EVALUATION OF THE CHILD HEALTH CHECK INITIATIVE AND EXPANDING HEALTH SERVICES DELIVERY INITIATIVE

EVALUATION DESIGN REPORT

24 SEPTEMBER 2009

Contents

LIST OF ABBREVIATIONS

ACCHO	Aboriginal Community Controlled Health Organisations
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
AMS	Aboriginal Medical Service
CDC	Centre for Disease Control and Prevention
CHCI	Child Health Check Initiative
CHC	Child Health Check
COAG	Council of Australian Governments
DHF	(Northern Territory) Department of Health and Families
DoHA	Department of Health and Ageing
EDR	Evaluation Design Report
ENT	Ear, Nose and Throat
EHSDI	Expanding Health Service Delivery Initiative
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
GAA	Growth, Assessment and Action
HSDA	Heath Service Delivery Areas
IAG	Indigenous Advisory Group
MBS	Medicare Benefits Scheme
MoU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NT	Northern Territory
NT AHF	Northern Territory Aboriginal Health Forum
NTER	Northern Territory Emergency Response
NT KPIs	Northern Territory Key Performance Indicators
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PHC	Primary Health Care
PHRG	Primary Health Reference Group
PIRS	Patient Information Recall Systems
RAHC	Remote Area Health Corps

1. INTRODUCTION

1.1 PROJECT RATIONALE

The Office for Aboriginal and Torres Strait Islander Health (OATSIH), a division of the Australian Government Department of Health and Ageing (DoHA) commissioned the evaluation of the Child Health Check Initiative (CHCI) and the Expanding Health Service Delivery Initiative (EHSDI).

The CHCI and the EHSDI were implemented as part of the Northern Territory Emergency Response (NTER) in 2007 and 2008 respectively. Specifically focused on improving the health status of Aboriginal and Torres Strait Islander people(s) in the Northern Territory (NT), these two initiatives were part of a suite of activities implemented by the Australian Government. The Government commissioned the evaluation project in order to better understand the process of developing and implementing these programs, the outcomes associated with them and, where possible, the impact CHCI and the EHSDI have and continue to have on the Aboriginal and Torres Strait Islander people(s) in the NT.

The overarching purpose of the evaluation is to examine the performance of the CHCI and the EHSDI in relation to their:

- Effectiveness – to improve the health of the remote Aboriginal and Torres Strait Islander people(s) in the (NT);
- Efficiency – to deliver the services in a cost-effective manner; and
- Appropriateness – to make sure the right services are delivered in the right way to the target population in a timely manner and in accordance with Australian Government priorities and policy.

This project builds on several existing progress reports on the CHCI, and will include consideration of other relevant reports on the establishment and implementation of the EHSDI.

1.2 PROJECT SCOPE

The scope of this project extends to undertaking monitoring and evaluation of the CHCI and EHSDI activities. Other evaluation projects are addressing the other aspects of the NTER.

The evaluation design recognises that the CHCI is nearing completion, noting that provision of follow-up services will continue for some time. However, the process of primary care development encompassed by the EHSDI is part of a longer-term approach that is in the process of implementation. There is an expectation that the shape and structure of the programs under the EHSDI will continue to evolve, hence the need for a formative approach to monitoring and the evaluation of this initiative. The evaluation will need to consider policy implications arising from the findings for both the CHCI and EHSDI.

While the NTER was initiated in response to the sexual abuse of children, the CHCI and the EHSDI program objectives do not aim to directly affect the prevalence of sexual abuse of Aboriginal and Torres Strait Islander children in the NT. This evaluation will not attempt to assess impacts on this problem. The focus of the evaluation is against the specific program objectives and goals for CHCI and EHSDI, set out in section 2.

1.3 PURPOSE OF THE EVALUATION DESIGN REPORT

This Evaluation Design Report (EDR) sets out how the project team will address the evaluation objectives for the CHCI and the EHSDI, and proposes the methodology and process for the project as a whole.

The EDR is centred on the evaluation objectives, and includes specific recommendations relating to how the project team will approach each of those objectives, as set out below.

CHCI evaluation objectives

The objective of the evaluation of the CHCI is to measure the implementation of the NTER CHCI and its impact on and outcomes for the target population. The evaluation will:

1. Assess the extent to which the Child Health Checks (CHCs) reached the target population;
2. Identify the prevalence and, if possible, the severity of the health conditions found through the CHCs and validate these findings with data from other sources;
3. Assess the extent to which requested primary care, allied health and specialist follow-up services have been received, gaps in existing health service delivery, and barriers to the completion of follow-up treatment; and
4. Explore the possibility of undertaking more complex evaluative analyses which could include questions about:
    - 4.1 Whether or not the CHCI has led to improvements in health service delivery for Aboriginal and Torres Strait Islander children;
    - 4.2 Health status of children in relation to the social determinants of health and access to comprehensive primary health care; and/or
    - 4.3 Treatment outcomes.

The Australian Institute of Health and Welfare (AIHW), in collaboration with the MoU Evaluation Partners, has made considerable progress in monitoring and reporting relevant to CHCI evaluation objectives one, two and three. The evaluation should assess the feasibility of completing the analyses set out in point four, and make recommendations regarding these analyses.

EHSDI evaluation objectives

The EHSDI evaluation will assess the:

1. Impact and sustainability of the EHSDI on primary health care service delivery and equitable distribution of resources. This will include measurement against indicators relating to the number, range, and accessibility of services compared with agreed standards for primary care across the NT;
2. Extent to which Aboriginal and Torres Strait Islander people(s) were engaged and empowered to contribute to health service planning, governance and responsiveness of services;
3. Impact and sustainability of the Remote Area Health Corps (RAHC) Agency on health workforce availability and flexibility in the NT. This will include measurement against indicators relating to workforce supply across all locations and the effectiveness of clinical governance structures;
4. Efficiency of the EHSDI in terms of how well it has maximised health service delivery with the available funds;

5. Effectiveness of the EHSDI in achieving change in health status. This will include measurement against primary care related health indicators as development through the NT Key Performance Indicators (NT KPIs) project and the analysis of the NTER CHC program; and
6. Impact of the regional reform process on:
    a. Efficient and effective operation of health services;
    b. Clinical governance, including quality of health services delivery; and
    c. Information systems and planning capacity.

Some of these analyses are challenging from an evaluation standpoint, and, as with the CHCI evaluation objectives, will require a feasibility assessment and recommendations for approaches to these questions.

The evaluation project team expects that the EDR will continue to be revisited and, where necessary, revised during the course of the project. While evaluation processes need to be undertaken within an agreed framework, there also needs to be room for flexibility and responsiveness. The project team will work with the MoU Management Committee to ensure the EDR remains relevant throughout the course of the evaluation.

1.4 METHODOLOGY FOR THE DEVELOPMENT OF THE EDR

Key tools:

- **Mapping the evaluation objectives and questions**
- **Program models**
- **Working in partnership with Aboriginal and Torres Strait Islander people(s)**
- **Data and information sources**

The EDR has been developed by the project team using a number of tools and sources of information. The initial development took place using the information provided in the tender documentation for this project, and in initial discussions with the key contact people at the DoHA. Members of the project team visited Canberra and Darwin in mid-June 2009, and used the opportunity to collect information, agree expectations and processes for the project, and to agree timelines and reporting requirements. Members of the project team then attended a workshop in Alice Springs on 27 July 2009 to get feedback from the MoU Management Committee and an expanded group of AMSANT members on a draft Evaluation Design Report. All these factors are reflected in this EDR.

1.4.1 MAPPING THE EVALUATION

The project team developed a matrix (see summary of the matrix in section 4.2) based on the evaluation objectives specified for the CHCI and EHSDI evaluations.

For each objective, the project team identified a set of relevant questions to present to stakeholders. The project team then identified known and potential data sources, and gaps in information that will

require either further investigation, and/or the development of proxy indicators. The balance of qualitative and quantitative information was considered for each objective. The resulting matrix forms the basis of the evaluation design.

In addition, the project team has used the RUFDATA framework[1] to identify the critical questions and decisions inherent in this project. RUFDATA is an acronym for the following:

- What are the **R**easons and purposes for this evaluation?
- What will be the **U**ses for our evaluation?
- What will be the **F**oci of our evaluation?
- What will be the **D**ata and evidence for our evaluation?
- Who will be the **A**udience?
- What will be the **T**iming for the evaluation?
- Who should be the **A**gency conducting the evaluation?[2]

This set of questions was used to guide initial thinking on the content and key components of the evaluation based on the objectives, program objectives and goals already identified.

1.4.2 PROGRAM LOGIC MODELS

Program logic or theory has been identified as a key tool to use in the evaluation, both in terms of the summative evaluation of the CHCI, but more particularly for the formative evaluation of the EHSDI.[3]

Program logic often begins with a model that "…identifies and links program outcomes with interventions and processes and the theory and assumptions or principles underlying the program. The model provides a map for the program, illustrating how it is expected to work, what activities need to come before others, and how desired outcomes are achieved."[4]

The logic model starts with the assumptions that were made when the program was first being formulated. It then identifies the resources that a program needs to accomplish a set of activities, and then how these resources and activities will work together to achieve the expected outcomes. In this case, the objectives for CHCI and EHSDI have been established, as have the objectives of the evaluation processes themselves.

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[1] Sanders M. (2000) "Beginning an evaluation with RUFDATA: theorising a practical approach to evaluation planning." *Evaluation* 6(1) pp7-21.

[2] This final question is applicable to agencies that are considering whether to commission an evaluation.

[3] Summative evaluations judge the overall effectiveness of a program and are conducted after completion of the program (or after a program has stabilised). These contrast with formative evaluations which focus on ways of improving or enhancing programs and are conducted during the development or early implementation of a program. So summative evaluation reports on a program, whereas formative evaluation reports to the program (based on definition in Patton MQ. 1997. Utilisation-focused evaluation. Sage: California). The distinction between formative and summative has been summed up by Bob Stake: "When the cook tastes the soup, that's formative; when the guest tastes the soup, that's summative" (in Madaus GF. & Kellaghan T. "Models, metaphors, and definitions in evaluation" in *Evaluation models: viewpoints on educational and human services evaluation.* Kluwer: Boston).

[4] W Kellogg Foundation (2004) *Logic Model Development Guide: using logic models to bring together planning, evaluation and action*. W.K Kellogg Foundation: Michigan.

A logic model framework can be presented as describing the relationships between, resources/inputs, activities, outputs, and outcomes, in that order. Descriptions of all these factors will include assumptions, in particular assumptions about how the component parts of the program will come together to achieve the desired impact. In addition, there are factors influencing the relationship of the component parts, some of which are within the control of the program and its stakeholders, and some which are not. The process of developing a logic model makes these assumptions and mediating factors explicit, and therefore creates a shared, clearly understood description of the program, its component parts, and the assumptions that underpin it.

For ongoing programs, the model can identify successes and barriers, and the factors that will need to be addressed to achieve the best possible outcome. The logic model itself can become a tool for improving the understanding of a program. For work that is largely or fully completed, the logic model can be used to clearly identify and articulate aspects of the program (including assumptions) that were implicit in the program design, and assess their influence on and contribution to the outcomes and impacts (where known).

Program logic modelling use for the CHCI

The CHCI was not informed by a comprehensive program logic or theory. However, there were a number of assumptions underpinning the program and the evaluation will be able to test these assumptions, and identify barriers and facilitators that have influenced the program's outputs and outcomes. The project team propose to first approximate the program's theory within the context of the evaluation, and then to use the evaluation process and findings to revise and elaborate on this theory over the course of the evaluation. Ultimately, we plan to develop a program logic model – not of CHCI but informed by its evaluation – of child health or child wellness checks that could be used to inform future policy and practice in this area, both in the NT and more broadly.

Program logic modelling for evaluation of the EHSDI

In formative evaluation such as that proposed for the EHSDI, a logic model can help to support and, where necessary, improve the development and implementation of a program. The logic model can help by establishing a shared vision for the project among stakeholders, including sets of agreed activities and milestones. Stakeholders and evaluators can use the model to assess the program's progress, and to bring continuous quality improvement in an explicit part of the evaluation model. It is important, therefore, that formative evaluation is understood to mean more than an evaluation focusing only on the initial stages of a program.

There are limitations to this approach. The process of developing a logic model for comprehensive formative use is time consuming, and may take resources away from other evaluation activities. It will also increase the demands on all key stakeholders as it requires extensive engagement and commitment from all parties in order to be meaningful. A disadvantage of this approach is that it is likely to require diverting evaluation resources from directly addressing the EHSDI evaluation objectives, making it difficult to meet the objectives, at least in the timeframe for the current evaluation project.

The project team has drafted a program logic model for EHSDI, and intends to further develop and elaborate the model as the evaluation progresses. The program logic will form an integral part of the proposed formative approach. We will regularly revise the model in collaboration with the MoU Management Committee and PHRG, and identify key assumptions to test in the evaluation.

Our proposed approach to using program logic as an evaluation tool is discussed in section 4.4.

1.4.3 *Working in partnership with Aboriginal and Torres Strait Islander People(s) in the Northern Territory*

The project team is committed to working with Aboriginal and Torres Strait Islander people(s) to ensure that the evaluation is accurate, relevant, and reflects their needs and desires as the target group for both the CHCI and EHSDI programs.

In order to ensure the evaluation process is appropriate and effective, the project team has undertaken to use existing formal guidelines for working with Aboriginal and Torres Strait Islander people(s), and also at a practical level in working with local community contacts to engage with Aboriginal and Torres Strait Islander people(s) in ways that are culturally safe.

The project team will work with the Indigenous Advisory Group (the IAG) throughout the monitoring and evaluation project, seeking advice on strategies for consulting with and feeding back to people in the target communities on how the CHCI and EHSDI are performing. The IAG is also mandated by its terms of reference to provide advice on the analysis, interpretation and reporting of data. This is particularly important for situations in which additional information and/or data are collected for the evaluation. Consent must be obtained for the safe and ethical use, storage and sharing of any information related to this project.

The project team's commitment to working in partnership with Aboriginal and Torres Strait Islander people(s) is also covered in section 3.3, evaluation standards.

1.5 Data and information sources

This evaluation will rely on a range of data and information sources, including primary and secondary data, process and outcome data, and quantitative and qualitative information. As a general principle, we will look to using existing data before deciding to collect new information. Data information and sources is discussed in section 4.6.1.

1.5.1 *Literature search and review*

The data will be supplemented by information gathered in a literature search, designed to capture relevant published and grey literature that provides contextual and comparative material for this evaluation.

The literature search will be initially conducted using the following terms:

- NT /Aboriginal community participation/engagement/empowerment/ controlled;
- Primary health care / health service delivery/planning/governance/ responsiveness;
- Northern Territory/Health Services/Primary Health Care/ remote health services/ health service costs /cost-effectiveness;
- Aboriginal health/Indigenous health/Torres Strait Islander health/health status/health outcomes;
- Aboriginal controlled health services;

- Chronic care/Northern Territory/Aboriginal and Torres Strait Islander chronic care/Access/outcomes;
- Aboriginal child health/Torres Strait Islander child health; and
- Northern Territory / health workforce.

The search will focus initially on the NT; however relevant models, data and information from other jurisdictions may be included if appropriate. A complete list of references will be included in all reports. However, it will not include the development of a full literature review.

The material sourced through the literature review will supplement the program and related documents that have been provided to us to date. However, it serves a slightly different purpose. The literature review will be used to further understanding of the context for the programs, and how previous programs have worked, and to help us to draw conclusions from a wider evidence base.

1.5.2 DATA AND INFORMATION MANAGEMENT

All aspects of data collection, storage, management and use involving data concerning Aboriginal and Torres Strait Islander people(s) will be governed by the National Aboriginal and Torres Strait Islander Health Data Principles, in partnership with Aboriginal and Torres Strait Islander people(s).

The selection of sources of qualitative data will be designed to meet the requirements of the evaluation design. These data and information sources will be guided by advice from the MoU Management Committee and the IAG. This is critical where it involves consulting and working with Aboriginal and Torres Strait Islander people(s)' communities, and in the validation and balancing of information collected from communities, as outlined in the adapted Swiss Evaluation Society (SEVAL) standards (see attachments one and two).

2. BACKGROUND AND CONTEXT

In June 2007, the Australian Government announced immediate implementation of measures to protect children, stabilise communities, normalise services and infrastructure and provide longer term support to build communities. These services are known as the Northern Territory Emergency Response, or NTER, and were implemented in response to the report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, commonly known as *Little Children are Sacred*. Released in 2007, the report outlined significant issues with the functioning of remote Aboriginal communities in the Northern Territory.

The report included a range of recommendations, aiming to address the social and economic conditions that have placed these communities at such disadvantage over long periods of time. The Australian Government's response – the NTER – was implemented across 'prescribed areas' in the NT, including 73 remote NT towns and more than 500 Aboriginal and Torres Strait Islander communities, camps, town camps, and outstations. The NTER covered approximately 70 percent of Aboriginal and Torres Strait Islander people(s) in the NT (45,500 people).

The NTER comprises a range of initiatives, of which the CHCI and the EHSDI are part. The main areas of activity are:

- Welfare reform and employment;
- Law and order;
- Enhancing education;
- Improving child and family health (including the CHCI and the EHSDI);
- Housing and land reform; and
- Coordination.

The NTER was reviewed in 2008[5], and several recommendations made on each of the above areas. The primary findings related to the positive effects of the NTER being delayed and dampened by the manner in which it had been implemented. However, the review also noted that the NTER had precipitated some positive changes. The challenge lies in maintaining positive momentum through sustainable, effective projects in the longer term. This is important contextual information for the lessons from the CHCI, and the ways in which the EHSDI will develop in the future.

It should be noted that the scope of this evaluation covers only the CHCI and the EHSDI. Other components of the NTER have been or are being evaluated in separate projects. The context of the NTER is, however, an important factor in setting the scene for the evaluation of CHCI and the EHSDI.

Both the NT and Australian Government have policies on "Closing the Gap" – addressing the disadvantages suffered by Aboriginal and Torres Strait Islander people(s) compared to other Australians. The budget for *Closing the Gap-Northern Territory Indigenous Health and Related Services Measure* includes $131.1 million over three years from 2009-2010. Although the bulk of the funding is allocated for continued regional reform of remote Indigenous primary health care, part of the funding is for other elements (Alcohol and Other Drugs Services and Child Special Services) which are outside the scope of

[5] *Report of the NTER Review Board* (2008). Accessed 12 August 2009 at: www.nterreview.gov.au/docs/report_nter_review/ default.htm

this evaluation. This initiative demonstrates the nature of primary health programs which may build on, but extend far beyond the scope and lifespan of the NTER.

2.1 CHILD HEALTH CHECK INITIATIVE (CHCI)

The CHCI was one of the first NTER programs put in place. It rolled out from July 2007, providing health checks for all Aboriginal and Torres Strait Islander children less than 16 years of age, living in the remote communities covered by the NTER.

The objectives of the CHCI were to:

1. Provide medical teams to conduct voluntary health checks and follow-up health care of Indigenous children less than 16 years of age living in the areas prescribed under the NTER; and
2. Deliver a broad range of follow-up services including primary health care, allied health and specialist services to Indigenous children less than 16 years of age living in the areas prescribed under the NTER.

Key assumptions implicit in the design and delivery of CHCI include:

- Health checks would help improve the health status of Aboriginal and Torres Strait Islander children by identifying those with specific needs and facilitating access to services to address those needs;
- A lack of services and/or lack of access to services was a significant issue for Aboriginal and Torres Strait Islander families;
- Health (and social) conditions included in the CHCs significantly contributed to low health status for Indigenous children living in the prescribed areas; and
- Health (and social) conditions included in the CHCs are amenable and remediable by either the health professionals undertaking the CHCs or the follow-up and referral services arising from CHCs.

The CHCI generally involved teams comprising of a doctor and up to three nurses, and administrative staff. These teams were located in the communities and worked alongside local services for up to three weeks. The checks themselves focused on general aspects of health and wellbeing, and were performed using a standard group of tests and questions (height, weight, haemoglobin, hearing and vision testing, pervious medical history, vaccination status etc). The checks also collected information on education, housing status, smoking and parental wellbeing, providing some general contextual information about the child's determinants of health and social networks. Checks for adolescents aged 12-15 years include questions about alcohol and drug use. It is important to note that the checks were voluntary and dealt with matters relating to abuse or neglect according to guidelines and legislation current in the NT at the time.

