local government officials, management, public health, and community advisory groups), the development of a shared vision of health, assessment of community needs, strengths and resources, and the development of an implementation plan.	The evaluation of the Healthy Communities Initiative involved questions focusing on processes and outcomes through surveys, interviews and success stories of community partners in order to develop indicators of success. There is a three-level evaluation design. The first level emphasizes looking at performance measures that make sense to the community and reflect what community members see as evidence of accomplishment. The health agency should work with communities to help them identify key indicators that are measurable and reportable. The second level is cluster evaluation, looking at a group of projects to identify common threads and themes about how to implement such initiatives in the future. There is considerable attention paid to the utility of community capacity (the structural and relational factors that make it possible to organize around and act on issues of concern), relating to concepts such as asset-based community development, community competence, or social capital. The David Thompson Health Region (DTHR), which funds the community health-promotion projects, addresses seven domains: communication, participation, ongoing learning, shared vision, sense of community, knowledge/skills/resources, and leadership.

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				Based on the findings of the evaluation, communities within the region identified key priority areas for planning their healthy communities. The authors concluded that evaluations are beneficial for the HCI as it helps uncover optimal practices, capacity, lessons learned, and strategies for effective intersectoral collaboration and opportunities.
Evaluating Healthier Communities and developing indicators for New Mexico (19)	*Publication date:* 2000 *Jurisdiction studied:* New Mexico, United States *Methods used:* Descriptive study	Twelve communities participating in New Mexico Healthy Communities program	The evaluation involved a baseline assessment and follow-ups with communities.	This study describes the development of the Participatory Evaluation Model for evaluating New Mexico's Healthier Communities program. The New Mexico Healthy Communities program aimed to improve family health and lower rates of violence and substance abuse. The model evaluated the process, structure and systems related to the implementation of the healthy communities program. The evaluation involved a community profile of population-health statistics and existing collaborations and leadership, a process evaluation of leadership and coalition changes, an impact evaluation of programs, systems, or policy changes, and an outcome evaluation of economic, health or social-welfare indicators. Interviews were conducted with informal and formal community leaders by graduate students. The students observed coalition meetings and compiled population-based statistics. The questions addressed the community's recognition of the Healthier Communities principles, its level of participation and collaboration, forces that promote or inhibit collaboration, and how state agencies need to change to respond effectively to communities. The model proposes implementing logs and annual assessments of planning and implementation process, and of intermediate community-level system impacts, as well as long-term changes in morbidity/mortality to measure outcomes. The authors concluded that the evaluation model requires a consistent negotiated relationship between the evaluator, researchers and community members, and a deep understanding of community needs and relevant indicators.
Evaluating California healthy cities and communities program (12; 13)	*Publication date:* April to June 2008 *Jurisdiction studied:*	The 20 participating communities were selected based on a competitive process and awarded a total of $125,000 over a three-year	The two studies provided details of specific components of the evaluation of the California Healthy Cities and Communities (CHCC) Program. The same	The evaluation of the California Healthy Cities and Communities (CHCC) Program by two researchers is described in two studies. Each participating community in the CHCC program is responsible for planning a broad-based and multisectoral governance structure, developing a shared vision, conducting an asset-based community

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	California, United States *Methods used:* Mixed-methods evaluation	period. Communities were diverse in population size, density and socio-economic characteristics.	methods were used to collect data for the evaluation, namely semi-structured interviews with coordinators and community leaders, focus groups with coalition members, a self-administered mail questionnaire, and a document review.	assessment, and implementing action plans focused on youth development, civic capacity-building, neighbourhood improvement, lifelong learning and economic development. The evaluation consisted of a cross-case analysis of a multiple case study of 20 participating communities in the program. One study assessed the extent to which community coalitions implementing the program leveraged financial resources, expanded programs, and influenced organization policies. The other study assessed leadership development opportunities among communities in the program as means to enhance capacity and engagement with residents. A coding scheme was developed with coding categories in the evaluation framework. Survey responses and data on new leadership opportunities were grouped into four types of communities, based on population density and urban influence: rural region, rural municipality, urban municipality, and urban neighbourhood. The evaluation consisted of semi-structured interviews with coordinators and community leaders, focus groups with coalition members, a self-administered mail questionnaire, and a document review. The researchers assessed the number of residents through the survey and progress reports, sector representation through survey data and interviews, and factors influencing community participation through interviews and focus groups. The evaluation team classified sites into three categories based on amount and significance of organizational change, variety of organizations affected, and extent to which changes reflected a shift in power roles to benefit community interests. Based on the findings of the studies, the authors concluded that the CHCC Program has the potential to strengthen the organizational infrastructure of communities, and that the capacity of the program was enhanced by expanding leadership opportunities at the civic-participation level.
Identifying characteristics and community capacity in 49 sites implementing healthy-eating and active-living interventions (28)	*Publication date*: June 2015 *Jurisdiction studied*: United States *Methods used*: Quantitative survey	Community partnership members and representatives (n=608) from 48 of the 49 partnerships in the *Healthy Kids, Healthy Communities* (HKHC) program completed the survey between December 2012 and April 2013. Most were female (69%), white (68%), African American	The survey consisted of 82 items about partnership and community capacity, and used a four-point Likert-type scale (strongly agree to strongly disagree) to rate each item. Evaluators used factor analysis and descriptive statistics to assess the survey results and generate findings.	The aim of the study was to describe the characteristics of the HKHC partnerships, the leadership, and their relationships with the broader communities they served. A survey was completed by partnership members. and factor analysis and descriptive statistics were used to assess the results and generate findings. An 82-item partnership and community capacity survey instrument was administered to measure and assess perspectives of community partnership members and community representatives on the structure and function of their partnerships, and the capacity to create change.

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
		(12%) or Hispanic or Latino (11%), and between 26 and 45 years old (45%), or 46 and 65 years old (43%).		Using factor analysis and descriptive statistics, the evaluators described the indicators: common characteristics of the partnerships, their leadership, and their relationships to the broader communities. To identify themes from the survey, evaluators performed an exploratory factor analysis. Within each factor, responses to survey items were summarized using cumulative proportions reflecting agree and strongly agree versus disagree and strongly disagree. Each site was also evaluated individually and received an analysis summary. Results from the study survey revealed that partnerships were viewed as being led by competent leaders who were motivating, worked well with diverse groups, and were well respected in their roles. The majority of respondents (77%) agreed that partnerships had processes in place to deal with conflicts, organize meetings and structure goals, but 21% were either unaware of whether this structure was in place or felt that such processes did not exist. Some respondents also felt that sustainability opportunities were limited by lack of resources. Findings from this study highlight the value of strong leadership in managing healthy community partnerships and ensuring that they are effective at forming and growing their structure, collaborating with communities to make policy and environmental changes, and planning for sustainability. Through consensus building and collaboration across community organizations and stakeholders, partnerships were able to increase access to resources and advocate for healthy-eating and active-living initiatives. To ensure the sustainability of the HKHC partnerships, efforts are made to assess programs and initiatives on an ongoing basis in order to inform future interventions.
Assessing the evidence for Healthy Cities (24)	*Publication date*: November 2009 *Jurisdiction studied*: Europe *Methods used*: Literature review	Not reported	A conceptual framework combining insights from theoretical perspectives on health-policy development and evaluations and planned intervention approaches was used to assess how evidence is used to support the implementation of Healthy Cities	This study evaluates Healthy Cities methodologies and how they should be regarded as a package, in context, and as part of the endeavour to compile evidence about the impact and experiences of Healthy Cities. A conceptual framework was applied combining insights from knowledge utilization theory, theoretical perspectives on (health) policy development, theory-based evaluations and planned intervention approaches. With respect to the nature of social and academic evidence on health promotion in cities, the study concludes that even when produced