The program was due to be completed by 30 June 2009, however hearing and ear, nose and throat (ENT) follow-up services will now be provided for one additional year and dental follow-up services will now continue for another three years. The Medicare Benefits Scheme (MBS) Item 708 CHCs were not specifically mentioned within the list of core primary healthcare services to be implemented under the EHSDI; however the NT DHF, DoHA and AMSANT have agreed that comprehensive child health checks will be part of the core service set.

In 2007-08, $53.4 million was spent on the health-related aspects of the NTER, covering the checks, primary health care and specialist follow-up services; alcohol and substance abuse treatment and outreach, and child special services, including sexual abuse outreach services. In July 2008 the Government allocated a further $9.5 million for provision of dental, ENT and hearing services for children in the remote Aboriginal communities in the NT. The table below shows allocation for the 2007-08 period, along with the expenditure for the following two years of the CHCs and the follow up services.

Table 1. Summary of allocation and expenditure for the CHCI ($million)

	Allocation 2007-2008	Expenditure 2007-2008	Expenditure 2008-2009	Total expenditure to date
Child Health Checks				
AG provided CHCs		7.371	0.003	7.368
NTG provided CHCs		3.457		3.457
ACCHO provided CHCs		1.718		1.718
Capital & Infrastructure		2.878		2.878
Other (incl. training and data collection)		2.253	0.261	2.514
Total Child Health Checks	**58.300**	**17.677**	**0.258**	**17.935**
Child Health Check Follow up				
Hearing & ENT	7.100	7.135	5.200	12.350
Dental	4.886	3.413	3.990	7.423
PHC and Other Follow up		9.036	0.837	9.874
Total Follow up	**11.986***	**19.585**	**10.027**	**29.647**

*Note that for the period 2007-2012 a total of $35.785 million has been allocated for the CHC follow up services.

**Note that the figures provided only include those funds directly attributable to the stated program. Further expenditure towards this outcome may have come from other programs.

2.2 EXPANDING HEALTH SERVICE DELIVERY INITIATIVE (EHSDI)

The original objectives for the EHSDI, agreed between DoHA, the NT DHF and AMSANT in April 2008, were to:

1. Expand primary health care in remote Indigenous communities in the NT;
2. In partnership with the NT Government and the Aboriginal community-controlled health sector, strengthen regionalised approaches to service delivery and support opportunities for structural reform;
3. Increase services to deliver a core level of integrated and comprehensive primary health care services;
4. Establish the Remote Area Health Corps (RAHC) Agency to attract and support urban based health professionals to work in remote Indigenous communities in the NT;
5. Review the capacity of the workforce model to be extended to other remote Indigenous communities; and

6. Ensure longer term services and workforce arrangements complement and build on the initial phases of work undertaken through the NTER.

In February 2009, the NT Aboriginal Health Forum (NT AHF) agreed to the following program goals for EHSDI:

- Program Goal 1. To increase access by Aboriginal people(s) to core primary health care services.
- Program Goal 2. To establish agreed Heath Service Delivery Areas (HSDAs) as a basis for more sustainable services.
- Program Goal 3. To improve primary health care service coordination and integration through: (a) developing and delivering against a coordinated service delivery plan in each HSDA; and (b) moving towards integrating existing service delivery to a single health service provider in each HSDA.
- Program Goal 4. To increase the uptake of quality improvement activities (clinical, governance, management and workforce) across the PHC sector.
- Program Goal 5. To increase the number of Aboriginal people(s) involved in the delivery, management and control of PHC services at a range of levels.
- Program Goal 6. To increase the involvement of Aboriginal communities in health decision-making following the principles of the "Pathways to Community Control" framework.
- Program Goal 7. To allocate resources equitably and efficiently to support service expansion in line with agreed priorities.
- Program Goal 8. To include the effectiveness of, and progress towards, the Program Goals in the evaluation of the EHSDI.

The NT AHF also agreed to commit to the Council of Australian Governments' (COAG) six targets to close the gap between Indigenous and non-Indigenous Australians, two of which relate directly to health. These targets are specifically to close the gap in life expectancy within a generation; and to halve the gap in mortality rates for Indigenous children under five within a decade. In this context the above EHSDI program goals represent a continuing commitment by the NT AHF to reform primary health care and contribute to the aspirations set out by COAG for Aboriginal and Torres Strait Islander people in the NT.

The EHSDI program objectives are more fully developed and specified in the EHSDI program goals, and the latter are the focus for this evaluation. However, the evaluation also considers EHSDI program objectives 4, 5 and 6, relating to the RAHC/short-term deployment workforce model.

EHSDI has five component parts working to achieve these objectives and goals:

- Expanded primary health care services;
- The Remote Area Health Corps (RAHC);
- Development of regions (regionalisation) and move towards community control;
- Capital and infrastructure; and
- Evaluation.

The EHSDI officially began on 1 July 2008, with a four year timeframe and a budget of $99.7 million for the first two years. At the present time, EHSDI will continue through to June 2012. Budgetary allocations and the set of services and initiatives will be confirmed as the initiative progresses. The table below displays the various aspects of EHSDI and the expenditure to date. A total of $182.136 million has been allocated for the entire period ending 2012.

Table 2. Summary of the allocation and expenditure for EHSDI ($ million)

	Allocation 2008-2009	Expenditure 2008-2009	Allocations			Total expenditure to date
			2009-10	2010-11	2011-12	
Service Expansion		17.807				17.807
Regional Reform		1.201				1.201
Hubs		0.973				0.973
CQI		0.212				0.212
Total PHC Expansion and Transition			**41.500**			
Capital & Infrastructure		13.141	0.705			13.141
RAHC		5.001	7.500			5.001
Other (including evaluation)		0.562	1.443			0.562
Total EHSDI	**38.952**	**38.898**	**51.148**	**45.271**	**46.765**	**38.898**

*EHSDI allocations for 2009-10 are provisional.

**Total allocation for 2009-10 through to 2011-12 also includes $18 million for the Closing the Gap in the NT National Partnership Agreement which is appropriated directly to Treasury.

3. PROJECT FRAMEWORK AND METHODS OF WORK

This section briefly sets out the structural parts of the project which will determine how the project team works with the MoU Management Committee, and the other project stakeholders.

3.1 PROJECT MANAGEMENT

The project plan for the evaluation will be finalised once the EDR is agreed by the MoU Management Committee.

3.2 COMMUNICATIONS PLANNING AND PROTOCOL

A communications protocol for the evaluation has been developed and will be finalised once the EDR is agreed by the MoU Management Committee.

The project team expects that the communications protocol will develop as the project progresses, and will be flexible and responsive to any additional or changed communications requirements. The basic protocols of communication between the project team and the MoU Management Committee will remain unchanged unless otherwise agreed by all parties.

3.3 EVALUATION STANDARDS AND GUIDELINES

The project team will use a number of sources of information to guide its practice for this project. This includes a specifically adapted version of the SEVAL evaluation standards[6], see Attachment one. The adapted SEVAL standards have been informed by various ethical guidelines, standards, and literature.[7]

[6] Widmer T, Landert C, Bauman N (2000) *Evaluation standards of SEVAL, the Swiss Evaluation Society*. Accessed 8 August 2009 at: www.seval.ch/en/standards/index.cfm

[7] Berends L, Roberts B "Evaluation standards and their application to Indigenous programs in Victoria, Australia." *Evaluation Journal of Australasia* 3(2) pp54-59; Australasian Evaluation Society. 1998. *Guidelines for the ethical conduct of evaluations.* Canberra: Australasian Evaluation Society; Australian Institute of Aboriginal and Torres Strait Islander Studies. No date. *Guidelines for Ethical conduct in Aboriginal and Torres Strait Islander Health Research*; Australian Health Ministers' Advisory Council. 2004. *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009.* South Australia: Department of Health; NSW Health. 2004. *Communicating Positively: a guide to appropriate Aboriginal terminology.* Sydney: NSW Department of Health; Taylor R "An Indigenous perspective on evaluations in the inter-cultural context: how far can one throw a Moree boomerang?" *Evaluation Journal of Australasia* 3(2) pp44-52; National Health and Medical Research Council (NHMRC). 2005. *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander People(s) about Health Research Ethics.* Canberra: Commonwealth of Australia; NHMRC. 2002. *Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research.* Canberra: Commonwealth of Australia; Aboriginal Health and Medical Research Council & The Sax Institute. 2007. *CRIAH (Coalition for Research to Improve Aboriginal Health) Tools for Collaboration.* Australia: CRIAH; NHMRC. 2003. *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research.* Canberra: Commonwealth of Australia; AHMAC. 2006. *National Aboriginal and Torres Strait Islander Health Data Principles;* SPEaR Social Policy Evaluation and Research). 2008. *SPEaR Good Practice Guidelines.* New Zealand.

The standards address the areas of utility, feasibility, propriety and accuracy, and have been tailored by the project team to be appropriate to the context of Aboriginal and Torres Strait Islander people(s) in the NT.

The adapted standards set out an ideal that all evaluations should aim to fulfil. The project team has used these standards to develop a set of guidelines that provide specific direction on how the standards will be applied given the practical limitations of undertaking this evaluation work (including time and resource constraints), and of the context of the evaluation of CHCI and EHSDI. The evaluation guidelines are included as Attachment two.

3.3.1 ETHICS APPROVAL

The draft evaluation design includes a proposal to use unit record data to compare children who had a CHC with those who did not, and the use of case studies (referring to proposed approaches to CHCI objectives 1, 3, 4(a); and EHSDI objectives). Further investigation of the data gaps and information needs for the evaluation may result in the need to collect additional data, or to analyse data at more specific levels (i.e. individual or community levels). These processes will result in the use of data that does or could potentially be used to identify individuals**.**

There are two Human Research Ethics Committees (HREC) sponsored by the NT Department of Health and Community Services operating in the Northern Territory, one for Central Australia and one for the Top End. Ethics approval will be sought from both committees through the completion of the National Ethics Application Form (NEAF) – the same form can be submitted to both committees. These committees meet on a monthly basis for Central Australia and bi-monthly for the Top End, with proposals submitted two weeks prior to the meeting.

The project team has prepared the application through the NEAF website and will submit the proposal for consideration by the Top End HREC on 30 September 2009 and to Central Australia HREC by 15 October 2009. It is proposed that ethical approvals will be sought in a two stage process. The initial proposal will include details of both the qualitative information, which will be sought through the case studies, along with the analysis of existing data collections. A follow up application will be submitted with details of any unit record data which may be used in the evaluation. This is most likely to include using unique identifiers, such as hospital record numbers, to identify children who had a CHC and those who did not have a CHC, and then collating relevant information on these two groups from existing data collections. The reason for this two phased approach is because at the time of the initial submission, details of the datasets and the information required were not yet known. We will seek support from the MoU Management Committee, including letters of support from key partners, prior to finalising the ethics approval applications.

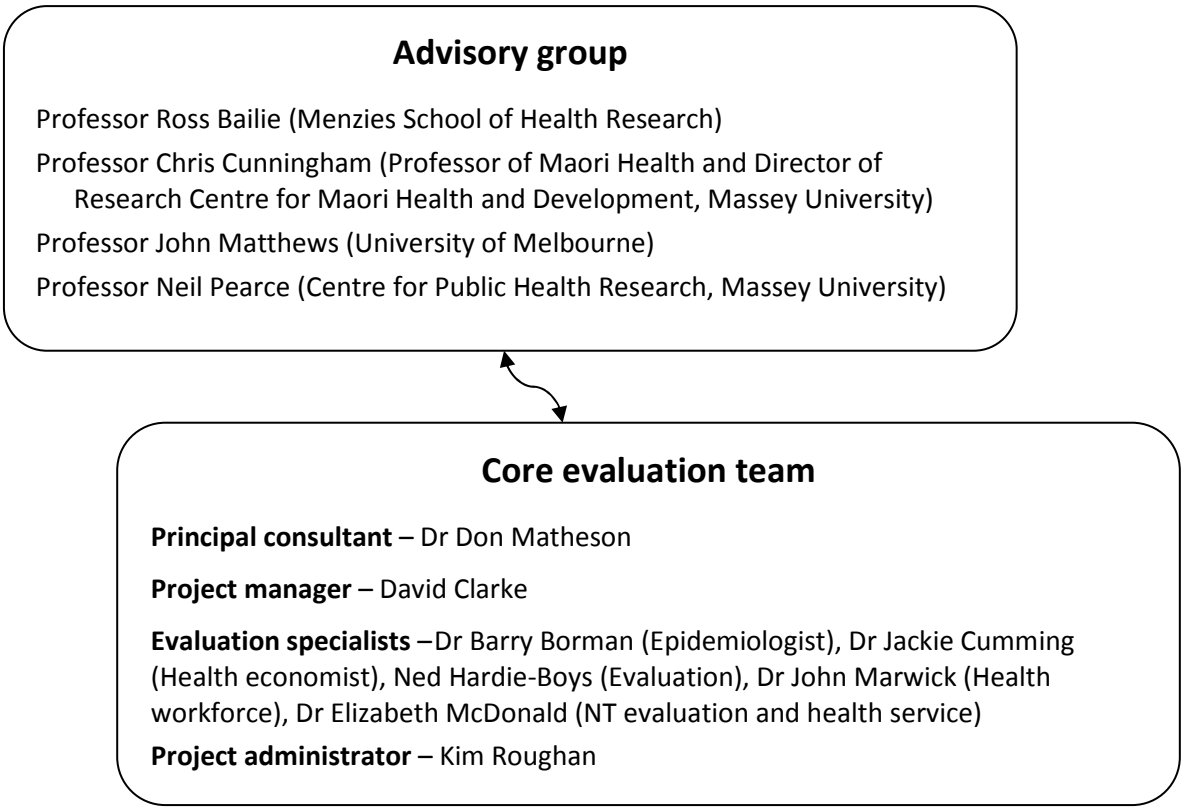
All work with Aboriginal and Torres Strait Islander health data will be undertaken with particular reference to the National Aboriginal and Torres Strait Islander Health Data Principles regarding ethical data collection, management, use and storage; and respect for understanding of data ownership and sharing. The adapted SEVAL standards (see attachments one and two) also provide a framework for ethical standards for health data for Aboriginal and Torres Strait Islander people(s).

With regards to the use of information held in the CHCI data collections, the consent procedure for these collections, as stated on the CHC form itself, stated that copies of the forms were provided to the Commonwealth Government for the purposes of evaluating the program and improving services, and that data were to be shared with the Northern Territory Government to see if children received the

follow-up services they needed. The MoU Management Committee decided that consent to the use of the CHCI data for evaluation purposes should be regarded as time-limited. For the purposes of de-identified data-linkage with NT DHF data holdings on services provided to children with a referral arising from their CHC, the MoU Management Committee agreed this limit would be December 2009. The second stage application for ethical approval will set out a strategy for ensuring that appropriate consent is either in place or obtained for the proposed analyses.

3.4 THE EVALUATION TEAM

A diagram of the evaluation team and their principal roles follows:



4. THE DRAFT EVALUATION DESIGN

4.1 INTRODUCTION

In determining an appropriate evaluation design, we have considered 'design' as one step within a broader framework for planning and implementing program evaluations. The framework we have used is based on the Centre for Disease Control and Prevention's (CDC's) *Framework for Program Evaluation in Public Health*[8], which is organised around six steps:

- Step 1 - Engage stakeholders;
- Step 2 - Describe the program(s);
- Step 3 - Focus the evaluation;
- Step 4 - Gather credible evidence;
- Step 5 - Justify conclusions; and
- Step 6 - Ensure use of evaluation findings and share lessons learned.

The framework has an underlying logic: good evaluation is about more than gathering strong evidence and drawing valid conclusions (steps 4 and 5); it is about maximising the chances that evaluation results will be used (step 6). To do this you need to focus the evaluation on the most salient, relevant and important questions (step 3); which need to fit the full 'landscape' of the program description (step 2); and by ensuring engagement with stakeholders who care about the questions and want to take action on the results (step 1).

'Evaluation design', in its strict sense, fits into the third step (focus the evaluation). However, the first three or four steps are focused on activities at the planning phase of an evaluation, and in 'designing an evaluation', in a more conventional sense, it is also necessary to look forward and consider implementation issues associated with analysing and reporting information (steps 5-6). As a result, our evaluation design covers issues under each of the six steps, although the focus is on steps 1-4, and especially steps 3-4.

4.2 SUMMARY OF EVALUATION DESIGN

Before discussing our proposals for each of the evaluation steps, we have summarised the key features of the evaluation design, for both CHCI and EHSDI, in Tables 3 and 4. Further explanation of the key design features – questions, data sources, methods, key stages – is included under step 3 (focus the evaluation) and step 4 (gathering credible evidence) below.

[8] CDC. 1999. *Framework for Program Evaluation in Public Health.* Atlanta: CDC, United States Department of Health and Human Services.

Table 3. Summary of CHCI evaluation design

Evaluation objective	Evaluation questions	Data sources and methods
Overarching	Were the CHC questions related to the gap in health status experienced by the children?	In addition to the analysis of CHC and comparable data collections included in other CHCI evaluation objectives (below), will involve key informant interviews with policy makers, and reviewing policy documents on the background to CHCI, and published literature on characteristics of effective health service delivery for child health/Indigenous health gain in the NT and effective interventions for conditions covered by CHCI. Aim to understand the extent to which CHCI has contributed to any demonstrated changes in health status of Indigenous children in the NT, and whether any changes were the result of structures and processes consistent with good practice; or changes that would have occurred anyway; or changes that have taken place in spite of the CHC process.
	Were the planned services as a result of the CHCs appropriate to address the observed health and social conditions?	
1. Assess the extent to which the CHCs reached the target population.	1.1 Who got checked, and what were their characteristics?	Will use CHC data collections to describe population that got checked by set of characteristics including location/remoteness, age, sex, date of check, who did check, history of previous checks and health status according to reviewed conditions.
	1.2 Who did not get checked, and what were their characteristics?	Will use comparable data collections to do above for non-checked population, including data collections covering NT Indigenous population and, where possible, the non-checked population that were within scope of the program (may involve corroborating data from local studies).
	1.3 What was the difference between those who got checked and those who did not?	Comparative analysis of the above but also draw on qualitative information from case studies to understand context for the CHCs, and to identify what worked well and what did not. Also compare uptake of CHCs against baseline and trend in child health/wellness checks. Ultimately trying to understand whether coverage increased, and for whom (ie. whether children that needed checks the most got them).
2. Identify the prevalence and, if possible, the severity of health conditions found through the CHCs and validate these findings with data from other sources.	2.1 What was the prevalence of reviewed conditions?	Update previous analyses of prevalence of reviewed conditions. Define severity for key conditions and corroborate with data from other sources, including from local studies at community, health centre or demographic group level. Compare prevalence and severity over time to see what impact CHCs had. Describe prevalence and severity in case study communities and corroborate with qualitative information from health professional working in those communities.
	2.2 What was the severity of conditions found?	
	2.3 What was result of severity and prevalence in each community?	