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				using accepted research methodology, this kind of evidence may not have a significant impact on policy. The study speaks to the idea that the evaluation of the impact of Healthy Cities approaches does not fall into traditional research methodologies, such as the randomized controlled trial or quasi-experimental designs, because of the complex social issues that exist in Healthy Cities settings. It references the use of the 'Fourth Generation' (4GE) or 'naturalistic' inquiry for Healthy Cities evaluations in which stakeholder perspectives are incorporated into the development process for evaluation parameters. 'Realist evaluation' is another philosophical approach suggested for effective evaluation in complex socio-political settings. To ensure that cities entering the WHO-EHCN network would collect the data needed for monitoring and evaluation, cities were required to implement a program of systematic health monitoring and evaluation. Unfortunately, less than half of the cities in the WHO-EHCN followed through with evaluation and reporting obligations within designated timelines. The WHO-EHCN also evaluated the impact of the network itself by distributing a questionnaire to all cities in the network in July 2002. A questionnaire was chosen as the method of evaluation because the scope and resources required to conduct interviews, focus groups and document analysis in each city in the network was too extensive. The findings of this study speak to the range of issues with conducting evaluations of Healthy Cities and concludes that evaluative methodologies should be developed in context and with flexibility to adjust as Healthy Cities evolve.
Applying a mixed-methods evaluation to Healthy Kids, Healthy Communities (25)	*Publication date*: June 2015 *Jurisdiction studied*: United States *Methods used*: Mixed-methods evaluation	Representatives from all 49 community partnerships of the *Healthy Kids, Healthy Cities* (HKHC) program participated in this evaluation	The evaluation consisted of eight overlapping components that specifically assessed the complexity and impacts of HKHC partnerships through a performance monitoring dashboard, a quantitative cross-site impact evaluation, and a qualitative cross-site process and impact evaluation.	The aim of this study was to assess the progress of the HKHC evaluation towards meeting its aims, and to describe the array of methods and tools used for the evaluation. The HKHC evaluation consisted of a combination of an online performance-monitoring dashboard system, interviews, direct observation, surveys, environmental audits, group model building, photos and videos, and secondary data sources. For the performance-monitoring dashboard, a total of 17,400 actions were entered by HKHC partnerships from March 2010 to May 2014. The actions were coded by evaluators using a taxonomy consisting of 593 codes that tagged each action for the types of settings, geography populations, and organizations involved.

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				A total of 41 environmental audits and 17 direct observations were carried out as part of the enhanced evaluation of parks and play spaces, street design, food markets, and childcare-nutrition and physical-activity standards. Trained local evaluation officers also conducted 264 telephone and in-person interviews with project staff, partners, or community representatives about the operation of the community partnerships, the community dynamics that influenced policy-making processes and resources, and the costs and sources of revenue for the partnerships. Group model building was another HKHC evaluation method used that consisted of using group model building exercises to determine partnership and community representatives' perspectives on the value and influence of the partnerships on system-level policy, and environmental changes that promoted healthy and active living of children in the communities. An 82-item partnership capacity survey was completed by partnership representatives to gain a better understanding of partnership capacity and functioning, leadership, political influence, relationship with partners, and perceptions of community members. Photos and videos showing the condition of community facilities and environments complemented the feedback collected from representatives as well as surveillance data from partnership records and reports. All data from the evaluation was recorded and coded in an Access database for analysis. Key lessons learned from the evaluation included the value of systems approaches to evaluation, the need to build local capacity, the value of practical dissemination strategies, and the importance of an upstream focus.
Increasing community capacity for participatory evaluation of healthy-eating and active-living strategies through direct observations and environmental audits (29)	*Publication date*: June 2015 *Jurisdiction studied*: United States *Methods used*: Mixed-methods evaluation	For the enhanced evaluation, 164 individuals from 31 of the *Healthy Kids, Healthy Communities* (HKHC) partnerships were trained on how to use data collection tools	The enhanced evaluation consisted of collecting data on several cross-site strategies using direct observation and environmental audits. Local evaluators had to be trained on how to use data collection tools for the enhanced evaluation.	This study assessed the protocol development process and the training and capacity-building activities for the enhanced evaluation portion of the HKHC program evaluation. The enhanced evaluation was an optional component of the overall evaluation and involved collecting additional data on six cross-site strategies using direct observations and environmental audits. Enhanced evaluation was adapted across unique settings. Six cross-site strategies were selected at the outset by tracking policy, system and environmental strategies for healthy eating, active living, and

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
				prevention of obesity across the 49 HKHC communities. There was optional participation by community partnerships, who received invitations outlining the criteria and requirements to participate. The use of multiple auditors/observers to increase inter-rater reliability was encouraged. All 31 community partnerships had two to 15 individuals participating in the trainings. However, many partnerships collected data in teams which limited the evaluation team's ability to conduct inter-rater reliability. The enhanced evaluation needed practical tools to be applied in different community contexts. Each tool (n=10) had an associated protocol which defined and operationalized the measures in the tool. Evaluators could also modify tools to add questions relevant to their communities or remove items irrelevant to the evaluation of HKHC. Training sessions were conducted for HKHC community partnerships, and Spanish versions of tools, protocols and training materials were made available, allowing participation of Spanish-speaking residents in five communities. Data was analysed using Microsoft Excel and a coding guide. Data for environmental audits were entered twice by two different evaluation team members, and then checked for errors. Evaluators checked 10% of the data entered from direct observation. They then calculated and fixed entry errors. Descriptive tables in Excel were produced for environmental audits, while direct observation data used R; basic frequencies and counts were calculated. Data was then cleaned, analyzed, and summarized. Participation in the enhanced evaluation was optional for communities and required the appointment of an onsite coordinator to recruit community members to assist with data collection, coordinate training with data collectors and the evaluation team, review data entered into evaluation tools, and coordinate the transmission of data to the evaluation team. Evaluators selected to conduct the direct observations and environmental audits were trained on how to use the tools, and given the opportunity to practice using the tool at a facility. Lessons learned from evaluation efforts included the importance of creating accessible tools in the language of the communities, finding a balance between working in teams and conducting inter-rater reliability, the ability to document future use of evaluation tools, and the need to build local capacity.

Focus of study	Study characteristics	Sample description	Key features of the intervention(s)	Key findings
Implementing Healthy Cities' principles and strategies in Israel (9)	*Publication date*: December 2006 *Jurisdiction studied*: Israel *Methods used*: Cross-sectional, quantitative study	Of the 36 coordinators or contact persons of Israel's Healthy Cities Network in 2003, 18 completed the assessment questionnaire used in the study. Of the 18 people that did not participate, 11 did not appoint a coordinator and did not engage in health-promotion activities, and in the other seven cities, a lack of political support in the previous two years lead to the suspension of Healthy Cities activities. Two-thirds of respondents were female and almost 90% of coordinators were employed by the municipality.	The assessment questionnaire for Israel's healthy cities, which was designed based on the Monitoring Accountability Reporting Impact (MARI) assessment framework, consisted of both open-ended and closed questions and covered six dimensions: • equity policy and political support; • management; • health-promotion programs and activities; • community participation; • intersectoral partnerships; and • environmental protection activities. A ranking score was assigned to each measure in a consensual process.	This study aimed to describe the level of implementation of the Healthy Cities' principles and strategies by each of the cities in Israel's Healthy Cities network. The aim of the cities and towns in the Healthy Cities network is to adopt the principles of a 'Healthy City' and achieve the following: • to produce a health profile and plan that aligns with the strategic aims of 'Agenda 21' and 'Health for All'; • to implement the strategies of the Ottawa Charter for Health Promotion; • to nominate a city coordinator and a steering committee; and • to participate in network activities. Thirty-six coordinators/contact persons enrolled in the Healthy Cities network in 2003 were contacted, and 18 coordinators participated by completing a questionnaire with the assistance of key informants in the municipality. The other 18 were contacted for a follow-up. The evaluation tool (questionnaire) had both open-ended and closed questions. It covered six dimensions of Healthy Cities' principles and strategies: equity policy and political support; management; health-promotion programs and activities in the city; community participation; intersectoral partnerships; and environmental protection activities. Each dimension has multiple components and measures, with each measure scaled as either yes-no or rank-order questions. The open-ended questions were categorized. The sum of scores, with the highest given to the ideal pattern/outcome, was generated from component scores. Each dimension's sum of scores was compiled with weighting according to component. Cronbach's alpha tested internal reliability of the components and dimensions. Inconsistent measures or components were excluded, with one component given special consideration. Some questions also referred to the impact of the network and assessment of its contribution to the city's health-promotion activities. All data were analyzed and total scores of each dimension were converted to a 0-10 scale. This analysis was based on Donabedian's model for assessing quality of healthcare. Spearman's correlation coefficients and ANOVA were also used. Findings from this study's review of the assessment questionnaire results revealed that: • intersectoral partnerships achieved the highest score in most cities while environmental activities had the weakest scores; • in cities where coordinators invested over 20 hours a week into the work of the Healthy Cities network and participated in four to five network activities in the last two years, a higher mean