Evaluation objective	Evaluation questions	Data sources and methods
3. Assess the extent to which requested primary care, allied health and specialist follow-up services have been received, gaps in existing health service delivery, and barriers to the completion of follow-up treatment.	3.1 What primary care, allied health and specialist follow-up services were requested?	Update previous analyses of CHC data collection against the follow-up data collections (chart review, audiology, dental) and NT DHF matched hospital-related follow-up data. Include analysis by type of provider, condition, location, age and time referral made.
	3.2 What requested primary care, allied health and specialist follow-up services were received?	
	3.3 Of those referred, how many received and when did they receive it?	
	3.4 What was the appropriate follow-up treatment, and were guidelines/referral procedures kept to?	Select a condition for each referral pathway (primary care, allied health and specialist), describe the appropriate journey through each pathway for condition, and match local data of childrens' pathways against this 'ideal' pathway. Through regional and community level interviews with health centre staff collect information on the likely effectiveness/relevance of the referral procedures.
	3.5 What is completion for each condition, what evidence is there of completion, and what were barriers to completion?	Describe prevalence of conditions assessed in follow-up services (refer 2.1), and define completion of follow-up treatment for each of these conditions. Match against treatment data (refer 4c.1) for a sample of specific conditions to identify gaps in completion. Corroborate against qualitative information from hospital specialists and health service staff in case study communities to identify gaps in health service delivery and barriers to completion.
4. Explore the possibility of undertaking more complex evaluative analyses which could include questions about:		
4a. Whether or not the CHCI has led to improvements in health service delivery for Aboriginal and Torres Strait Islander children	4a.1 Did health service delivery improve?	Will consider in terms of health service availability, and utilization. For availability, focus on the impact of CHCI on indicators covering each building block or essential service requirement of the health system: governance, management and leadership; funding; linkages; infrastructure; and workforce. Data on these indicators will need to be followed over time to assess what CHCI added to the system (ie above baseline), and what happened post-CHCI funding. Expect some data to be available centrally (DHF and AMSANT), and will explore in more detail through administered questionnaires in case studies. The sustainability question will also be addressed in more detail in case studies, but also in interviews at central level. For utilization, will address in terms of data collected for objective 1 and 3 above, including more detailed data for case studies. Again, issues of sustainability will be addressed through interviews conducted in case studies and with central agencies (DHF and AMSANT). Interviews in case study sites will collect information about perceptions of service accessibility, acceptability, and care coordination for referred services.
	4a.2 What did the CHCI do to the existing health system?	
	4a.3 Did health service utilization increase above the background for Aboriginal and Torres Strait Islander children?	
	4a.4 What happened afterwards (did impacts continue)?	

Evaluation objective	Evaluation questions	Data sources and methods
4b. Health status of children in relation to the social determinants of health and access to comprehensive PHC	4b.1 Has health status changed?	From the analysis for objectives 1-3, will select small number of high level indicators that are a reasonable measure of health status and track change over time of CHCI (before/after) to assess change in health status for target population.
	4b.2 Have social determinants changed?	Will use CHC data collection (e.g., data on housing, smoking and education) to compare social determinants for checked population with comparable data. In case study communities, collect more detailed information on selected indicators (e.g., healthy housing, water supply, sewerage system, food supply and tobacco use) using Healthy Community Assessment Tool developed by Menzies. The tool will be completed as an administered questionnaire. Where possible select indicators that have been used previously so can determine change; where not, collect qualitative information that can be used to estimate change.
	4b.3 Is change in health status related to change in social determinants, and/or to access to comprehensive PHC?	Findings of 4b.1 will be analysed against results of 4b.2 and 4a.3.
4c. Treatment outcomes	4c.1 What specific treatment was provided as part of the CHC and specialist follow-up services?	Complete analysis of treatment data for each condition in CHC data collections.
	4c.2 What was the result of this treatment?	Address as part of 3.5 (above), including qualitative information from interviews with health and social service staff in case study communities to assess barriers to positive treatment outcomes.

EHSDI evaluation design

In line with the proposed formative approach to the EHSDI evaluation (see section 4.5.3), the project team expects to workshop the evaluation questions in the following table with the MoU Management Committee and PHRG. We have not proposed any overarching evaluation objectives for EHSDI, principally because many of the existing objectives are high level. However, our analysis will need to synthesise findings according to 'first-order' questions such as:

- Is EHSDI making progress towards: expanding health service delivery equitably; improving health service delivery structures and processes; meeting the health needs of the Aboriginal and Torres Strait Islander population; and improving Indigenous health outcomes?
- What is the NT PHC reform story, how have different EHSDI activities contributed to a unified PHC system, and how is EHSDI adding value to the broader PHC reform process?
- Is the reform direction appropriate, and what are the potential gaps in the reform system?
- What are the barriers to achieving success (particularly in terms of on-the-ground implementation)?

- How can partners better work together to strengthen the reform process/agenda?
- Who exactly holds the reform vision, is it shared by each of the actors, and is it becoming a system vision (especially with regards to community control)?

Once again, we propose work-shopping overarching evaluation questions with the PHRG and MoU Management Committee.

Table 4. Summary of the EHSDI evaluation design

Evaluation objective	Evaluation questions	Data sources and methods
1. Impact and sustainability of the EHSDI on PHC service delivery and equitable distribution of resources (including measurement against indicators relating to the number, range and accessibility of core services compared with agreed standards for primary care across NT)	1.1 What was happening before EHSDI in terms of PHC service delivery and resource distribution?	Take a health systems approach by addressing these questions in terms of indicators drawn from the building blocks or essential service requirement of the health system (governance, management and leadership; funding; linkages; infrastructure; and workforce), and relating to the agreed understanding of PHC in NT. Likely to include financial data, and capacity and capability measures. Will require data pre-EHSDI, and post-implementation. Consider impacts on service delivery for both government and community-controlled sectors. Will also require an agreed definition of sustainability. Information will be collected from program documents and implementation plans, key informant interviews at central level (AMSANT, DHF and DoHA), and interviews and administered questionnaires at case study sites.
	1.2 How is PHC understood by stakeholders, and is the PHC core services agenda appropriate?	
	1.3 Has the service 'gap' between existing arrangements and those required to achieve health equity been identified?	
	1.4 What categories of core PHC is EHSDI funding being spent on?	
	1.5 What is happening now?	
	1.6 Is the emerging model sustainable (politically, financially, administratively) and how will the momentum for system development be continued post EHSDI?	
2. Extent to which Indigenous people were engaged and empowered to contribute to health service planning, governance and responsiveness of services	2.1 What level of Aboriginal community involvement in delivery, management and control of PHC services was happening before regional reform?	Review range of service models currently in place, describe what has and is currently being offered in terms of capacity building training, etc, and assess the appropriateness and effectiveness of such services/mechanisms. Assessment of barriers will include those for individuals (e.g., receptiveness, capacity), systems and organizational barriers and external barriers outside of the control of the health system. In addition to program documentation and implementation plans, will involve interviewing community health service managers and staff, and members of Area Health Service and Regional Boards at case study sites.
	2.2What did EHSDI offer in terms of training, capacity building and community representation mechanisms?	
	2.3 How effective and appropriate were the collaborative policy and planning processes in supporting Indigenous engagement and empowerment ?	
	2.3 What is happening now?	
	2.4 What are the barriers to the engagement and empowerment of Indigenous people?	

Evaluation objective	Evaluation questions	Data sources and methods
3. Impact and sustainability of the RAHC Agency on health workforce availability and flexibility in the NT (including measurement against indicators relating to workforce supply across all locations and the effectiveness of clinical governance structures)	3.1 What workforce capacity has been added by RAHC (and by the recruitment of short-term workers during the CHCI)?	Use RAHC program reports (e.g., deployment data and exit interview information), NT workforce and recruitment data, interviews with health centre staff in case study communities, interviews with a sample of practitioners who have been deployed through RAHC, and key informant interviews with staff in Aspen Medical, DoHA and NT DHF. Analyse information to assess what extra supply has been added, how well RAHC supply matches need, the quality of deployed workers, and the impact on NT efforts to get a sustainable workforce. A key element of the analysis will be examining the impact and relationship RAHC has had on the broader workforce agenda of the NT public health system.
	3.2 What has been the impact of short-term deployments - extent to which they have met local needs; impact on quality of service delivery (including clinical and cultural aspects); on NT workforce recruitment, retention and flexibility; and on Indigenous and other workers?	
	3.3 Has RAHC been successful in deploying staff with sufficient skills and expertise to work in remote or urban Aboriginal PHC?	
	3.4 What effect has RAHC had on clinical governance - quality of care (including support to short-term workers and demands on existing staff) and what is the nature of the relationship of RAHC to NT clinical governance arrangements?	
4. Efficiency of the EHSDI in terms of how well it has maximised health service delivery with the available funds	4.1 How effective and appropriate were the collaborative policy and resource allocation processes guiding investment? 4.2 What is known about the actual costs of delivering effective and sustainable PHC services in remote settings in the NT? 4.3 What funding allocation model/s were used to guide EHSDI investment? 4.4 What did EHSDI cost (inputs) and what was delivered (outputs)? 4.5 Did the resources that were allocated get to the program? 4.6 What proportion of resources went to front line services and what barriers were there to the use of resources to deliver front line services? 4.7 What proportion of resources were allocated to non-frontline services (within OATSIH, AMSANT and NT DHF) and what was the rationale and return on investment from such services? 4.7 Were the services that were bought 'value for money', or were they paying 'over the odds' for this type of service? 4.8 What would it cost to deliver the services in other ways? 4.9 What would it cost to get this outcome in other ways? 4.9.1 Is this the best way to achieve this outcome?	Before developing the approach further, discuss objective and questions with the MoU Management Committee and the PHRG to ascertain: what 'efficiency' looks like from their perspective, and what investment plans and funding information would help address questions around efficiency. Also need to review literature on what it costs to deliver remote health services, and define front line and non-front line services.

Evaluation objective	Evaluation questions	Data sources and methods
5. Effectiveness of EHSDI in achieving change in health status (including measurement against PHC-related health indicators as developed through the NT KPIs project and the analysis of the NTER CHC program)	5.1 Are the NT KPIs sufficient to measure effectiveness over the time required to address health status? 5.2 Are the NTER CHC data collections sufficient to measure change in child health status (attributable to EHSDI)? [refer 4b.1 in Table 1] 5.3 What are the outcomes, where do the indicators sit in this, what's the logic and where are the gaps?	Before developing this approach further, workshop discussion with PHRG and MoU Management Committee to address feasibility questions (5.1 and 5.2). Likely to include synthesis of findings from previous EHSDI evaluation objectives (that focus on process evaluation), and indicative assessment against indicators.
6. Impact of the regional reform process on:		
6a . Efficient and effective operation of health services	6a.1 Was the rationale behind regionalisation sound? 6a.2 What was the level of rigour related to planning and consultation? 6a.3 How have things changed as a result of regionalisation, in relation to governance, management, quality, service delivery, and overall costs?	Too early to measure outcomes so will be about short- and medium-term outcomes, testing assumptions in the program model. Will include workshop findings and key informant interviews.
6b. Clinical governance, including quality of health service delivery	[Refer 6a.3]	Before developing the approach further, discuss objective and questions with the MoU Management Committee and the PHRG to agree focus. Potentially focus on impact on health service delivery, and establishment of systems to support this. Information collected through key informant interviews at central (DHF and AMSANT), regional and community levels.
6c. Information systems and planning capacity	6c.1 What information is available on system performance to governors, managers, clinicians, and the community? 6c.2 How is this information used to support improved health service delivery?	Before developing the approach further, discuss objective and questions with the MoU Management Committee and the PHRG to agree focus. Will need to consider existing report arrangements and involve reviewing what information is available and used where in the health system. Information collected as part of case study enquiry at central (DHF and AMSANT), regional and community levels.

4.3 STEP 1 – ENGAGE STAKEHOLDERS

Engaging stakeholders is the first step in our evaluation plan, but it is also important that we represent stakeholder needs and interests throughout the evaluation process.

4.3.1 WORK TO DATE

We have identified key evaluation stakeholders at the community, Territory and Commonwealth level, and initiated engagement with many of these stakeholders during the week 15-19 June 2009. We have also developed a communications protocol (as discussed in section 3.2) that lists different types of stakeholders and identifies how and when we might expect to engage with them during the evaluation process. During meetings over the week 15-19 June, we also began to identify stakeholder interests in and perspectives on the evaluation, including what they considered to be the main purpose of the evaluation, what success (in terms of the programs and the evaluation) might look like, what were (in their opinion) the key evaluation questions, and how they might use the evaluation findings.

Since 19 June, we have continued to engage with the MoU Management Committee and have begun discussions with specific stakeholders for particular interests.

4.3.2 ONGOING ENGAGEMENT

On the back of this draft report, we propose further engagement with the individual stakeholders within the PHRG and the MoU Management Committee to, in particular, ensure their primary interests are likely to be addressed by the evaluation questions we have drafted. We also plan to engage with PHRG and the MoU Management Committee in further developing the EHSDI program logic model described in this report, and for developing a program logic model for a child wellness/health check that would inform policy in this area. Section 4.5.3 describes a particular approach to engaging with the MoU Management Committee and PHRG over the formative approach to the EHSDI evaluation.

In terms of data sources and methods of collecting information for the evaluation, in addition to engaging further with the MoU Management Committee, we will continue to discuss quantitative methods with AIHW, NT DHF, and AMSANT, and qualitative methods with, in particular, representatives of the IAG and AMSANT.

Proposals for engaging with stakeholders over the longer-term are also reflected in section 4.5.3 and the communications protocol.

4.4 STEP 2 – DESCRIBE THE PROGRAMS

Clarity about the programs' activities, outcomes, and their inter-relationships sets the foundation for good program evaluation. Program logic models or program theories are commonly thought of as appropriate tools to describe programs in such a way. Program evaluations based on program theory ideally begin with a well developed and validated theory of how the program works. However, as in the case of CHCI and EHSDI, this is frequently not the case, and an initial stage of the evaluation is to approximate such a theory within the context of the program evaluation. As discussed in section 1.4.2,

we propose taking this initial approach in the evaluation of CHCI and EHSDI, but as the evaluation progresses the resultant program logic models will be revised and elaborated for different purposes:

- For the CHCI evaluation, we will begin with an approximate theory for CHCI, but as the evaluation progresses we will build up a program theory for child wellness checks more generally. This theory, presented as a program logic model, should usefully inform future policy, planning, monitoring and evaluation of child wellness initiatives.
- For the EHSDI evaluation, we have drafted a basic program logic model (see Figure 1) and will revise, elaborate and validate this in collaboration with members of the PHRG and MoU Management Committee. As a result, we expect to come to a shared understanding of the program, how it is suppose to work, and what it hopes to achieve (ie its theory). As the evaluation progresses, and recognising the proposed formative approach to the evaluation as discussed in section 4.5.3, we will develop a more sophisticated model that identifies the key assumptions underpinning the implementation of EHSDI. The program theory or program logic model will be a useful tool to guide EHSDI implementation and evaluation into the future (beyond the period of this evaluation) and will help us identify assumptions or key linkages that would benefit from testing through the evaluation. We have also drafted a sequence map for EHSDI (see figure 2) to help understand the projected achievements of EHSDI (and the actions required) over time.

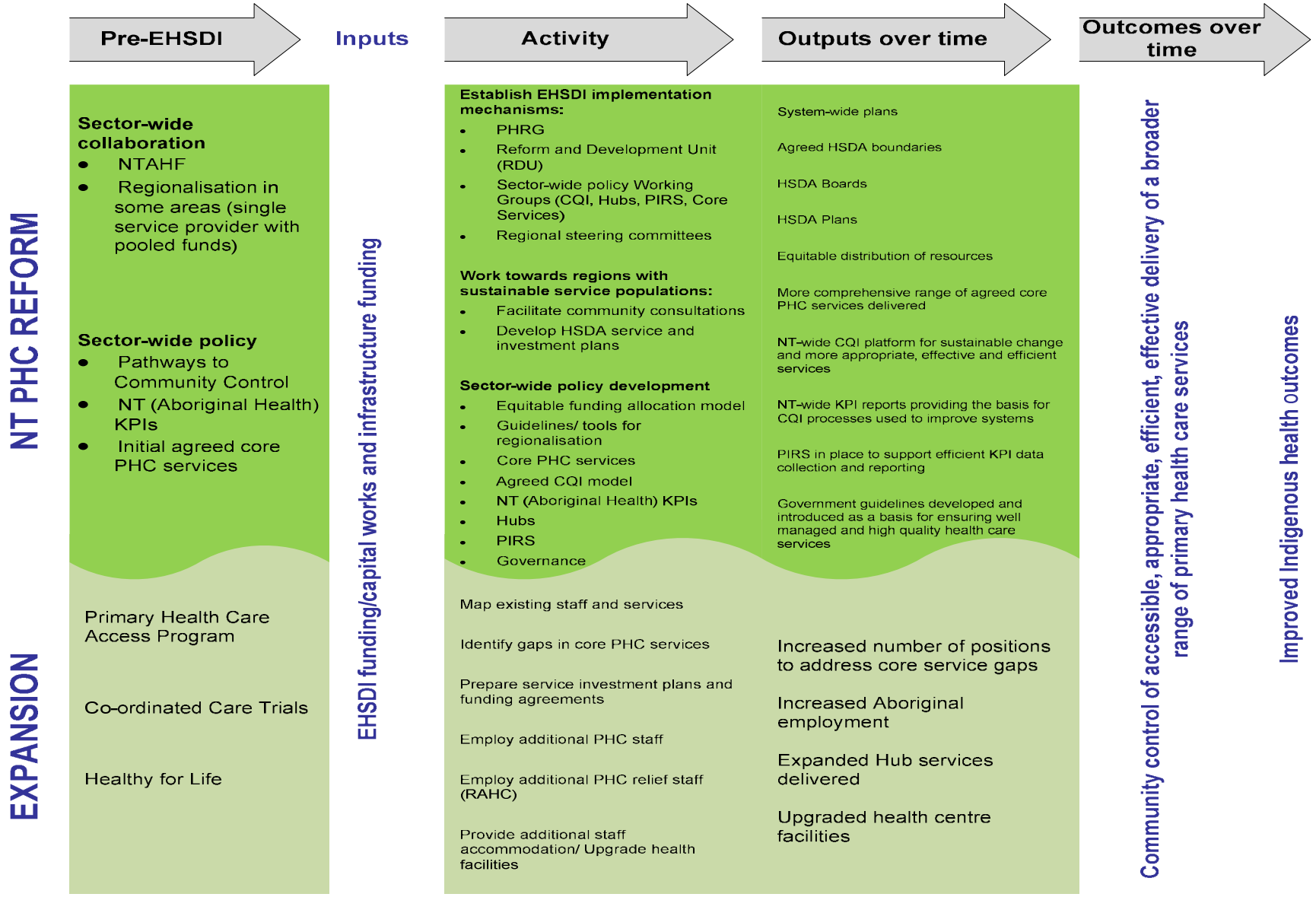
We are aware of the limitations of program logic or program theory approaches, including:

- They risk over-simplifying and de-contextualising programs;
- They imply a program or funding stream focus, and we are aware of a preference for us to adopt a systems-approach to the evaluation by examining how the various programs and activities are contributing to the broader NT primary heath care reform process;
- They have the potential to divert resources from the other evaluation tasks of collecting and analysing evaluative information;
- If the program theory is not sound, it can misrepresent the program and be counter-productive to both program improvement and the evaluation; and
- Programs evolve, so what might have been a sound theory at the start of a program may have little relevance at later stages.

Nevertheless, in such an activity-rich environment, we consider the program logic approach will help to bring some focus as to what it is that we will be evaluating. Furthermore, with regards to EHSDI where the program is still being implemented and the evaluation's focus is formative, the program logic approach has the potential to:

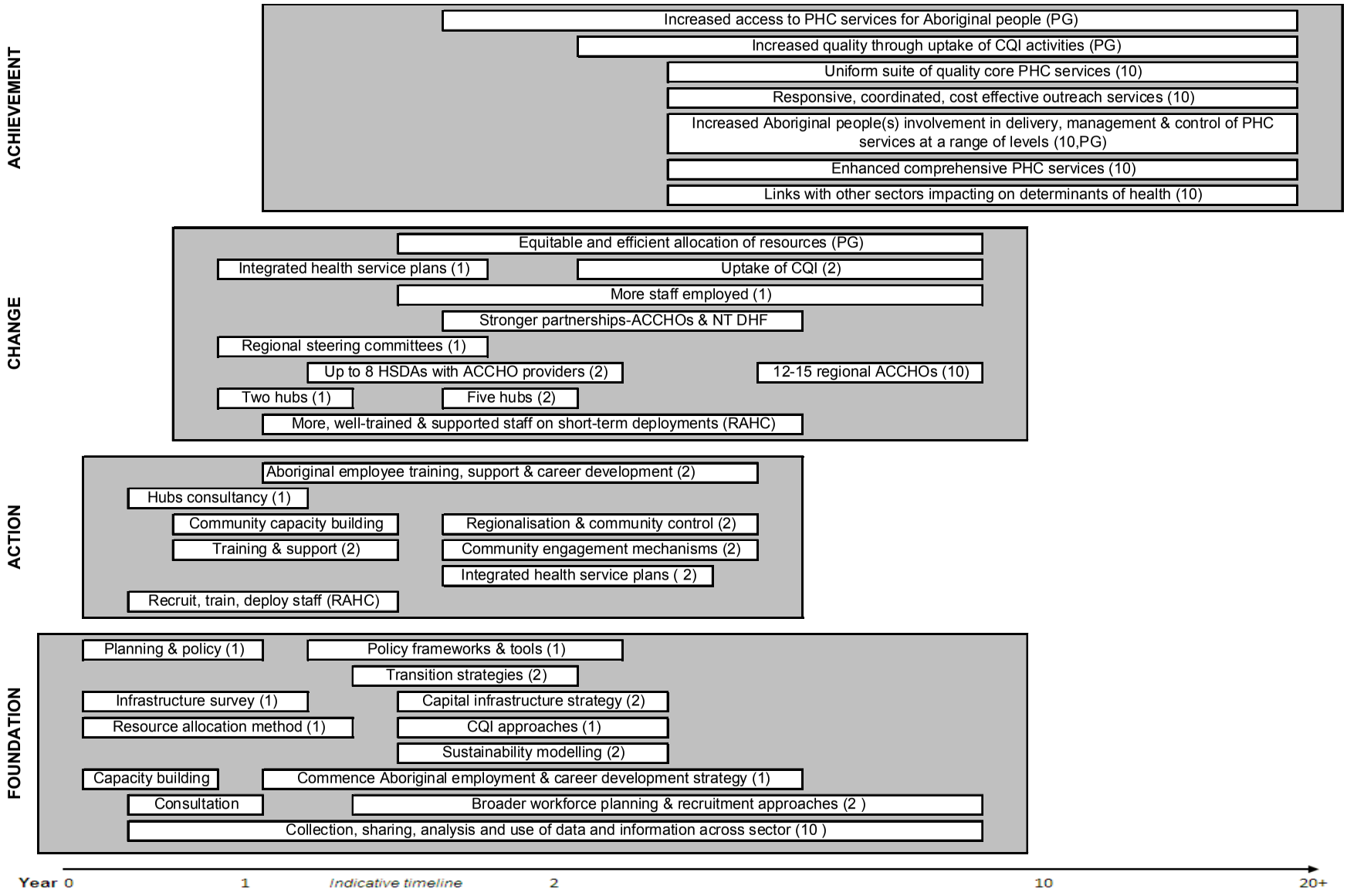
- Help program staff to identify gaps or inconsistencies in the program logic (e.g., in activities), and therefore be able to make immediate changes to program implementation to address these;
- Promote a common explicit model that helps program staff to keep focused on the most important aspects of the program (ie prioritising), and helps with cooperation across staff and across agencies; and
- Focus evaluation and monitoring processes at the most important aspects of the program, and help to identify any timely adjustments to the program (which may be particularly important given the ultimate outcomes of the program are long-term).

Figure 1. EHSDI program logic model*



*Note- this is an initial draft only and will be further developed in collaboration with members of the PHRG and MoU Management Committee.

Figure 2. EHSDI sequence map



Note: Information in brackets refers to source: 1=PHRG 1 year vision, 2=PHRG 2 year vision, 10=PHRG 10 year vision; PG=NT AHF program goal for EHSDI.

4.5 STEP 3 – FOCUS THE EVALUATION

We have used the draft program model and evaluation objectives to determine the evaluation focus. This step involves focusing the evaluation in terms of:

- The type(s) of evaluation;
- The priority evaluation questions; and
- An appropriate evaluation design.

4.5.1 TYPE OF EVALUATION

The type of evaluation is largely determined by its purpose(s), user(s) and use(s). The evaluation contract requires that the evaluation be both **formative** and **summative**, and focus on **implementation** issues and **impacts** (for both CHCI and EHSDI). The overarching evaluation objectives require us to also address the programs in relation to their:

- Effectiveness;
- Efficiency; and
- Appropriateness.

The relevance of these high-level foci was confirmed in our initial discussions with the key program partners, for example:

- We sensed a strong appetite for a formative approach that will support improvements to the EHSDI program and to the wider NT PHC reform process, particularly given EHSDI's early stage of implementation (see next section 'A formative approach to evaluation of EHSDI'); and
- Given the late stage of implementation of CHCI, there is a good opportunity, and apparent need, for a summative assessment that documents and reports on the impacts and lessons from the program, and can be used to support improvements to wellness checks and child health more generally.

We also gained numerous more specific insights into how the evaluation results will be used, such as to validate resource allocation models, and we need to confirm that our proposed design will support as many of these uses as possible.

4.5.2 TYPE OF EVALUATION - CHCI

The evaluation of CHCI will be largely summative, focusing on the impacts of the CHCs in terms of coverage, diagnosis of health conditions, effectiveness of follow-up services, and impacts on service delivery, health status and treatment. In analysing impacts, the evaluation will need to consider implementation issues, such as how the health checks were run in different communities, and what else was happening in these communities (before and during the implementation of CHCs). The analysis will also need to test the original assumptions that led to the program being established. In terms of the overarching evaluation objectives, the evaluation of CHCI will focus on effectiveness and appropriateness.

The project team is aware of the rich data sets resulting from CHCs and follow-up services, and of the considerable amount of analysis and reporting to date from these data collections. We intend focusing on how we can add value to what has been done before, and in a cost-effective way that

recognises the limitations in the data collections. To this end, we propose working closely with AIHW in the ongoing analysis of the CHCI data collections, and focusing on:

- Updating analysis of follow-up services, and treatment outcomes;
- Assessing impacts over time (ie recognising that CHCs were not delivered in isolation of existing child wellness checks, and were delivered over a short window of time, what benefit did they add over and above what was happening anyway?);
- Assessing impacts against comparable populations that did not receive CHCs; and
- Identifying what happened (health outcomes) when CHCs were done well, and what constituted an 'effective' CHC.

The project team is also aware that the utility (usefulness) of the CHCI evaluation findings is an important consideration given the status (complete) of the initiative. This suggests focusing on follow-up services (which are still being delivered) and considering the implications of the findings for future policy and planning. This is where a logic model for child wellness/health checks (as discussed in section 4.4), informed by the CHCI evaluation findings, may be a useful evaluation output.

4.5.3 TYPE OF EVALUATION - EHSDI

As EHSDI is a relatively recent initiative (funded since July 2008) and is only at an early stage of implementation, we propose that its evaluation will be based on formative evaluation principles. The key focus will be on capturing program information that can be shared with those responsible for implementing EHSDI to improve and enhance the development and implementation of the initiative. The 'formative' aspect of the evaluation becomes the interaction between the evaluation and the program implementation. As evaluators, the project team essentially play the role of a 'critical friend' – we ask challenging questions about the program, but as advocates for the success of the program we collect and analyse information to address these questions in a constructive and collaborative way.

Principles of formative evaluation

Formative evaluation is based on the understanding that designing and implementing an initiative is often an iterative and developmental process. A formative evaluation approach therefore needs to be both flexible and responsive, and recognise that programs will evolve and develop over time. Such approaches involve evaluators working closely with those involved in developing and implementing initiatives, in order to ensure the evaluation findings are relevant and credible, and contribute to the continuous improvement of the initiative.

Taking a formative approach to the evaluation of EHSDI will influence our evaluation process, and in particular how we engage with the MoU Management Committee and the PHRG over the course of the evaluation. The process will be more open-ended, with the potential to evolve over time, than the predominantly summative approach proposed for CHCI. As a result, the EHSDI evaluation design (in terms of the questions, data sources and methods) proposed in this report will develop over time, and we anticipate that we may need to make adjustments to the design to ensure that the approach continues to meet the needs of the partners and is focused on their view of the most relevant and important questions.

In practice, whatever evaluation approach we take with EHSDI will necessitate frequent engagement with those responsible for implementing the initiative such engagement will be focused on data collection through interviews with stakeholders. With the proposed formative approach, in addition

to this engagement, the project team would engage with the MoU Management Committee and PHRG to:

- Finalise evaluation questions;
- Agree definitions or criteria for judging specific elements of the evaluation (e.g., sustainability and efficiency);
- Identify and review current evaluation priorities (e.g., specific implementation barriers identified by members of the PHRG that might benefit from an independent and critical evaluative assessment);
- Discuss progress with program implementation;
- Share and discuss interim evaluation findings (prior to formal reporting);
- Report on actual evaluation findings; and
- Discuss implications of findings for policy and practice.

We are aware that the key stakeholders involved in the implementation of EHSDI have high workloads and limited time to spend contributing to the formative evaluation. For this reason, we propose limiting the majority of stakeholder involvement to two clearly structured workshops with members of the PHRG and the MoU Management Committee (as discussed below). In between workshops, we would report to the PHRG/MoU Management Committee group on specific issues that have either been identified in the first workshop or critical issues that arise during the course of our work that would be beneficial to report. Beyond this engagement, we will continue to hold regular telephone conferences or face to face meetings on key issues with the MoU Management Committee, and propose instituting bi-monthly newsletter updates on the EHSDI evaluation that will be available to a wider audience.

Proposed workshops

We propose holding two formative evaluation workshops with the PHRG and the MoU Management Committee (including the IAG). These workshops will form a key part of the ongoing formative evaluation cycle of reflection and improvement by project partners. Building an effective relationship through face to face workshops will be critical to ensuring data and evidence gathered by the evaluation team is credible and relevant to key partners. We believe these workshops will facilitate greater understanding and collaboration between the evaluation team and the project partners and will provide a productive environment for discussing the strengths and weaknesses of EHSDI and areas for improvement.

We propose holding the first workshop in October 2009. The contents of the workshop will be discussed further with key stakeholders to ensure it focuses on the most crucial aspects of the program and evaluation and making the best use of people's limited time. At this stage, we have identified the following points to cover at the first workshop:

- Confirm formative evaluation approach, and what this means in practice (including tasks, actions and milestones);
- Agree on EHSDI evaluation questions;
- Agree on definitions of terminology in overarching evaluation purpose and within specific evaluation objectives (e.g., primary health care, efficiency, effectiveness, appropriateness and sustainability);
- Identify any current barriers or challenges to EHSDI implementation;
- Identify any current specific priority areas of focus for the evaluation, and/or specific feedback/reporting required;

- Review the EHSDI program logic model; and
- Discuss content for second workshop.

A second workshop is proposed for April 2010 once the evaluation is well underway, and at which point we will be able to report interim findings from our work in case study sites. Other topics that might usefully be covered in the second workshop include:

- Identify any current barriers or challenges to EHSDI implementation;
- Identify opportunities for program improvements;
- Identify what is required to make EHSDI sustainable;
- Identify any current specific priority areas of focus for the evaluation, and/or specific feedback/reporting required, including for the final evaluation report;
- Update the EHSDI program logic model;
- Discuss the implications of the interim evaluation findings for policy and practice; and
- Discuss future monitoring and evaluation needs (beyond the life of the current evaluation).

The workshops would constitute formal deliverables agreed as part of the evaluation. We would expect to provide a written report on each of the workshops within two weeks of them being held.

4.5.4 EVALUATION QUESTIONS

To date, the evaluation questions have been largely driven by the evaluation objectives, some of the underlying assumptions and contexts for the programs (sourced from both program documents but also from our initial meetings and discussion with stakeholders since mid-June), and further shaped by utility and feasibility issues (e.g., the stage of program implementation, resource and logistical considerations).

We have identified a number of key principles that overlay the more detailed evaluation questions. As we continue to work through the design, it is possible that we will add to this list. Key principles identified to date include:

- Our overall approach is to describe the trajectory of the NT health system as regard to child health and PHC development, and assess the impact of CHCI and EHSDI on this trajectory. This translates into an overall question: 'How was the health system performing in relation to these areas of interest over the last decade, and how was this performance changed or influenced by the health related aspects of the NTER?'
- The second principle is, essentially, a localised version of the first. Different communities were at different 'starting points' on this trajectory at the time CHCI and EHSDI were implemented. The concept of 'distance travelled' (along the trajectory) may, therefore, be as important as outcomes; and
- Health system performance and the impact of health service delivery is highly contextualised and, in drawing conclusions, the evaluation will need to synthesise performance and impact from multiple levels and perspectives (e.g., NT, community and individual levels, and governance, management, service provider and service user perspectives).

The key evaluation questions are presented in the tables in sections 4.2 and 4.6.3, and are not repeated here.

4.5.5 EVALUATION DESIGN

The evaluation will take an objectives-based approach, by addressing the questions in 4.5.4 which are based on the pre-determined evaluation objectives and any further questions that arise from the program modelling. As noted earlier, it will consider implementation (or process) as well as outcomes, and attribution of outcomes. Time-series analysis – looking at what was happening before and after the implementation of the programs – will be used to measure progress and this will also help to inform attribution (given the proximity in time between program implementation and the past data collection (for CHCI) and proposed data collection as part of the evaluation (for EHSDI)).

The evaluation design will include multiple units of analysis. It will look at datasets relevant to the programs as a whole (e.g., CHCI data collections), regional and community-level analysis, and potentially tracking of individuals (e.g., through unit record data). The community-level analysis will be used, in particular, to validate the findings for CHCI against comparable datasets (which may only be available at a community level), and to contextualise the analysis. This will include the use of case studies which will be used to understand the impacts of both CHCI and EHSDI in different community settings, where we expect the concept of 'distance travelled' will be critical to understanding impacts.

Analysis at an individual level will add another perspective to the overall change we are trying to measure. For CHCI, tracking data on individuals (through unit record data) will help us to determine, for example, the appropriateness of referrals and follow-up service delivery. For EHSDI individuals' perspectives will provide rich information about the impact of the system-level expansion, regionalisation and workforce programs.

The evaluation will also include consideration of a number of issues relating to efficiency. We will track inputs/resources, outputs, and outcomes in order to gain an overall sense of the costs and consequences of the EHSDI program in particular. Assessing the relative cost-effectiveness of this program is, however, reliant on gaining a sense of how the resources might be better used, according to key informants, and an idea of the costs and consequences of similar programs delivered for similar communities. The latter will be assessed against findings from a literature search of published and grey literature (see section 1.5.2).

4.6 STEP 4 – GATHER CREDIBLE EVIDENCE

This step includes:

- Identifying indicators and sources of information/data;
- Developing methods of collecting information/data; and
- Setting out detailed plans for collecting information.

4.6.1 INDICATORS AND DATA SOURCES

Indicators are specific, observable, and measureable statements that help define exactly what we mean or are looking for. They cover both process and outcome indicators and quantitative and qualitative data.

A number of the evaluation objectives and questions in the summary table in section 4.2 serve as indicators as well (e.g., the prevalence of reviewed conditions, follow-up services requested, the NT KPIs). However, some of the objectives and questions require a more detailed indicator and/or evaluation criteria to define the information and/or so we are able to judge what happened (e.g.,

"severity" of conditions, "appropriate" follow-up treatment, "completion" for each condition, "improve" health service delivery, Aboriginal "community involvement", "equitable" distribution of resources, "sustainability" of EHSDI and RAHC). In defining indicators or evaluation criteria for these questions we will first draw on existing indicators or frameworks developed or under development by others, such as standards for PHC, referral guidelines and procedures, and the community participation continuum and partnership matrix developed in *Pathways to Community Control.* An example of how we might consider "sustainability" is outlined in the box below.

Defining "sustainability"

The origins of CHCI and EHSDI as part of the NTER were strongly focused on the need for a rapid and effective "emergency" response. The first question to explore is whether this initial focus left space to consider the issues of sustainability during the time of the programs' inception. In discussing sustainability, it will be important to first establish the different actors' views of which elements of sustainability they consider most relevant. Program continuity over time can be either threatened or enhanced by changes both internal and external to the program. These changes may be political, administrative, financial, social, epidemiological, behavioural, environmental or ecological in nature.

Change may occur in one of these elements, or in combination. Some of these are under the direct control of the participating organisations, and others are not. So the second question is to seek clarification of which domains are most relevant in this setting for exploring sustainability.

The evaluation objectives include sustainability of EHSDI on primary health care delivery and equitable distribution of resources. Notwithstanding the need to also define "equitable", this may require addressing questions such as:

- What consideration has the MoU Management Committee and PHRG given to the sustainability of PHC service delivery by EHSDI?
- What factors are considered as critical in ensuring sustainable PHC service delivery?
- How has EHSDI been structured to address the identified sustainability factors?

For RAHC the focus is on sustainability of workforce availability and flexibility. Consideration must also be given to workforce capacity and capability, of infrastructure developments, and alignment with existing service delivery mechanisms. This may require addressing questions such as:

- To what extent has the availability of RAHC short-term deployments affected the ability to staff health centres?
- To what extent are RAHC deployments used as part of remote area workforce planning by NT DHF – or are they mainly used to close short-term needs as they arise?
- How is RAHC contributing to building organisational resilience – does it build capacity, does it lessen the impact when key staff members leave?
- What, if any, impacts do RAHC deployments have on the ability to use health care staff in flexible ways so as to improve sustainability (e.g., building new cadres of workers and supporting innovative skill development)?
- Is there any encouragement for RAHC recruits to consider long-term positions – if so how successful, if not is this feasible or are have other ways for RAHC to support long-term sustainability been considered?
- What, if any, effect has RAHC had on the sustainability of workforces that are not involved in its recruitment programs – e.g., Indigenous health workers?

The evaluation will source both quantitative and qualitative information. The specific quantitative data sources we will use in the evaluation of CHCI will be identified through a process illustrated in

the table included in Attachment three. We have identified the following 'long-list' of potential health and social indicators:

- Attended antenatal care during pregnancy;
- Birth weight, stunting, underweight, wasting;
- Anaemia;
- Ear disease, middle ear conditions, hearing loss;
- Visual impairment, prevalence of trachoma;
- Prevalence of untreated caries, gum disease, decayed teeth;
- Prevalence of skin sores, scabies, ringworm;
- Prevalence of rheumatic heart disease, asthma, recurrent chest infection, and hospital admissions for respiratory disease;
- Immunisation status
- Regular smoker, smoker in the household;
- Working bath or shower, working toilet; and
- Hospital admission rate, principal diagnosis, condition present at admission.

We have also identified the potential populations of interest (local populations, CHCI target population (those that received a check and those that did not)), and the NT Aboriginal and Torres Strait Islander population aged 0-15 years. We have begun to map known data sources against these factors, and aim to complete this in discussion with AIHW, NT DHF, AMSANT, and selected health researchers (the latter especially in regards to studies concerning 'local populations', or subgroups of the NT Aboriginal and Torres Strait Islander population, such as within specific geographic communities). Once we have completed the map we will select the particular health and social indicators and data collections that are most directly comparable across the populations and time period of interest (taking into account technical feasibility and utility considerations), and which provide (collectively) a reasonable measure of health status for Indigenous youth in the NT (again upon advice from AIHW, AMSANT, DHF and other health researchers).[9] These indicators will provide the focus for the subsequent CHCI evaluation. As discussed in section 3.3.1, we are committed to seeking appropriate ethics approval for the use of the data sources we identify as being most suitable for addressing the evaluation objectives.

The evaluation will include other collections of quantitative data, including on actual funding allocations and expenditure, workforce data, and RAHC reporting data.

The main source of qualitative data will be from interviews and consultations with key informants at various levels – commonwealth, territory, regional and community (see section 4.6.3). For CHCI we will need to source qualitative information on:

- The approaches, at a community level, to promoting access to health checks;
- Effectiveness and relevance of referral guidelines/procedures;
- Specialist and service user perspectives on gaps in health service delivery; and
- Provider and service user perspectives on what CHCI did to the existing health system.

For EHSDI we will need to source qualitative information on:

[9] The selection of indicators and analysis of data will need to account for limitations relating to data quality. Data quality issues relating to the CHCI data collections are discussed in detail in the two public CHCI progress reports produced by the AIHW in May and December 2008.

- Allocation of resources (models, methods, plans, budgets, financial reports) across elements of EHSDI;
- Perspectives on sustainability of changes ESHDI is contributing to;
- Level of engagement and empowerment by Indigenous people in delivery, management and control of PHC services (to include assessment of suitability of data from NT KPI 18);
- Effectiveness and appropriateness of community engagement activities (e.g., training, community representation mechanisms);
- Perspectives (deployed staff, community, provider, Agency, DoHA, DHF, AMSANT) on RAHC model and its implementation; and
- Effectiveness and appropriateness of regional reform process.