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				score was found in all dimensions except the environmental dimension; • prior work experience of the coordinator in public health, health promotion or community service was associated with higher scores on community participation and intersectoral partnerships when compared to those with lack of work experience; • political support was strongly associated with the equity policy dimension, and equity policy also strongly correlated with management and intersectoral partnerships. The evaluation process and study findings had a beneficial impact on the network in that some cities reactivated their membership, and addresses activities that had low scores. Given that political support and commitment enabled coordinators to participate more in network activities, it was recommended that the network should invest in strengthening political support and capacity building of the coordinators.
Evaluating Healthy Communities adolescent-health program in Uganda (10)	*Publication date*: February 2020 *Jurisdiction studied*: Uganda *Methods used:* Mixed-methods evaluation	The Healthy Communities program is aimed to design and implement interventions to reduce HIV infections, maternal and child mortality, malnutrition, malaria, and tuberculosis	The process evaluation combined quantitative and qualitative data collection methods, which included a needs assessment, program theoretical approaches findings, document review, direct observation during on-site monitoring, and consultations with ARC program staff.	The authors derived a common analysis framework from written documents, theme and code categories for the qualitative analysis. The framework includes components, questions, indicators and data-collection methods. For example, the components highlighted were context, reach, dose delivered, dose received, and fidelity. Examples of indicators included existing health policies, access to services, exposure to health messages, stakeholder engagement, percentage of intended participants, and number of changes made during program implementation. This study collected data on program coverage, reach and factors influencing implementation. Specifically, the "evaluation outcomes of interest were to understand ARC's program design and coverage factors that influenced program implementation, and the program's effectiveness in reaching the intended target populations." They did this using mixed methods including direct observation during site-monitoring activities, consultations with program staff, and review of program documents. Process-evaluation was used, as well as qualitative thematic content analysis. Data analysis software was used for data structuring. The quantitative data were analyzed using the program's "Monitoring, Evaluation, and Learning Plan", which focused on indicators such as exposure to family-planning messages, knowledge, awareness and contraception prevalence rates.

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				The authors indicated that monitoring and evaluation should be developed during program inception and design for proper accountability.
Leveraging Neighborhood-Scale Change for Policy and Program Reform in Buffalo, New York (26)	*Publication date*: December 2009 *Jurisdiction studied*: Buffalo, New York *Methods used:* Descriptive study	The Healthy Communities Initiative (HCI) focused on employees working in the Buffalo Niagara Medical Campus and neighbouring residents	The Active Living by Design community-action model was implemented in the HCI partnership. The initiative used the 5P strategies (i.e., preparation, promotion, programs, policy, and physical projects like walking and bicycling) focused on active living.	This study described the HCI at the Buffalo Niagara Medical Campus, NY. It collected information on the systemic, environmental and policy changes to support active living in the target area and city at-large. The experiences described in the study reported key lessons when developing an evaluative approach such as the: 1) critical need to engage neighbourhood residents from the beginning; 2) cultivating a diverse partnership; 3) using a comprehensive approach; 4) balancing long-term goals with short-term accomplishments; 5) integrating active-living initiatives into existing policy and planning mandates; and 6) making sustainability a priority.
Model of health and well-being evaluation framework manual (14)	*Publication date:* November 2019 *Jurisdiction studied:* Ontario, Canada *Methods used:* Evaluation framework	Community health centres in Ontario	The framework used an outcomes-based model and evaluation questions and indicators to evaluate the services provided by community health centres.	This document describes the Community Health Centre Evaluation Framework that was designed around three values and eight attributes of the Model of Health and Wellbeing (MHWB) used in Ontario's community health centres. The MHWB provides a conceptual framework against which all services of community health centres can be evaluated. The attributes describe these services as: • interprofessional, integrated and coordinated; • anti-oppressive and culturally safe; • accountable and efficient; • grounded in a community-development approach; • community governed; • based on the determinants of health; • population-needs based; and • accessible. These attributes were derived from the values of commitment to health through the lens of the social determinants of health, community vitality and belonging, and health equity and social justice. The framework consists of overarching evaluation questions and indicators, and a Results-Based Logic Model (RBLM) that was developed to show how health centre activities and their outcomes are linked to the attributes of the MHWB. Key questions were derived from each of the three direct outcomes of the RBLM, and indicators were developed to be used to assist centres in answering these questions. In order to be meaningful, indicators were designed

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				to be valid, reliable, sensitive, feasible, acceptable, universal and inclusive. The document also provides a guide for users collecting information for the evaluation, including registration data, individual service event (or encounter) data, and personal-development group data. Questions intended to guide evaluation of the framework arise from four direct outcomes of the RBLM, each of which have their own performance indicators. These outcomes are: 1) reduced risk, incidence, duration, and effects of acute and episodic physical, social and psychological conditions, and of chronic diseases, at individual and community level; 2) increased access for people who are experiencing barriers; 3) increased integration and coordination; and 4) increased community capacity to address the determinants of health. Individual client information was gathered, with data being either mandatory, required or optional. The types of data included registration data (i.e., identifiers, socio-demographic data, etc.), individual service event (or encounter) data (i.e., procedures), and personal-development group (PDG) data (i.e., group life span). Community initiative (CI) data was collected separately.

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