4.6.2 METHODS

The complexity of the evaluation and data sources requires the use of multiple methods, and we have referred to the proposed methods in the summary table in section 4.2. The suite of methods includes:

- Analysis of existing data collections – we need to agree protocols around how we access this information, who analyses it, how we propose to use the information, and seek any necessary ethics approval. As discussed elsewhere, we think there is a need to analyse the data at three levels: at a program level (for CHCI) to identify the characteristics of who accessed the program and who did not; at a community level to validate the CHCI data against other, comparable data source and to contextualise the results; and at an individual level so that we can follow people through the process of check-up and follow-up to assess appropriateness.
- Key informant interviews – these will be based on semi-structured interviews tailored to specific information needs, cover a range of issues (e.g., many of the qualitative information sources listed above under 4.6.1), and involve individuals within the Australian Government, NT DHF, AMSANT, and RAHC Agency (see section 4.6.3);
- Case studies – these will give us, and the evaluation, a strong understanding of context, through providing rich/thick descriptions of implementation experiences and impacts (see section 4.6.3).
- Document review – focusing on those directly related to the programs.

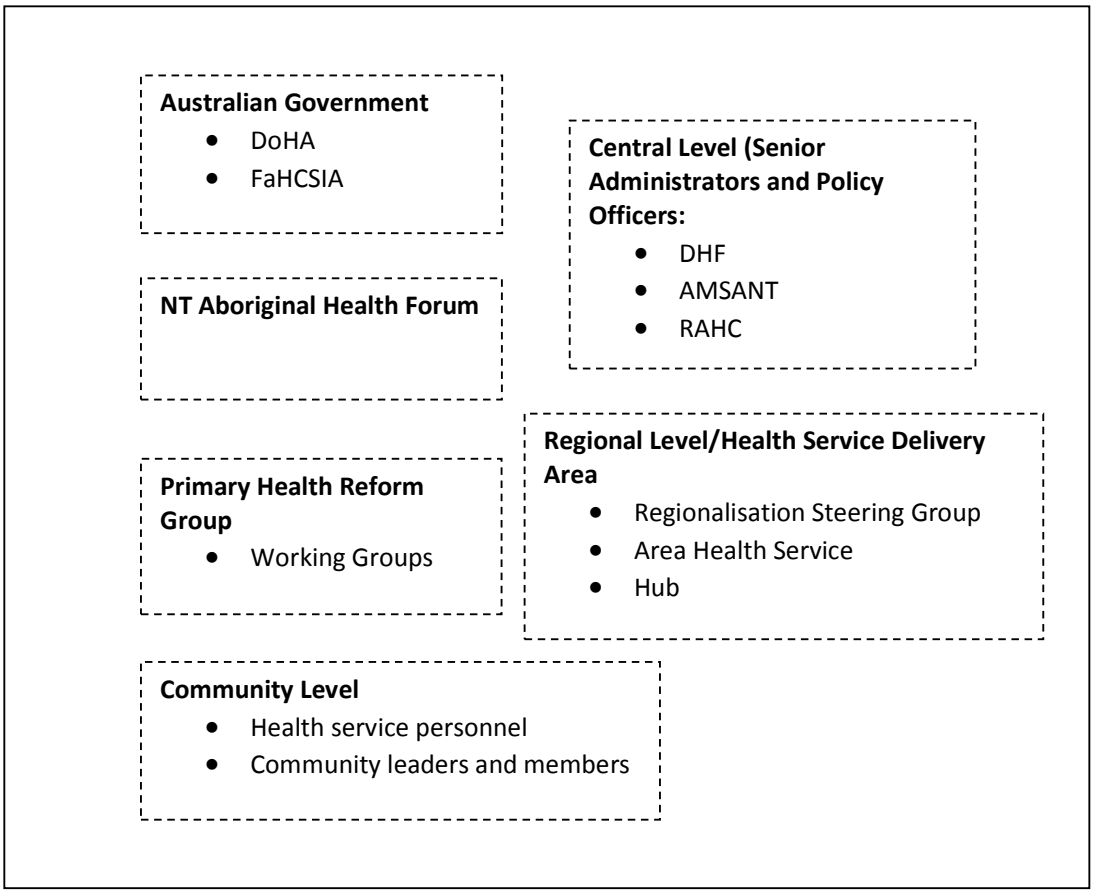
4.6.3 QUALITATIVE METHODS

The primary qualitative method that will be used in the evaluation is case studies. The case study method allows for taking a systems approach and to see if policies and policy approaches actually work in the real world. It also allows for an in-depth study of a particular situation and is useful to use to focus a very broad or complex topic for evaluation. The method will allow the use of a mix of qualitative and quantitative information. The process of triangulation of information will help to clarify meaning and verify the repeatability of an observation or interpretation and help avoid misinterpretation. The case study method can take into account the various views and experiences of different participants and the social, physical and cultural contexts that shaped these views and experiences, that is, to identify participants' different realities.

Case study unit of analysis

A case study will include all levels of the primary health care system (as shown in Figure 2), as these levels are relevant to both CHCI and EHSDI, and to the planned HSDA level.

Figure 3. NT primary health care system levels



Methodologies

Data collection will include semi-structured interviews, administered questionnaires and observation. In each case study community, a community member will be employed to act as cultural broker and interpreter to ensure appropriate and effective communication between the evaluation team and community members.

Interviews will be structured so participants will be encouraged to tell their story in a free narrative style about their experiences concerning the CHCI and EHSDI. The interviewer will use a check list to ensure information has been provided to answer the key evaluation questions. If this information is not freely forthcoming, then the interviewer will need to prompt the participant to collect information to contribute to answering these questions. The interviewer will take written notes during interviews and, if participants consent, discussions will also be recorded. Doing this will provide an accurate record of the interview and allow the evaluation team to later clarify their notes and ensure that significant information has not been missed or misinterpreted. A recorded interview will allow for a second person to check the veracity of the interviewer's notes.

Administered questionnaires will be used to:

- Collect information from health centre managers about health service staffing levels in case study communities;

- Assist health service staff, members of health advisory committees, regional steering committees and Area Health Service Boards to assess their capacity and capability as it concerns promoting and working towards achieving community engagement, regionalisation and community control of health services; and
- Determine the current standards and levels of community housing, essential utilities and municipal services that play an important role in protecting health (especially child health), for example – water, power, sewerage, and rubbish collection. This will involve adapting the process and tool used in The Healthy Community Assessment Tool developed by Menzies School of Health Research.

The evaluators will observe that the information provided by health service staff and others is supported by activity and is not shown to be contradictory by aspects of the physical environment, the behaviour of an individual or the group, or by other available information.

Sampling/sample size

Purposive sampling will be used for all qualitative data collection activities. Stakes (2005)[10] recommends that cases be chosen from those from which we can learn the most rather than only on the basis of representativeness. Balance and variety are considered important but the opportunity to learn is often considered more important.

Four case studies that focus on four proposed HSDAs are planned. Each case is seen to be unique because of social, political, cultural and contextual factors. This approach prevents attempts to generalise findings. Case studies allow generalisations about program theory and its application or validity in the context of particular case studies. Four case studies will allow for regional and health service delivery model differences and not compromise taking an approach that seeks to gain an in-depth understanding of a health service reform of great complexity.

Sampling frame

The process of regionalisation and establishment of the HSDAs has only recently commenced. The proposed HSDAs are to replace the existing NT Health Service Delivery Areas (these are the same as the current NT OATSIH Planning Regions). Originally 14 HSDAs were proposed (Katherine West and Katherine East are not included in this number as these are already area health services under community control). However, at the time of writing it seems the existing East Arnhem and Central Australian service areas will remain and not divide into smaller HSDAs. Regional steering committees have been or are in the process of being established to foster the development of the proposed new HSDAs. Some NT Health Service Delivery Areas are moving more quickly along the pathway of regionalisation and community control than others. In some cases, HSDA boundaries are still under negotiation, while in others it is proving more difficult to engage with community leaders and the momentum to move towards regionalisation is slow. HSDAs are at different stages along the pathway to regionalisation and community control so it is still necessary in some cases to use the existing NT Health Service Delivery Areas (or NT OATSIH Planning Regions) as reference points (Table 5).

[10] Stake,R.E. 2005. Qualitative Case Studies in *The Sage Handbook of Qualitative Research.* 3rd Ed. Denzin, N.K. and Lincoln, Y.S. Eds. Sage Publications. Thousand Oaks. pp. 443-466

Table 5. Proposed EHSDI Health Service Delivery Areas

Proposed EHSDI Health Service Delivery Areas	Current NT Health Service Delivery Areas	Number of health services and current health service provider/s	Approx. size of population*
Darwin (Urban & Rural)	Darwin Rural Darwin Urban	2 (1DHF + 1 ACCHS)	1,085 ?
Top End West	Top End West	5 (4 DHF + 1 ACCHS)	3,404
West Arnhem (Red Lilly Interim Health Board)	West Arnhem	5 (4 DHF + 1 ACCHS)	2,453
Tiwi Islands	Tiwi Islands	3 (DHF)	2,326
Maningrida	Maningrida	1 (DHF)	2,660
East Arnhem Includes: EA – Central EA – North EA – South	East Arnhem	 4 (1 DHF + 3 ACCHS) 4 (3 DHF + 1 ACCHS) 5 (DHF)	10,275
South-East Top End (Borroloola)	Borroloola	2 (DHF)	1,236
Barkly	Barkly	6 (DHF)	4,015
Central Australia Includes: Warlpiri-Anmatjere Luritja-Arrernte Pitantjatjara	Central Australia	 8 (DHF) 9 (DHF + ACCHS) 4 (2 DHF + 2 ACCHS) 8 (DHF + ACCHS)	10,999

*Australian Bureau of Statistics. 2008. Experimental Estimates of Aboriginal and Torres Strait Islander Australians. Cat. No. 3238.0.55.001

Identifying cases

The process to identify the HSDAs for case studies includes:

- Excluding sites that: i) received no initial EHSDI funding; ii) consist of one major community with outstations; or iii) operate in largely urban contexts;
- Seek geographic representation (2 case studies from the Top End and 2 from the Central Australian/Barkly regions);
- HSDA case studies to represent a range of service models, for example – mixed mode (includes DHF and Aboriginal community controlled health services); community controlled; DHF health services only; and a region where historically there was inequity in funding; and
- Include HSDAs/regions that received small to large amounts of EHSDI funding.

The criteria to guide identifying and selecting one community belonging to a HSDA as part of the case study includes:

- Population size;

- Remoteness;
- Service model (as described in *Pathways to Community Control* report);
- Availability of electronic patient information record system (prior to CHCI and continues);
- Health service currently has paper based patient information record system;
- When NTER child health checks completed (early in the 2-year period, mid-way or late);
- Who and how the CHCs were completed (fly-in/fly-out teams, mixed or by the health service alone);
- The proportion of CHC uptake (high, moderate or low);
- If there is/is not a GP usually resident in the community; and
- Whether there are still some staff employed by the health service that were there before, during and after the NTER CHCs program.

The purpose of these criteria is to ensure a variety of cases are chosen and not like cases for the purpose of making comparisons. In a planned HSDA that includes DHF and Aboriginal community controlled health services, two communities will be included to gain a better understanding of the contexts and issues.

At the MoU Management Committee workshop held in Alice Springs on 27 July 2009, committee members nominated four persons to comprise a small group to select (according to the aforementioned criteria) four to six HSDAs to be the focus of case studies. The MoU Management Committee will make the final decision on the four HSDAs to be the focus of case studies.

Number of participants

At community level: The number of interviews to be completed cannot be prescribed but information will be sought from a diverse range of people to try to gain as many different perspectives on issues as possible. The number of interviews completed will depend on the number of people who make themselves available and consent to participate in the evaluation. It is anticipated that 'snowballing' might occur with some participants recommending that other individuals be interviewed because of their superior knowledge and experience as it concerns the CHCI and EHSDI reforms.

When collecting information to answer the CHCI evaluation questions, every effort will be made to interview independently all health staff (doctors, nurses, health workers and clerical staff) who were present in the community before, during and after the CHCs were completed. In the case of not one of the existing staff having primary information about the CHCs, interviews will be restricted to collecting information concerning CHC follow-up activities and EHSDI activities. The primary caregivers of two children who presented their children for child health checks will be invited to participate in the evaluation, as will the primary caregivers of two children who did not present their children for child health checks. A minimum of two key community leaders will be approached to collect information concerning levels of community engagement and perceptions and attitudes, as these issues concern moving towards regionalisation and community control.

At regional level: Information will be sought from a diverse range of people to try to gain as many different perspectives on issues as possible. This includes from Regionalisation Steering Group Committee members, Regional Board members, Area Health Service board members and employees, and Hub employees.

Primary Health Care Reform Group: All members of this group will be interviewed.

At central level: Key administrative and operational personnel to be interviewed from NT DHF, AMSANT and RAHC.

Aboriginal Health Forum: All members of this group will be interviewed.

Australian Government Department of Health and Ageing and FaHCSIA: Relevant senior staff will be interviewed.

Case study selection update: The evaluation team have recently completed a case study selection process with a subgroup of the MoU Management Committee. Initially, the process involved consideration of the selection criteria listed on the pages 40-41. As the selection process proceeded it became apparent that some of the criteria were of less importance, while two selection factors (at the HSDA level) became more critical: the interest in and progress towards regionalisation; and the per capita gap in funding to the EHSDI benchmark. In addition to these specific criteria, the selection process considered a number of overarching factors, including: the selection, as a group of sites, provides good variety in terms of population size, geographical regions, health service models, regionalisation and resourcing; and each case study site (at a community level) is likely to generate rich information and provide learnings relevant to EHSDI as a whole.

As a result of this process, the MoU Management Committee has agreed on the following case study sites, comprising five communities within four HSDAs. The selection includes back-up sites, in case it is not practical to undertake the evaluation in the selected communities. The organisations governing health services within the five communities will be approached to seek their agreement to participate in the evaluation.

Health Service Delivery Area#	Community	Alternative Community
East Arnhem	• Ramingining (DHF) • Galiwinku (Miwatj)	• Gapuwiak (DHF) • *
Katherine East	• Wugularr (Sunrise HS)	• Barunga (Sunrise HS)
Barkly	• Canteen Creek (DHF)	• Ali-Curung (DHF/ Anyinginyi)
Central Australia	• Nyrippi (DHF/WYN)	• Hermannsburg (DHF/WAHAC)

Alternative HSDA Top End West (Wadeye community)

* No alternative community health service. Will need to reconsider selection if Galiwinku is not included.

Case study reports

The reports will provide contextual information to allow interpretation of quantitative findings concerning the CHCI, and other information concerning the processes and changes associated with EHSDI reform activities across the primary health care system. The reports will be written largely according to a template that ensures the focus generally remains on answering the key evaluation questions and precludes extraneous descriptive information. Reporting case studies in this way will promote standardised reporting for each of the case study sites. We will incorporate in the reports narratives provided by individual participants from various levels of the primary health care system.

4.6.4 DETAILED PLANS

Tables 6 and 7 show the various stages required to address each evaluation objective and accompanying set of questions. They also refer to the primary method(s) that will be used in each stage. This table will be used as a basis for developing a more detailed project plan for the evaluation, which identifies more specific tasks and assigns project team members and timeframes to each task. We have not detailed stages for each of the EHSDI objectives, as in taking a formative

approach, it is appropriate to complete this after further discussion with the MoU Management Committee and PHRG.

Table 6. Stages by evaluation objective for CHCI evaluation

Objective: CHCI overarching **Questions:** Were the CHC questions related to the gap in health status experienced by the children? Were the planned services as a result of the CHCs appropriate to address the observed health and social conditions?		
Stage	**Considerations**	**Method(s)**
Stage 1: Describe the health status of Indigenous and non-Indigenous children in the NT	Social determinants of health Assumptions regarding causation of health conditions and gaps in health status	Literature review Analysis of existing data collections Review of policy documents and program foundation documents Key informant interviews (eg DoHA, FaHSCIA) Case study interviews with health workers
Stage 2: Map conditions against the described health status and needs of Indigenous children in the NT	Conditions covered by the CHCs Conditions for which follow-up care was available/accessible (might be a subset) Social determinant factors covered by the CHC	
Stage 3: Determine whether the CHC and its sequalae were an effective intervention in the NT (NB EHSDI not a sequalae of CHC) Draft an approximate program logic model for CHCI Regularly revise draft and develop into a program logic model for future child wellness checks	Evidence that CHC intervention was effective in itself and per condition (many interventions) Assumptions of causal linkages between the CHC and changes in health status (based on characteristics of the CHC and use patterns of sequalae services)	

Objective:

1. Assess the extent to which the CHCs reached the target population

Questions:

1.1 Who got checked, and what were their characteristics?

1.2 Who did not get checked, and what were their characteristics?

1.3 What was the difference between those who got checked and those who did not?

Stage	Considerations	Method(s)
Stage 1: Describe the CHCI target population by the following factors: • Community (prescribed areas) • Age (15 years or less) and any other demographics Confirm (with NT DHF, AMSANT and AIHW) health and social conditions and data collections to be included in analysis in subsequent stages Apply for ethics approval	Focus is on *coverage* of CHCs, as opposed to results of the checks AIHW has already made substantial progress in addressing this objective, and need to consider progress of AIHW/DHF data linkage collaborative work CHCI communities will need to be assigned a Remoteness Factor (using the adapted ARIA++ classification used in the EHSDI funding formula) As a starting point, propose indicators relating to NT KPIs regarding: • Timing of first antenatal visit • Birth weight • Immunisation • Underweight • Anaemic Select a small number of other key indicators, in discussion with AMSANT, NT DHF and AIHW	Analysis of existing data collections Key informant discussions
Stage 2: Describe the population that got checked by the following factors: • Community ID • Age group • Sex • Remoteness • Date of check • Who did check (DoHA team/local health service) • Previous checks (Medicare 708, newborn, HSAK, GAA, Paediatric review, DMO/GP review) • Immunisation status	Selection of sample populations will need to consider: • Availability of comparable data (local studies) • De-identification and ethics Ideally, sample populations match case study communities, but otherwise similar range in terms of, for example, large and small communities, communities that have different types of health centre, communities that took different approaches to implementing CHCs	Analysis of existing data collections

• Selected health and social conditions identified in Stage 1 Select some sample populations (eg case study communities) and describe the population that got checked by above factors		
Stage 3: Identify those children that are within scope of the CHCI target population but that did not get checked Repeat Stage 2 but for the target population and cohorts that did not get checked	Target population estimated at 16,259 Checked population approximately 10,523 (64.7%) So not checked population within scope of CHCI approximately 5,736 NT Indigenous population 0-15 years = 19,803 (ABS, Census 2006)	Analysis of existing data collections
Stage 4: Quantify characteristics associated with the populations and communities that got checked, and the target population and communities that did not	Focus on low and high uptake communities Trying to understand whether children that needed checks the most got them	Analysis of existing data collections
Stage 5: Explain any difference through: • Assessing, qualitatively, what happened in high and low uptake cohorts Identify what worked well and what did not – what is/is not an effective and appropriate child health/wellness check process	Consider impact of a range of contextual factors, including: • Who performed the health check (local health centre or DoHA team) • Type of health centre (AMC or NT DHF) • Demographics of children • Decisions of carers • Whether delivery of CHCs displaced other services • The logic underpinning the selection of the prescribed areas	Interviews in case study communities Review of policy documents and program foundation documents
Stage 6: Assess impact of CHCI on child health/wellness check activity levels by: • Assessing uptake against baseline information • Assessing uptake against recent trend in uptake of child health/wellness checks	Need to determine whether the health system was going to deliver these benefits anyway, and/or what impact it had on the trend for child health/wellness checks in the NT and within different cohorts Baseline information may not be directly comparable Consider availability of trend data from particular communities (eg Congress and Katherine West)	Analysis of existing data collections (including Medicare 708 data for baseline and ongoing)

Objective:

2. Identify the prevalence and, if possible, the severity of health conditions found through the CHCs and validate these findings with data from other sources

Questions:

2.1 What was the prevalence of reviewed conditions?

2.2 What was the severity of conditions found?

2.3 What was the result of severity and prevalence in each community?

Stage	Considerations	Method(s)
Stage 1: Quantify prevalence of health conditions	AIHW has already made substantial progress in addressing this objective AIHW's progress reports contain information on prevalence at NT level and by region Also covered in Stage 2 under Objective 1	Analysis of existing data collections
Stage 2: Define 'severity' for each health condition, and quantify the severity of health conditions	Require clinical consensus on 'severity' definition	Analysis of existing data collections Key informant discussions
Stage 3: Compare results of prevalence and severity with other data sources	AIHW's progress reports contain comparisons of prevalence for certain conditions, and further comparisons will result from AIHW/DHF data linkage collaborative work Propose further comparative work with selected communities where data allows, including data from local studies AIHW's comparative work to date includes: • Prevalence of ear disease (HSAK) • Trachoma (HSAK) – not directly comparable though • Untreated caries (Child Dental Health Survey) – assessing feasibility • Skin sores and Ringworm (HSAK and East Arnhem Regional Healthy Skin Project) • Scabies (East Arnhem Regional Healthy Skin Project) • History of rheumatic heart disease (RHD registers) • Asthma and smoker in the household (National ATSI Health Survey)	Analysis of existing data collections

	• Anaemia (GAA and HSAK) – geographic area for GAA slightly different • Stunting, underweight and wasting (GAA) – geographic area for GAA slightly different	
Stage 4: Explain any difference in results for CHCs and other data	Data sources not always directly comparable (eg geography, demography, time periods, definition of 'prevalence' rates)	Analysis of existing data collections Key informant interviews Interviews with health workers in case studies

Objective:

3. Assess the extent to which requested primary care, allied health and specialist follow-up services have been received, gaps in existing health service delivery, and barriers to the completion of follow-up treatment

Questions:

3.1 What primary care, allied health and specialist follow-up services were requested?

3.2 What requested primary care, allied health and specialist follow-up services were received?

3.3 Of those referred, how many received and when did they receive it?

3.4 What was the appropriate follow-up treatment, and were guidelines/referral procedures kept to?

3.5 What is completion for each condition, what evidence is there of completion, and what were barriers to completion?

Stage	Considerations	Method(s)
Stage 1: Describe follow-up services requested and received by type of referral and relevant variables such as: • Community ID • Age group • Sex • Remoteness • Date of referral Calculate 'conversion rate' of service request to service received, by above variables Calculate time elapsed between service request and service received, by above variables	AIHW progress reports cover referrals to: • PHC clinic follow-up • Dental • Paediatrician • Tympanometry and audiology • ENT • Cardiology and cardiac investigations • Optometrist or ophthalmologist • Family and community services • Dietician or nutritionist Missing data ranged from 10-36% Will require matching against non-CHC data collections where feasible	Analysis of existing data collections
Stage 2: Select three conditions requiring	Chose conditions requiring different types of follow-up (primary care, allied	Review clinical guidelines (CAPRA) and any other

follow-up services Describe appropriate follow-up treatment for these conditions according to guidelines Match data against this pathway of appropriate care and treatment Interview regional and community level health staff regarding relevance of guidelines/procedures, effectiveness of follow-up services, and barriers to receipt of appropriate follow-up services	health and specialist)	guidelines/procedures specifically developed for CHCI Analysis of existing data collections Interviews with health workers in case studies
Stage 3: Define completion for conditions selected in Stage 2 Analyse treatment data for these conditions Identify gaps in completion (and barriers), including gaps in health service delivery	AIHW currently looking at treatment data (provided in open-text form on forms)	Analysis of existing data collections Interviews with health workers in case studies

Objectives:

4a. Whether or not the CHCI has led to improvements in health service delivery for Aboriginal and Torres Strait Islander children

4b. Health status of children in relation to the social determinants of health and access to comprehensive PHC

4c. Treatment outcomes

Questions:

4a.1 Did health service delivery improve?

4a.2 What did the CHCI do to the existing health system?

4a.3 Did health service utilisation increase above the background for Aboriginal and Torres Strait Islander children?

4a.4 What happened afterwards (did impacts continue)?

4b.1 Has health status changed?

4b.2 Have social determinants changed?

4b.3 Is change in health status related to change in social determinants, and/or to access to comprehensive primary health care?

4c.1 What specific treatment was provided as part of the CHC and specialist follow-up services?

4c.2 What was the result of this treatment?

Stage	**Considerations**	**Method(s)**
Stage 1: Identify indicators applicable to health	Data availability against valid indicators	Analysis of centrally held data on governance,

system building blocks Identify select number of indicators that provide reasonable measure of overall health status Identify social determinant indicators Clarify treatment data available through CHC data collections and being analysed by AIHW	Availability of data over time to allow for assessment of change Availability of data at central level (DHF and AMSANT) Fill data gaps with regional and community level data	management and leadership, funding, linkages, infrastructure and workforce Collect more detailed data on above through administered questionnaires in case studies Analysis of existing CHC data collections Administered questionnaires in case study communities using an adapted version of the Healthy Communities Assessment Tool (developed by Menzies) Interviews in case study communities about perceptions of service accessibility, acceptability, and care coordination, and about barriers to treatment
Stage 2: Collect data, including from existing data collections and through administered questionnaires		
Stage 3: Analysis of data collected in Stage 2, and synthesis of findings for Objectives 1-3 concerning health service delivery, health determinants and treatment outcomes		

Table 7. Stages by evaluation objective for EHSDI evaluation

Objective:

1. Impact and sustainability of the EHSDI on PHC service delivery and equitable distribution of resources (including measurement against indicators relating to the number, range and accessibility of core services compared with agreed standards for primary care across NT)

Questions:

1.1 What was happening before EHSDI in terms of PHC service delivery and resource distribution?

1.2 How is PHC understood by stakeholders, and is the PHC core services agenda appropriate?

1.3 Has the service 'gap' between existing arrangements and those required to achieve health equity been identified?

1.4 What categories of core PHC is EHSDI funding being spent on?

1.5 What is happening now?

1.6 Is the emerging model sustainable (politically, financially, administratively) and how will the momentum for system development be continued post EHSDI?

Stage	Considerations	Method(s)
Stage 1: Agree questions and priorities with PHRG and MoU Management Committee in initial workshop Define criteria and definitions of sustainability, equitable distribution and PHC	Will require data pre-EHSDI and post implementation	Workshops Analysis of centrally held data on governance, management and leadership, funding, linkages, infrastructure and

Identify indicators Validate EHSDI program logic model with PHRG and MoU Management Committee		workforce Collect more detailed data on above through administered questionnaires in case studies
Stage 2: Data collection	Detail of this and subsequent stages to be determined through workshop with PHRG and MoU Management Committee	

Objective:

2. Extent to which Indigenous people were engaged and empowered to contribute to health service planning, governance and responsiveness of services

Questions:

2.1 What level of Aboriginal community involvement in delivery, management and control of PHC services was happening before regional reform?

2.2 What did EHSDI offer in terms of training, capacity building and community representation mechanisms?

2.3 How effective and appropriate were the collaborative policy and planning processes in supporting Indigenous engagement and empowerment ?

2.4 What is happening now?

2.5 What are the barriers to the engagement and empowerment of Indigenous people?

Stage	Considerations	Method(s)
Stage 1: For the NT describe the level of Aboriginal community involvement in delivery, management and control of PHC services before regional reform. For the NT describe what was offered in terms of training, capacity building and community representation mechanisms.	The range of service models currently in place The number of services (approx. 73) DHF and AMSANT providing this service	Review health service documentation (held by AMSANT, DHF and area health service), including program documents, implementation plans
Stage 2: Describe what was received (and the perceived appropriateness of what was offered) in terms of training, capacity building and community representation mechanisms by staff and community members/health advisory committee members at the community level in case study communities. Also, by regional steering committee members, members of regional boards, and area health services Describe what mechanisms are currently in place to achieve community engagement	The various perceptions of appropriateness will need to be taken into account Need to take into account the receptiveness and capacity of individuals	Program documents (eg training records, regional planning documents, minutes of regional steering groups) Interviews with health service staff and managers at community level, and regional/area health service staff (as part of case study work)

Stage 3: Develop assessment tool for use in case studies Determine whether the training, capacity building and community representation mechanisms offered were appropriate and effective Identify the barriers to the engagement and empowerment of Indigenous people	Need to take into account the receptiveness and capacity of individuals Need to identify internal system barriers and external barriers outside of the control of the health service/system	Administered questionnaire (tool) for staff/community members and members of Area Health Service and Regional Boards in case study communities to assess their own level of capacity and capability regarding community engagement Program documents (eg minutes of regional steering groups and other reports for case study sites)

Objective:

3. Impact and sustainability of the RAHC Agency on health workforce availability and flexibility in the NT (including measurement against indicators relating to workforce supply across all location and the effectiveness of clinical governance structures)

Questions:

3.1 What workforce capacity has been added by RAHC (and by the recruitment of short-term workers during the CHCI)?

3.2 What has been the impact of short-term deployments - extent to which they have met local needs; impact on quality of service delivery (including clinical and cultural aspects); on NT workforce recruitment, retention and flexibility; and on indigenous and other workers?

3.3 Has RAHC been successful in deploying staff with sufficient skills and expertise to work in remote or urban Aboriginal PHC?

3.4 What effect has RAHC had on clinical governance - quality of care (including support to short-term workers and demands on existing staff) and what is the nature of the relationship of RAHC to NT clinical governance arrangements?

Stage	**Considerations**	**Method(s)**
Stage 1: Planning Identify datasets to describe RAHC Identify datasets to describe NT workforce need/supply Identify datasets to describe communities Study relevant papers and research Plan workforce questions that can be part of community case-study Plan interviews/surveys to gather data from other health centres and from recruited practitioners Plan interviews with key informants in DoHA, RAHC (Aspen), and NT DHF	Less than 12 months experience with RAHC – include experience with recruitment for CHCs RAHC has different objectives to regular NT recruitment efforts – must compare to expectations Collect information from centres and communities that have had RAHC workers and from workers Try to identify needs that were not met Look at impact on NT workforce activities – including NT KPIs 13-16	Review RAHC progress reports and deployment reports plus any data available about workforce from CHC experience Review other RAHC implementation data (eg exit interviews, information on requests, minutes or reports from RAHC Board and Workforce Advisory Committee) NT workforce datasets – (eg data collected for NT KPIs 13-16)

Stage 2: Data gathering Describe RAHC deployments – practitioner type, ethnicity, place qualified, where sourced, place and length of deployment, redeployments Describe NT workforce supply and demand Describe community/health centre experience with RAHC recruited workers Describe RAHC workers' experience Describe views/experience of DoHA, Aspen, NT DHF and other informants	Unclear how much detail RAHC collects Unclear about availability of NT workforce information Experiences preferably from several sources Interviews and/or surveys needed to find out about impact on clinical governance Will require quantitative and qualitative approaches	Review of RAHC reports Analysis of existing NT workforce data Interviews of health workers in case study sites Analyse any RAHC exit interview records Interview/survey sample of practitioners who have been deployed by RAHC Interview key informants DoHA, Aspen, DHF, others
Stage 3: Data analysis Assess what extra supply has been added Assess how well RAHC supply matches need Assess quality of workers Assess impact on NT efforts to get sustainable workforce	Always bear in mind objective of RAHC Compare to previous or other short-term deployment capacity Ask whether RAHC is useful as part of a workforce approach – or does it aggravate problems?	Compare deployments against community isolation/need Compare deployments against requests Compare RAHC quality against CHC worker quality

Objective:

4. Efficiency of the EHSDI in terms of how well it has maximised health service delivery with the available funds

Questions:

4.1 How effective and appropriate were the collaborative policy and resource allocation processes guiding investment?

4.2 What is known about the actual costs of delivering effective and sustainable PHC services in remote settings in the NT?

4.3 What funding allocation model/s were used to guide EHSDI investment?

4.4 What did EHSDI cost (inputs) and what was delivered (outputs)?

4.5 Did the resources that were allocated get to the program?

4.6 What proportion of resources went to front line services and what barriers were there to the use of resources to deliver front line services?

4.7 What proportion of resources were allocated to non-frontline services (within OATSIH, AMSANT and NT DHF) and what was the rationale and return on investment from such services?

4.7 Were the services that were bought 'value for money', or were they paying 'over the odds' for this type of service?

4.8 What would it cost to deliver the services in other ways?

4.9 What would it cost to get this outcome in other ways?

4.9.1 Is this the best way to achieve this outcome?

Stage	Considerations	Method(s)
Stage 1: Agree questions and priorities with PHRG and MoU Management Committee in initial workshop Define criteria and definition of efficiency Identify indicators, data and comparable services Validate EHSDI program logic model with PHRG and MoU Management Committee	The starting point for efficiency is effectiveness – cannot be efficient unless it is also effective	Workshop Analysis of program allocations and spend Literature review To be determined on basis of workshop outcomes
Stage 2: Data collection	Detail of this and subsequent stages to be determined through workshop with PHRG and MoU Management Committee	

Objective:

5. Effectiveness of EHSDI in achieving change in health status (including measurement against PHC-related health indicators as developed through the NT KPIs project and the analysis of the NTER CHC program)

Questions:

5.1 Are the NT KPIs sufficient to measure effectiveness over the time required to address health status?

5.2 Are the NTER CHC data collections sufficient to measure change in child health status (attributable to EHSDI)?

5.3 What are the outcomes, where do the indicators sit in this, what's the logic and where are the gaps?

Stage	Considerations	Method(s)
Stage 1: Agree questions and priorities with PHRG and MoU Management Committee in initial workshop Address questions 5.1 and 5.2 in workshop, concerning the feasibility of addressing the objective in the course of this evaluation Add assumptions and linkages to program logic relating to change in health status, and identify any that require testing through the evaluation	Status and quality of NT KPI data collection	Workshop Further methods and subsequent stages to be determined through workshop with PHRG and MoU Management Committee

Objectives:

6. Impact of the regional reform process on:

   6a efficient and effective operation of health services

   6b clinical governance, including quality of health service delivery

   6c information systems and planning capacity

Questions:

6a.1 Was the rationale behind regionalisation sound?

6a.2 What was the level of rigour related to planning and consultation?

6a.3 How have things changed as a result of regionalisation, in relation to governance, management, quality, service delivery, and overall costs?

6c.1 What information is available on system performance to governors, managers, clinicians, and the community?

6c.2 How is this information used to support improved health service delivery?

Stage	Considerations	Method(s)
Stage 1: Agree questions and priorities with PHRG and MoU Management Committee in initial workshop Add assumptions and linkages to program logic relating to regionalisation, and identify any that require testing through the evaluation	Detail of this and subsequent stages to be determined through workshop with PHRG and MoU Management Committee	Workshops Key informant interviews at central (DHF, DoHA and AMSANT), regional and community level Review of program reporting documentation

4.7 STEP 5 – JUSTIFY CONCLUSIONS

At this stage of the EDR it is important to summarise our expectations in terms of data analysis and interpretation. We will need to address each of the evaluation questions by referencing, citing and integrating the relevant qualitative and quantitative information (including contextual information), and triangulating the analysis by checking for consistency of findings:

- Generated by different data collection methods;
- Generated by the same methods but from different data sources; and
- By using more than one analyst to review findings.

We expect the evaluation will benefit from different layers or techniques of analysis – from description, to interpretation and judgement. We expect to identify implications for future policy and planning and anticipate involving key stakeholders (users of the evaluation findings) in interpreting findings, discussing implications and drawing conclusions. This is more likely to lead to results that meet stakeholders' needs and interests, and therefore be used. As discussed in 1.5.2, in drawing conclusions, we also expect to consider the wider evidence-base to see if the evaluation results are consistent with what other research literature is saying about the effectiveness of comparable programs in Australia.

For CHCI, taking the overarching objective of effectiveness, the key question will be 'could and did CHCs make any difference?' The analysis will, therefore, initially need to focus on calibrating the results in the AIHW reports with:

- Data from other sources (such as local studies); and
- Any data existing before CHCI was implemented.

The analysis will also need to focus on the continuum of need/care: from the demographics (which will need to define the 'at risk' populations), to primary care, and secondary care; and whether any impacts were/are sustainable. This is where the analysis will require tracking individuals through the system.

The analysis will need to consider attribution. This will involve identifying other things that were happening at the same time as the programs, and other things that may influence outcomes. We understand that health checks were previously available to the target population and it is possible that, for example, CHCI only continued an existing trend, but quickened the rate of progress; or that there was an increase in the number of children seen by CHCI, but there was no continuing care or home environments did not change and, therefore, the impacts are not sustainable (i.e., problems are likely to recur). For CHCI, attribution will be managed to some extent by comparing results for the population that got checked with other, comparable populations that did not receive a CHC. Managing attribution with EHSDI is potentially more difficult, given the program is part of a broad system of reform and expansion in what is likely to be quite a 'crowded' environment. The question of attribution will be considered during case study work and in the workshops with PHRG and the MoU Management Committee.

4.8 STEP 6 – ENSURE USE OF EVALUATION FINDINGS AND SHARE LESSONS LEARNED

The precise content of the proposed reports and workshops will be planned as the evaluation progresses. This will include planning for dissemination of information/findings, in collaboration with the key stakeholders. The proposed deliverables and timeframes are shown in Table 8.

Table 8. Key evaluation deliverables and timeframes

Deliverable	Timeframe
Report 1 – Draft EDR	17 July 2009
Report 2 – EDR (this report)	28 August 2009[1]
Report 3 – EHSDI workshop and short report on workshop	mid November 2009
Report 4 – CHCI interim quantitative evaluation report	1 March 2010
Report 5 – EHSDI workshop and short report on workshop	mid May 2010
Report 6 – NTER CHCI and EHSDI final evaluation report	15 June 2010[2]

[1] Anticipated public release in late September 2009

[2] Anticipated public release in July 2010

The precise timing of report 4 should be agreed with the MoU Management Committee once the timing of the AIHW's final report on CHCI is confirmed and once the nature of the data analysis for the evaluation is agreed. The case study work will not be completed until March 2010, so information gathered on CHCI as part of this process will not be included in report 4 – instead, it will

be included in report 6. The MoU Management Committee may wish to consider delaying report 4 until after the case study work so that it is able to include the analysis of this additional information.

4.9 POTENTIAL LIMITATIONS OF THIS DESIGN

Potential limitations with this proposed evaluation design are set out in Table 9, together with mitigating actions or general responses.

Table 9. Limitations with the proposed design

Potential limitation	Mitigating factors
Access to comparable data sources for CHCI	Consider routine data collections and population based health studies.
Data quality	Use existing data. Triangulating quantitative data against qualitative will strengthen quality of analysis.
Statistical power issues	Select data sets that provide greatest level of statistical power for populations of interest.
Level of disaggregation possible	Balance level of disaggregation against quality of data, use de-identifiers at all levels of disaggregation.
Limited number of case studies	High quality and in-depth/thorough review of selected case studies. Robust process for selecting case studies.
Limited ability to generalise from case studies	Robust case study selection process provides variety in terms of population size, geographical regions, health service models, movements towards regionalisation, and resourcing. Mix of qualitative and quantitative data will support some transfer of learnings.
Timing of evaluation in life of CHCI	Provide evidence to inform policy and planning for future child wellness/health check initiatives.
Timing of evaluation in life of EHSDI (especially in terms of health status and impact questions)	Focus on implementation processes, and work closely with those responsible for implementing EHSDI so that lessons feed directly into implementation. Advise on appropriateness of NT KPIs and framework for future monitoring and evaluation activity.

4.10 STRENGTHS OF THIS DESIGN

The project team considers this proposed evaluation design has the following key strengths:

- It will provide a level of context-rich information, currently missing from the monitoring of CHCI progress;
- It will analyse the effects of CHCI over time to enable an estimate of the value-added by CHCs;

- It will assess changes over time for different but comparable population groups – those that got a CHC and those that did not;
- It will test some key assumptions underpinning CHCI and provide a child wellness check program theory to inform future policy in this area;
- By taking a health systems approach, it will consider all elements of the EHSDI expansion and reform agenda;
- By taking a formative approach, it will be responsive to the needs of those responsible for implementing EHSDI, and will produce real-time finings that can be used to support improvements to implementation processes;
- Case studies will provide rich 'stories' about the impact of EHSDI at a community and regional level; and
- Case studies will take account of different contexts, recognising that there were things happening before EHSDI and that communities were at different starting points in terms of the health service expansion and reform agenda.

ATTACHMENT ONE – ADAPTED SEVAL STANDARDS

Introduction

The following evaluation standards are based on the standards of the Swiss Evaluation Society (SEVAL Standards) and have been adapted to provide greater guidance and support to evaluators working with Aboriginal and Torres Strait Islander people(s).

These adapted standards were developed after a review of literature from Australia and New Zealand on best practice research and evaluation with Aboriginal and Torres Strait Islander people(s) and Māori.

The standards currently set out an ideal that all evaluations should aim to fulfil. However, it will not always be possible to adhere to each standard equally, and it is appropriate to tailor the standards to the specific evaluation setting. Based on these standards, the project team have developed a set of guidelines (see attachment two) that are further tailored to the particular context of the CHCI and EHSDI evaluation. The guidelines aim to describe how the standards will be applied or used in this evaluation setting.

Utility

The utility standards help ensure that an evaluation is oriented to the information needs of the intended users of the evaluation.

U1 Identifying Stakeholders

Those persons participating in, and affected by, an evaluation are identified in order that their interests and needs can be taken into account.

Those persons who should be considered as belonging to the environment of an evaluation include:

- Those who will be making decisions about the future of the object being evaluated (typically those with fiscal authority);
- Those responsible for the conceptualisation or structuring of the object being evaluated;
- Those involved in the practical implementation of the object under investigation (the project, program, law, product, etc);
- Those whom the object of evaluation directly or indirectly reaches or is intended to reach (target groups and their social environment). In particular, Aboriginal and Torres Strait Islander people(s) should be involved in and consulted as legitimate participants in any evaluation project that concerns them; and
- Other parties interested in the results of the evaluation, such as decision-makers who are planning similar projects, evaluators, or the public.

Such persons, groups, and institutions are called ‘stakeholders’.

U2 Clarifying the Objectives of the Evaluation

Those involved in an evaluation will ensure that the objectives of the evaluation are clear to all stakeholders.

The success of an evaluation depends on how clearly all the stakeholders understand its objectives. All actors involved are responsible for clearly communicating these objectives. This will help prevent exaggerated expectations from being placed on the evaluation, particularly by those who are commissioning it. Similarly, those responsible for carrying out the evaluation are also obligated to hold to these stated objectives. Clarifying the objectives will help avoid misunderstandings during the evaluation process.

Clarifying the objectives is also important when using a goal-oriented process for conducting the evaluation. Complete clarification is sometimes not fully possible at the start of an evaluation, but instead requires a lengthier process that should be regarded as a central element of the evaluation process itself.

When undertaking evaluation projects that involve Aboriginal and Torres Strait Islander people(s), the evaluation objectives must also take into account the principles and values of these people. A shared understanding must be achieved between the evaluators and Aboriginal and Torres Strait Islander people(s) about the objectives and methods for the evaluation. Where possible, the evaluation objectives need to clearly link to priorities and emerging needs articulated by Aboriginal and Torres Strait Islander people(s). The evaluators also need to demonstrate a willingness to modify the objectives or methods in accordance with the participating community's values and aspirations. There needs to be an honest exchange of information about research objectives (rather than evaluators simply telling the community what they want) with communities fully informed about the objectives and methods of the project, its implications, and potential outcomes.

U3 Credibility

Those who conduct evaluations are both competent and trustworthy: this will help ensure the evaluation's results are accorded the highest degree of acceptance and credibility possible.

The trustworthiness of evaluators decisively influences the ability to conduct an evaluation as well as how effective it will be. To be judged trustworthy by the various affected parties, the following characteristics are particularly important for evaluators: having personal integrity, showing independence, and demonstrating social and communicative competence.

In particular, when undertaking research with Aboriginal and Torres Strait Islander people(s), the evaluators need to demonstrate through ethical negotiation, conduct and dissemination of research that they are trustworthy, and will not repeat historical mistakes of other researchers and evaluators with Indigenous communities. It is important for evaluators to be ethical and honest during all evaluation activities.

It is good practice to include in the team advisors with an appropriate level of experience and knowledge of Aboriginal and Torres Strait Islander people(s)' protocols, and experience and knowledge of appropriate methods. Where possible and practical, it is recommended that members of the Aboriginal and Torres Strait Islander communities are included in the evaluation group to ensure greater trust, understanding and credibility and the development of evaluation skills, knowledge and capacity amongst Aboriginal and Torres Strait Islander people(s).

U4 Scope and Selection of Information

The scope and selection of the information that has been collected makes it possible to ask pertinent questions about the object of the evaluation. Such scope and selection also takes into account the interests and needs of the parties commissioning the evaluation, as well as other stakeholders.

In planning an evaluation project, it is necessary to specify which information is indispensable to answer the questions posed by or in the evaluation, and to be able to distinguish this from information that is merely interesting or desirable to know but not ultimately unnecessary. Attention should be paid to the resources available for data gathering to ensure they match which information is most needed to answer key questions, and to meet the needs of the most important groups the evaluation addresses.

When working with Aboriginal and Torres Strait Islander people(s) and considering the selection of information, it is important to realise that traditional information and knowledge systems can be a significant contribution to the evaluation process. Evaluators must respect the cultural property rights of Aboriginal and Torres Strait Islander people(s) in relation to knowledge, ideas, cultural expressions and cultural material, and it is fundamental to acknowledge the sources of any information and those who have contributed information to the evaluation.

The scoping and selection of information for evaluations involving Aboriginal and Torres Strait Islander people(s) should incorporate their perspectives, and this is often achieved by facilitating more direct involvement in the research by community members.

The collection, collation and utilisation of information should also be conducted in the most effective and efficient manner possible and minimise the burden on Aboriginal and Torres Strait Islander people(s).

U5 Transparency of Value Judgements

The underlying reasoning and points of view upon which an interpretation of evaluation results rests are described in such a manner that the bases for the value judgements are clear.

Interpreting the information gathered, as well as the results, is one of the most important and critical points of an evaluation. Evaluators utilise theoretical models and value orientations in this interpretation process. It is imperative to make the bases for any value judgements transparent if this interpretive process is to be convincing, comprehensible, and assessable. In addition, when working with Aboriginal and Torres Strait Islander people(s) it is good practice to check the validity of the analysis and the interpretation of information with participants to ensure different cultural perspectives and contexts are reported accurately.

U6 Comprehensiveness and Clarity of Reporting

Evaluation reports describe the object of the evaluation – including its context, goals, questions posed, and procedures used, as well as the findings reached in the evaluation – in such a manner that the most pertinent information is available and readily comprehensible.

Providing reports (or using another suitable communication form) in a comprehensive and clear format helps ensure that evaluation results and conclusions are communicated in a convincing way.

The language should be precise (for example, important terms should be explicitly defined and used consistently) yet readily understandable to the intended readers of the evaluation report.

Ideally, the format and type of report(ing) will be planned according to the most optimal perceptual mode of the intended target audience. However, an extensive final report in written form is not always the best way to do this for every group or in every situation. More notice may be taken of the conclusions if the information is presented in another way such as a lecture or a workshop, etc.

It is important that Aboriginal and Torres Strait Islander people(s) are informed of findings in ways that are useful and accessible.

U7 Timely reporting

Significant interim results, as well as final reports, are made available to the intended users so that they can be used in a timely manner.

An evaluation loses much of its intended effect if its timeframe does not correspond to the existing decision-making timeframe of the intended recipients. In many cases, as when evaluations are commissioned by public administrators, considerable advance time must be planned for, since the evaluation is processed internally (involving hearings or producing a complementary report), before a decision can be made. Sufficient time also needs to be allowed to consult with Aboriginal and Torres Strait Islander people(s) about interim results when they are stakeholders in a project. These timeframes need to allow for the competing demands and priorities of these people(s) and, if appropriate, any decision-making processes within their communities.

It is also worthwhile to communicate interim reports or preliminary conclusions during the evaluation process itself, particularly if the data is relevant to actions the intended addressees are planning. It is advantageous to take such feedback loops into account when planning an evaluation and budgeting resources for them.

As well as those who commissioned the evaluation, it is important to communicate results in a timely manner to all stakeholders, including Aboriginal and Torres Strait Islander people(s).

U8 Evaluation Impact

The planning, execution, and presentation of an evaluation encourage stakeholders both to follow the evaluation process and to use the evaluation.

Whether the results or recommendations of an evaluation are actually put into practice depends heavily on whether stakeholders expect beforehand that the evaluation will be of use to them. An important prior condition that helps promote or realise this expectation is to involve the relevant actors in planning and organising the evaluation project. It is also helpful if clear, frequent progress reports are regularly communicated to the stakeholders during the evaluation process.

There is an obligation on evaluators to give something back to contributing communities. The evaluation needs to be of value to Aboriginal and Torres Strait Islander people(s).

Aboriginal and Torres Strait Islander people(s) need to be involved in the development, impact and communication of the evaluation. To ensure the results or recommendations are put into practice, where possible, the evaluation objectives need to clearly link to priorities and emerging needs as

articulated by Aboriginal and Torres Strait Islander people(s). These people must be informed in ways that are useful and accessible and share in the results and flow-on outcomes of the evaluation.

Feasibility

The feasibility standards ensure that an evaluation is conducted in a realistic, well considered, diplomatic and cost-conscious manner.

F1 Practical Procedures

Evaluation procedures are designed so that the information needed is collected without unduly disrupting the object of the evaluation or the evaluation itself.

The goal in planning and carrying out an evaluation is not to employ procedures that are deemed the best from a scientific point of view. It is just as important to make sure that the methods and procedures chosen are as practicable as possible. Neither the object of the evaluation nor those people being surveyed should be unduly burdened. The methods that might yield the most information and seem most promising from a scientific point of view often cannot be used as they are too costly, time-consuming, or ethically unacceptable in a given situation.

The advantages and disadvantages of the chosen methods need to be openly clarified when planning the evaluation. The methods and procedures need to be discussed with those who commission the evaluation, and those individuals and groups to whom the results will be disseminated. It is important that Aboriginal and Torres Strait Islander people(s) are involved in the planning of the evaluation and development of the evaluation methods, and are able to participate in a way that does not unduly interrupt their own work and family priorities.

F2 Anticipating Political Viability

The various positions of the different interests involved are taken into account in planning and carrying out an evaluation in order to win their cooperation and discourage possible efforts by one or another group to limit evaluation activities or distort or misuse the results.

In order not to be taken by surprise by negative reactions to an evaluation, it is necessary to identify as many of the interested parties as possible. Beyond the immediate circle of those directly involved, this may include persons who can be counted as belonging to the wider environment the object of evaluation is situated in (including those who may offer various products that compete with the object under investigation). Negative reactions may be avoided or better managed if the needs of these various interests are recognised and taken into account. When working with Aboriginal and Torres Strait Islander people(s), it is important that they are involved in and consulted on all stages of the evaluation, and that evaluators are ethical and honest during all activities.

Beyond the openly expressed interests of such groups in the environment, there may also be significant hidden agendas. In considering the explicit and implicit needs and demands various actors place on the evaluation, one should not forget that those who commission the evaluation might also possess them.

F3 Cost Effectiveness

Evaluations produce information of a value that justifies the cost of producing them.

An evaluation is cost effective when the expected benefit is as large as or larger than the costs. The costs refer to the value of all resources needed, including the time necessary to conduct the evaluation or the costs that are borne by other institutions. The cost is thus the total social and monetary value (full cost) of all the resources needed to carry out the evaluation. The benefits refer to the sum of all values the evaluation brings forth (optimisation of effects, possible cost savings, acceptability of a program, etc.).

The cost-benefit relationship should be as optimal as possible in an evaluation. Thus, if there are various options that all promise identical benefits, one should choose that option with the least cost. Alternatively, where there are various designs available at similar costs, then the design with the highest anticipated benefits should be selected. If in every case costs remain higher than expected benefits, then the evaluation should not be conducted. When reviewing the costs and benefits of an evaluation involving Aboriginal and Torres Strait Islander people(s) it is important to recognise that potential benefits and costs may be viewed differently by these participants (according to their own values and priorities) and that these views need to be included in any decision making.

Propriety

The propriety standards ensure that an evaluation is carried out in a legal and ethical manner and that the welfare of the stakeholders is given due attention.

P1 Formal Written Agreement

The duties of the parties who agree to conduct an evaluation (specifying what, how, by whom, and when things are to be done) are set forth in a written agreement in order to obligate the contracting parties to fulfil all the agreed upon conditions, or if not, to renegotiate the agreement.

The relationship between the evaluator and those who commission an evaluation should be characterised by mutual respect and trust at the outset. This is the best time and environment in which to set out in written form what the most important rules and duties will be for both parties (e.g.,, a contract or commission confirmation, etc.). Formal agreements should cover the following areas: financing, timeframe, persons involved, reports to be produced or published, content, methodology, and procedures to be followed. It is particularly important to specify the exact rights and duties of the participants. If it becomes evident over time that revisions are necessary, it is possible to renegotiate the contractual conditions. A formal, written agreement reduces the likelihood that misunderstandings will arise between the contracting parties and makes it easier to resolve them.

As well as the formal written agreement with those who commission an evaluation, it is also important to have explicit agreements with Aboriginal and Torres Strait Islander people(s) when they are involved in an evaluation. Detailed agreements between evaluators and participating community groups should always be negotiated at the outset of a project. These agreements should clearly spell out the management of the data, the ownership of intellectual and cultural property and copyright, the dissemination and publication of results, the protection of individual and community identity, the evaluators' responsibilities to the community, and the rights of communities to control their participation in the study, and to withdraw at any time.

P2 Ensuring Individual Rights and Well-Being

Evaluations are planned and executed in such a manner as to protect and respect the rights and well-being of individuals.

Individuals have personal rights that are secured by law, by ethical practices, and by common sense and decency. Their rights and well-being should not be affected negatively in planning and carrying out an evaluation. This tenet needs to be communicated to all persons involved in an evaluation, and its foreseeable consequences for the evaluation discussed. Those contracting the evaluation should not push the evaluators to make decisions that might impinge upon an individual's rights or well-being. If an evaluation leads to well-founded conclusions that endanger the well-being of specific individuals one should carefully consider whether disseminating such results is justified.

In any evaluation with Aboriginal and Torres Strait Islander people(s), it is important that the groups' inherent right to self-determination and their rights to control and maintain their heritage and culture are protected. Evaluation should do no harm to Aboriginal and Torres Strait Islander people(s) and also to those things that they value. Any decision-making must be based on free and fully informed consent and ongoing consultation is necessary to ensure free and informed consent for the evaluation is maintained. Finally, people should be reimbursed for all reasonable costs arising from their participation in the evaluation process.

Any evaluation also needs to demonstrate that it will add benefit to Aboriginal and Torres Strait Islander people(s) and give something meaningful back to the community (for example, training of partnerships, gifting of or providing access to resources (people, knowledge, networks), assistance with social and economic development, or financial benefits).

P3 Respecting Human Dignity

Evaluations are structured in such a manner that the contacts between participants are marked by mutual respect.

Evaluators should avoid offending the dignity and self-respect of those people they contact during an evaluation. Antagonism toward the evaluation should be avoided by employing appropriate behaviour. This will help ensure human dignity is protected and also has a more practical benefit. Persons who feel their dignity or self-worth is being disrespected not only lose their creative potential, but can also often behave in a manner that limits the evaluation. It is therefore necessary to understand or learn the cultural and social values of those involved in the evaluation, and also consider what significance individuals attach to the evaluation.

When working with Aboriginal and Torres Strait Islander people(s) it is important to recognise and respect their different values, norms and aspirations, and the distinctiveness of their cultures. It is important to recognise the diversity in language, cultures, histories and perspectives within these communities. Any evaluation needs to be conducted in a manner sensitive to the cultural principles of Aboriginal and Torres Strait Islander people(s).

P4 Complete and Balanced Assessment

Evaluations are complete and balanced when they assess and present the strengths and weaknesses that exist in the object being evaluated, in a manner that strengths can be built upon and problem areas addressed.

A balanced presentation of strengths and weaknesses helps to provide a complete and fair assessment of the object under evaluation. Even when the primary goal is frequently to identify weak points, this does not absolve an evaluation from its obligation to also find strengths and draw attention to them. It is often possible, in fact, to correct existing weaknesses by using existing strengths. One should keep in mind, however, that correcting the weaknesses may result in impairing the strengths of the object under evaluation. It is thus useful to have the findings reviewed by those external to the evaluation before the final report is written, as they may have different ideas about presenting positive and negative points. In particular, it is important to involve Aboriginal and Torres Strait Islander people(s), where feasible, in the development and review of findings to ensure their views, principles and values are reflected accurately in the evaluation findings. In addition, if it is not possible to gather certain data due to time or financial restrictions, these gaps should be clearly indicated. Those commissioning the evaluation should avoid intervening in the evaluation in such a manner as would put balanced reporting in question.

P5 Making Findings Available

The parties who contract to an evaluation ensure that its results are made available to all potentially affected persons, as well as to all others who have a legitimate claim to receive them.

In disseminating the findings, one should try to ensure that all participants, or those who are affected by the evaluation, have access to the reporting. As the group of stakeholders may be very large, reports frequently need to be made public. Those actors most closely involved in the evaluation, namely the evaluator and those who commissioned the evaluation (but sometimes including additional persons), share the responsibility to ensure appropriate access and dissemination. In any evaluation involving Aboriginal and Torres Strait Islander people(s), it is important that these people(s) have input into deciding the most appropriate way to share and disseminate research findings with their communities. A report should also be written in such a way that it meets the needs of those to whom it is directed. This often requires that an evaluation is adapted so as to appropriately communicate to its intended audience. It is important that evaluators should not make the publication of findings a greater priority than feedback of findings to the Aboriginal and Torres Strait Islander people(s) in an appropriate and accessible way.

P6 Declaring Conflicts of Interest

Conflicts of interest are addressed openly and honestly so that they compromise the evaluation process and conclusions as little as possible.

There are many circumstances in which evaluators are faced with conflicts of interest. Evaluators themselves have interests which can impinge upon the results an evaluation reaches, including that they may be more or less dependent upon receiving future contracts to conduct evaluations. Evaluators may also have specific philosophical, theoretical, methodological or political viewpoints, and are themselves parts of organisational and personal networks. Conflicts between the various interests existing in the wider environment can also erupt in the course of an evaluation, with the result that the interpretation, the results, or even the process of evaluating itself can become

skewed or distorted. It is generally desirable to avoid conflicts of or between interests, but given the many possibilities for such conflicts to emerge, realistically speaking it is often not possibly to entirely avoid them. When they occur, one should find ways of addressing them that will not undermine the evaluation itself. This again reinforces the importance of evaluators being ethical and honest during all stages of the evaluation. Aboriginal and Torres Strait Islander people(s) need to be involved in and consulted on all stages of the evaluation, particularly on any changes that occur to the agreed evaluation process.

Accuracy

The accuracy standards ensure that an evaluation produces and disseminates valid and usable information.

A1 Precise Description of the Object of Evaluation

The object of an evaluation is to be clearly and precisely described, documented, and unambiguously identified.

The object of an evaluation, be it a measure, program, or organisation, is to be thoroughly investigated. One should pay attention to the fact that this object may take differing forms depending upon timeframe or contextual circumstances, and a description should make clear what exactly is being studied. This also enables people to draw comparisons with other evaluated objects. A precise investigation of the object under evaluation also makes it possible to discover connections between the object and its effects, or helps identify previously un-remarked side-effects. Particular attention should be paid to the discrepancies that may exist between the original form the object of evaluation was anticipated to take and its actual form in practice or when implemented.

A2 Analysing the Context

The influences of the context on the object of evaluation are identified.

The context refers to the entirety, in combination, of all the frameworks and conditions that surround the object under evaluation. These can include the degree of institutionalisation, the social and political climate, and the characteristics of the key stakeholders (including, where appropriate, the principles and values of Aboriginal and Torres Strait Islander people(s)); the structure of the policy arena, neighbouring and competing state or private activities, or the economic framework. These and other contextual factors need to be sufficiently closely investigated so as to appropriately situate the planning, execution, and communication of the evaluation. Such knowledge of setting is necessary if an evaluation is to be realistic about what the existing possibilities or limitations are. Contextual factors often have a decisive influence on the effects of an evaluation object. When working with Aboriginal and Torres Strait Islander people(s) it is to be expected that their values and aspirations will modify the objectives and methods of the evaluation.

A well-grounded analysis of the setting also makes it possible to estimate the extent to which evaluation conclusions can be applied to other contexts. In conducting such analysis, one should avoid defining the context too narrowly, but one should also avoid defining it too broadly, as the particular object can then not be sufficiently precisely analysed.

A3 Precise Description of Goals, Questions, and Procedures

The goals pursued, questions asked, and procedures used in the evaluation are appropriately described and documented so that they can be identified as well as assessed.

The goals pursued in an evaluation, the questions to be addressed, and the procedures chosen need to be carefully documented during the evaluation. They should also be communicated in clear and comprehensible language when reporting to the stakeholders of the evaluation (including Aboriginal and Torres Strait Islander people(s)); the goal of these standards is to make the process of evaluation transparent. When describing goals and questions, particular attention needs to be paid to divergent views. Documenting the procedures includes a detailed description of the organisation, data collection and processing, analysis and reporting. In particular, it is important to have detailed agreements between Aboriginal and Torres Strait Islander people(s) about the evaluation procedures (including evaluation objectives and methods and the management and ownership of data).

One should also pay attention to the fact that the procedures initially chosen may change during the evaluation so that the planned and actual procedures used may not be the same. The reason for and existence of such divergence needs to be explicitly stated. If goals and procedures are not declared, it can protect an evaluation, incorrectly, from justified critique, but it can also mean that inappropriate objections might be raised. Thus, when working with Aboriginal and Torres Strait Islander people(s), it is important that they are involved in and consulted on all stages of the evaluation, including any changes in procedures.

A4 Trustworthy Sources of Information

The sources of information used in an evaluation are sufficiently precisely described that their adequacy can be assessed.

Describing the sources of information permits stakeholders to draw conclusions about the quality of the information these sources provide. Such sources for an evaluation include individuals or groups, documents, audiovisual materials, and statistics. Using a variety of information sources allows comparisons to be drawn between the data gleaned from each. The credibility of an evaluation can be put in question if the source of the information is inadequately described or not described at all. Information should be assessed or qualified, and its trustworthiness should be taken into account when interpreting the conclusions drawn in or from the evaluation.

A5 Valid and Reliable Information

To ensure the validity and reliability of the interpretation, it is necessary to select, develop, and employ procedures for that given purpose.

To a certain degree, the empirical investigation of a particular object is subject to sources of error. Validity and reliability are designations for two qualities in the investigation that addresses error, though these qualities can only be estimated in the context of a specific evaluation and with respect to the specific goal set by the empirical investigation.

Validity is a term that asks whether or to what extent a measure accurately reflects the concept it is intended to measure. Reliability, in turn, asks about the consistency or stability of the quality measured, whether between measurement instruments, persons, or over time. The validity and

reliability of a measure are closely related, and in selecting or assessing data collection instruments, both qualities are to be addressed equally.

A6 Systematic Checking for Errors

The information collected, analysed, and presented in an evaluation is systematically checked for errors.

There are many possible sources of error in gathering, assessing, and interpreting information. These can be as simple as typing errors in data entry, and as complex as mistaken interpretations of the data collected. It is necessary to try to reduce potential sources of error as much as possible during an evaluation. Appropriate methods (plausibility tests, parallel data gathering, communicative validation, etc.) can be used to check the information gathered for possible errors. In reporting the evaluation, such error sources and their consequences need to be openly discussed, so that misleading interpretations and conclusions are not made. Erroneous assertions, though they may be of less material consequence, can discredit the entire evaluation. To avoid errors, it is therefore important to check the validity of the analysis and interpretation of information with participants to ensure different cultural perspectives and contexts are reported accurately.

A7 Qualitative and Quantitative Analysis

Qualitative and quantitative information are systematically and appropriately analysed in an evaluation, in a manner that the questions posed by the evaluation can actually be answered.

Conclusions are drawn in evaluations based on the analysis of qualitative as well as quantitative data. The analysis of the information collected should be done in a systematic fashion, and should follow the rules of qualitative and quantitative methodology. It is usually useful, as well as sensible, to draw upon both qualitative and quantitative information in an evaluation. The questions asked, as well as the quality and availability, decisively determine the selection of data and the methodology to analyse it. Factors such as the prior knowledge or preferences of the persons involved should play no role in making such decisions. The methodology choices made should be clearly described, and their consequences critically examined, particularly with reference to the significance of the method(s) and to their limitations.

A8 Substantiated Conclusions

The conclusions reached in an evaluation are explicitly substantiated in such a manner that stakeholders can comprehend and judge them.

The conclusions reached in an evaluation must be explicitly justified. They must also be clearly and explicitly described, together with their underlying assumptions and the procedures that were employed to reach them. The scope of the conclusions must also be indicated and alternate interpretations – and why they were not selected – discussed. In stating the premises on which the conclusions are based, one should avoid using assumptions not shared by the relevant actors. Adhering to these standards will enable those who use the conclusions of the evaluation to judge their significance, and will support how convincing the conclusions are. When working alongside Aboriginal and Torres Strait Islander people(s) it is therefore important to discuss any draft conclusions with participants to ensure different cultural perspectives and contexts are reported accurately, and to ensure the findings are presented in a way that is useful and accessible.

A9 Neutral Reporting

Reporting is free from distortion through personal feelings or preferences on the part of any party to the evaluation; evaluation reports present conclusions in a neutral manner.

Many different perspectives exist in the environment of an evaluation. Stakeholders themselves often hold diverging views of the object of an evaluation. Any given evaluation also runs the danger of being manipulated or captured by a particular group or interest, though an evaluation should avoid adopting any one specific point of view. Rather, it should be concerned to fairly represent all relevant interests, and it is important for that reason that an evaluation should take as independent a position as possible. An evaluation should avoid being too closely linked to those who have commissioned it, but should also avoid being too close to those persons who are responsible for the object of the evaluation. The relationship of those responsible for the evaluation to those who have contracted it, and to other relevant groups, should be clarified at the outset of the evaluation process.

There is an increased risk of bias being introduced when evaluations are conducted on highly politically and socially emotive issues, which can be the case with evaluations involving Aboriginal and Torres Strait Islander people(s). In these cases it is important to plan methods to prevent the introduction of bias at the evaluation design phase. To avoid introducing bias it is important that information is collected from a range of sources to ensure that, as far as possible, all perspectives on issues are recorded and reported. It is important to test the face validity of findings with a range of stakeholders and participants. The process by which findings and recommendation were identified, and who was involved in the process, needs to be clearly documented. In presenting findings, emotive or commonly identified value laden language needs to be avoided.

A10 Metaevaluation

The evaluation itself is evaluated on the basis of existing (or other relevant) standards such that the evaluation is appropriately executed, and so that stakeholders can, in the end, assess the evaluation's strengths and weaknesses.

Failed evaluations can lead to bad decisions. Evaluations can also be subjected to strong, if unjustified, critique. To avoid such situations, the quality of the evaluation itself can be checked by use of a metaevaluation (an evaluation of an evaluation), using the standards described here, for example. Depending on the situation, a metaevaluation can be summative or involve general stocktaking, or it can be formal or structural, and be conducted internally by the evaluation team itself, or externally by those uninvolved in that specific evaluation. As with evaluations themselves, metaevaluations can be either more or less extensive. While an in-depth and comprehensive metaevaluation may be useful only in particular cases, a brief self-evaluation on the part of those who participated in the evaluation should definitely not be omitted from the evaluation process. It is important that Aboriginal and Torres Strait Islander people(s) are involved in any metaevaluation of a project that concerns them. The relatively small financial resources needed for such a small metaevaluation ought to be planned into the evaluation from the outset.

ATTACHMENT TWO – EVALUATION GUIDELINES

The guidelines are divided into the four areas outlined in the adapted SEVAL standards; utility, feasibility, propriety and accuracy.

1. Utility

Utility standards help ensure that an evaluation is oriented to the information needs of the intended users of the evaluation. Many of the utility standards will be naturally addressed during the development of the project through the collaborative evaluation process with stakeholders (e.g. identify stakeholders, clarify objectives). These guidelines therefore address the more critical standards of: credibility, scope and selection of information; comprehensiveness, clarity and timeliness of reporting; and evaluation impact. In order to apply these standards to the CHCI and EHSDI evaluation, the evaluators will ensure:

1.1 Advisors are included in the project team who have an appropriate level of experience and knowledge of Aboriginal and Torres Strait Islander people(s). These advisors will include:

- Cultural brokers and interpreters (as required) in all case study work (information collection);
- Dr Elizabeth McDonald (all aspects of the project); and
- Prof Ross Bailie (advice on design, methods, analysis, reports).

Beyond the project team, the evaluation will draw on expert input from the IAG and other members of the MoU Management Committee. Ethical credibility will be assured through obtaining ethical clearance for the evaluation from the Human Research Ethics Committee of NT Department of Health & Community Services and Menzies School of Health Research and the Central Australian Human Research Ethics Committee.

1.2 The scoping and selection of evaluative information will capture multiple perspectives by:

- Collecting and using different types of information (e.g. quantitative and qualitative);
- Collecting and using different sources of information (e.g. health data collections, community-level data and information, and perspectives from individuals);
- Using different methods of collecting and analysing information (e.g. secondary data analysis, key informant interviews, surveys, case studies, document review); and
- Selecting case study sites that capture different perspectives, but that also include sites where we can learn the most.

The team will be guided on the appropriate data and information sources by advice from the MoU Management Committee and the IAG.

1.3 The process for scoping and selecting information will include the perspectives of Aboriginal and Torres Strait Islander people(s), and is as efficient and effective as possible. This will be achieved through working closely with the project advisors (refer 1.1), the IAG, and members of AMSANT.

1.4 Interim and final findings will be reported in ways that are timely, useful and accessible through seeking advice from partners during the course of the project, particularly the MoU Management Committee and the IAG, on the most appropriate way to feedback information to stakeholders and target audiences. This will ensure the communication process is responsive to any additional or changing communication requirements. In addition to formal written reports and regular updates to the MoU Management Committee, the project team will:

- Produce bi-monthly newsletter updates aimed at key stakeholders including NT DHF, AMSANT, and health services in case study communities; and
- Hold two workshops with the PHRG, the MoU Management Committee and the IAG to enhance the relevance and credibility of the evaluation. These workshops will form a key part of the ongoing formative evaluation cycle of reflection and improvement by project partners. The workshops will ensure key stakeholders are involved in interpreting findings and generation conclusions to ensure that the evaluation is oriented to the information needs of the intended users.

1.5 Stakeholders are encouraged to use the results and recommendations of the evaluation through their involvement in the planning, execution and presentation of the evaluation in line with the principles for formative evaluation. This will be achieved through:

- Regular briefing of the NT AHF;
- Producing high quality evaluation reports for Government and the public on the progress and outcomes of these programs;
- Two workshops held with the PHRG, the MoU Management Committee and the IAG to ensure the evaluation findings are relevant and credible and contribute to the ongoing improvement of the initiative (refer 1.4); and
- Regular involvement of the MoU Management Committee in interpreting findings and identifying implications for policy and planning as part of the iterative and developmental formative evaluation process.

2. Feasibility

Feasibility standards ensure than an evaluation is conducted in a realistic, well considered, diplomatic and cost-conscious manner. Most of the feasibility standards will be naturally addressed during the development of the project (e.g. anticipating political viability and cost effectiveness). These guidelines therefore address the more critical standard of ensuring that information is collected without unduly disrupting the objective of the evaluation or the evaluation itself (practical procedures). In order to apply this standard to the CHCI and EHSDI evaluation, the evaluators will:

2.1 Work closely with project advisors (refer 1.1) to ensure the chosen evaluation methods and procedures are as practicable as possible and are not too costly, time-consuming or ethically unacceptable to Aboriginal and Torres Strait Islander people(s) and health providers (including AMS).

2.2 Obtain ethical approval from the Human Research Ethics Committee of NT Department of Health & Community Services and Menzies School of Health Research and the Central Australian Human Research Ethics Committee for the use of specific data collections and for the case study methodology.

3. Propriety

Propriety standards ensure that an evaluation is carried out in a legal and ethical manner and that the welfare of the stakeholders is given due attention. Some of these standards will naturally be addressed as part of the partnership approach with stakeholders (e.g. complete and balanced assessment and declaring conflicts of interest). These guidelines therefore address the more critical standards of formal written agreements, individual rights and well-being, human dignity and making findings available. In order to apply these standards to the CHCI and EHSDI evaluation, the evaluators will ensure:

3.1 Formal agreements with shire councils and health services in case study communities are established at the outset. These agreements will cover timeframe, people involved, dissemination and publication of results, access to data, methods and procedures to be followed, protection of case study, community and individual identity, and the roles and responsibilities of participants and the evaluators.

3.2 Informed consent will be obtained from the primary caregiver of any child who the evaluators want to track through the CHC process.

3.3 Bi-monthly newsletters will provide updates and feedback to stakeholders (refer 1.4), including to health centres in case study communities.

3.4 Any reasonable costs to health centres and/or community informants engaged with are reimbursed.

3.5 The evaluators work closely with project advisors (refer 1.1) to ensure the evaluation is conducted in a manner sensitive to the cultural principles of Aboriginal and Torres Strait Islander people(s).

3.6 Interim and final findings will be made available to all affected groups through: bi-monthly newsletter updates sent to key stakeholders including health centres in case study communities (refer 1.4 and 3.3); two workshops will also be held with project partners (refer 1.4); other appropriate ways to share and disseminate research findings as identified by project partners, particularly IAG (refer 1.4).

3.7 All relevant ethics approval processes are completed.

3.8 All work with Aboriginal and Torres Strait Islander people(s) health data will be undertaken with particular reference to the National Aboriginal and Torres Strait Islander Health Data Principles regarding ethical data collection, management, use and storage; and respect for understanding of data ownership and sharing.

4. Accuracy

Accuracy standards ensure that an evaluation produces and disseminates valid and usable information. Most of these standards will be addressed in natural course of developing and implementing the evaluation and therefore do not need to be discussed in further detail. However, the process by which the project team identifies the influences of the context on CHCI and EHSDI needs further guidance. In order to apply the standard of analysing the context to the CHCI and EHSDI evaluation, the evaluators will ensure:

4.1 Project advisors (refer 1.1) are called on for advice on contextual factors (e.g. social and political climate, characteristics of key stakeholders, the structure of the policy arena) so as to appropriately situate the planning, execution and communication of the evaluation.

4.2 Interviews with key stakeholders capture information on contextual factors and this feeds directly into the analysis.

ATTACHMENT THREE – DATA MAP OF POTENTIAL INDICATORS AGAINST DIFFERENT POPULATIONS

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Antenatal care								
Attended antenatal care during pregnancy	Healthy for Life	9 sites in NT Same definition as NT KPIs	CHC data collection	Definition: ever/never attend for mothers of children aged 0-5 years Time: July 2007 to June 2009 Area: community name			NT KPIs	Before 13 weeks gestation; and at 13 weeks or after, but before 20 weeks; and after 20 weeks; and never Babies born in reporting period (12 months) By mother's age group, indigenous status and locality Time: Aug 2009, ongoing (for both NT DHF and ACC sectors)

[11] Defined as any other subgroup of the NT Aboriginal and Torres Strait Islander child population (e.g., children living in a specific geographic area).
[12] Ethical approval for any data linkage across the checked and non-checked population will be sought in the second phase of the ethics application.
[13] Unless otherwise indicated, age = 0-15 years; area = NTER prescribed areas.

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Physical growth								
Birth weight (gm)	Healthy for Life	9 sites in NT Weight of Indigenous babies (gms) over 12 month reporting period Report average	CHC data collection	Time: July 2007 to June 2009 Area: community name			NT KPIs NT Midwives collection	By birth weight group (low normal and high), mother's indigenous status, age group and locality Live births during 12 month reporting period Time: Aug 2009, ongoing (for both NT DHF and ACC sectors) Time: Since at least 1986, ongoing Mean birthweights and proportion of low birthweights
Stunting (height relative to age)			CHC data collection	Time: July 2007 to June 2009 Area: community name			GAA	Age: 0-4 years Time: Annual from 2004 to 2007 Area: Slightly different

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Underweight (weight relative to age) – weight (kg)			CHC data collection	Time: July 2007 to June 2009 Area: community name			GAA	Age: 0-4 years Time: Annual from 2004-07 Area: Slightly different
							NT KPIs	Age: 0-4 years Less than -2 standard deviations from mean weight for age, by Indigenous status and locality Time: Aug 2009, ongoing (for both NT DHF and ACC sectors)
Wasting (weight (kg) relative to height (cm))			CHC data collection				GAA	Age: 0-4 years Time: Annual from 2004-07 Area: Slightly different

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Anaemic								
Haemoglobin level (g/L) for children aged 6 months to < 5 years of age			CHC data collection				GAA HSAK NT KPIs	Age: 6 months to 4 years Time: Annual from 2004-07 Age: 4-15 years Time: 2007 Age: 6 months to 4 years, level <110g/L, by Indigenous status and locality Time: Aug 2009, ongoing (for both NT DHF and ACC sectors)
Ears and eyes								
Ear disease (perforation, bulging, otitis media, etc)			CHC data collection	Time: July 2007 to June 2009 Area: community name			HSAK	Age: 4-5 years

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Middle ear conditions (Eustachian tube dysfunction, acute otitis media, chronic suppurative otitis media, otitis media with effusion, dry perforation)			CHC audiology data collection	Definition: includes other children referred outside CHC process Time: Feb 2008, ongoing Area: community name				
Hearing loss			CHC audiology data collection	Definition: includes other children referred outside CHC process Time: Feb 2008, ongoing; and at first check/second check Area: community name				
Visual impairment (visual acuity)			CHC data collection	Age 6-15 years				

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Prevalence of trachoma			CHC data collection	Age: 6-15 years Time: July 2007 to June 2009 Area: community name			HSAK	Age: 4-15 years
Oral health								
Prevalence of untreated caries			CHC data collection	Time: July 2007 to June 2009 Area: community name			Child Dental Health Survey	
Prevalence of gum disease			CHC data collection	Time: July 2007 to June 2009 Area: community name				
Decayed (dmft)			CHC dental data collection	Time: XXXX, ongoing Area: community name				

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Skin								
Prevalence of skin sores	East Arnhem Regional Healthy Skin Project (EARHSP)	Definition: 5 or more skin sores Age: 0-14 years	CHC data collection	Definition: 4 or more skin sores			HSAK	Definition: Any number of skin sores Age: 4-15 years Time: 2007
Scabies (prevalence rate)	EARHSP	Age: 0-14 years Time: 2004-07	CHC data collection					
Prevalence of ringworm	EARHSP	Age: 0-14 years Time: 2004-07	CHC data collection				HSAK	Age: 4-15 years Time: 2007
Cardiac and respiratory								
Prevalence of rheumatic heart disease			CHC data collection	Date: history of RHD			Top End and Central Australian Rheumatic Heart Disease Registers	

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Prevalence of asthma			CHC data collection				National Aboriginal and Torres Strait Islander Health Survey	Age: 0-14 years Time: 2004-05
Hospital admissions for respiratory disease			CHC and DHF matched data				NT Hospital Morbidity data collection	By age, Indigenous status, gender Time: At least from 1993 to XXXX Area: ?
Prevalence of recurrent chest infection			CHC data collection					
Immunisation								
Immunisation status	Healthy for Life	9 sites in NT Same definition as NT KPIs	CHC data collection	Definition: due / up to date at time of CHC			Australian Childhood Immunisation Register (ACIR) NT KPIs	Ages: Up to date at 1, 2 and 6 years of age As above, by Indigenous status and locality Time: Aug 2009, ongoing (for both NT DHF and ACC sectors)

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Smoking prevalence								
Regular smoker			CHC data collection	Age: 12-15 years				
Smoker in the household			CHC data collection	Age: 0-15 years			National Aboriginal and Torres Strait Islander Health Survey	Age: 0-14 years Time: 2004-05
Housing situation								
Working bath or shower			CHC data collection					
Working toilet			CHC data collection					

Domain and indicator	Local populations[11]		CHCI target population				NT Aboriginal and Torres Strait Islander population (0-15 years)	
			Checked population		Not checked population[12]			
	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)[13]	Data collection	Definitions (time, age, area)	Data collection	Definitions (time, age, area)
Ambulatory sensitive hospitalisation								
Admission rate (per 1000)							NT Hospital Morbidity data collection	By age, Indigenous status, gender Time: At least from 1993 to XXXX Area?
Principal diagnosis (at time of discharge)							NT Hospital Morbidity data collection	By age, Indigenous status, gender Time: At least from 1993 to XXXX Area: ?
Conditions present at admission							NT Hospital Morbidity data collection	By age, Indigenous status, gender Time: At least from 1993 to XXXX Area: ?