

Healthy Mother Healthy Baby: Program Logic Model and Evaluability Assessment

by
Angela Bowen



Community – University Institute for Social Research

289 John Mitchell Building
118 Science Place
Saskatoon, SK S7N 5E2
phone (306) 966-2121
fax (306) 966-2122
e-mail cuisr.oncampus@usask.ca
www.usask.ca/cuisr

Copyright © 2004 Angela Bowen

Community-University Institute for Social Research

University of Saskatchewan

All rights reserved. No part of this publication may be reproduced in any form or by any means without the prior written permission of the publisher. In the case of photocopying or other forms of reprographic reproduction, please consult Access Copyright, the Canadian Copyright Licensing Agency, at 1-800-893-5777.

CUISR acknowledges the following for their contributions to this publication:

Annette Gibbins, Manager, Healthy Mother Health Baby

Nazeem Muhajarine, Academic Co-Director, CUISR; and Academic Co-Leader;

Stephen Whitehead, Community Co-Leader,

Community Health Determinants and Health Policy Module, CUISR

Kate Waygood, Community Co-Director, CUISR

Neil Soiseth, Editing, Interior Layout, and Design

Printed in Canada by Printing Services, University of Saskatchewan

ABSTRACT

Healthy Mother Healthy Baby (HMHB) is a community-based program that provides prenatal and postnatal support services to high-risk, vulnerable pregnant women within the Saskatoon Health Region. It strives to promote optimal pregnancy outcomes and healthy lifestyle choices through support and education to individuals in the context of their family and community. This project includes: a review of similar programs across Canada and the relevant literature; developing a Program Logic Model with Healthy Mother Healthy Baby staff, clients, and community partners; and creating an Evaluability Assessment that gives the program direction for evaluation activities.

While the Healthy Mother Healthy Baby is an anecdotal success, there has never been a formal appraisal to reflect whether the program meets its mandate. The program manager requested an evaluation for future policy development, program planning, and human resource allocation. In short, how do we measure whether they are doing a good job? This report provides the underpinnings for future HMHB evaluation activities.

A project plan was submitted for approval to the Faculty Advisor and Healthy Mother Healthy Baby manager (**Appendix A**). The project was also discussed with J. Franko, Ethics Coordinator of the Saskatoon Health Region. Feedback was received through meetings with twelve community partners, two client groups, and five clients in individual home visits.

ACKNOWLEDGMENTS

The Community-University Institute for Social Research (CUISR) provided financial support for this project. Appreciation is extended to Annette Gibbins (program manager), the staff, clients, and partners of the Healthy Mother Healthy Baby program for sharing their time and experiences. Thanks go to Susan Wagner, College of Nursing, and Dr. Nazeem Muhajarine, Community Health and Epidemiology, University of Saskatchewan, for their advice and encouragement.

INTRODUCTION

BACKGROUND

The Healthy Mother Healthy Baby program has been in place since 1983. During the past twenty years, it has provided service to approximately 400-600 women each year. The program offers community level interventions to a high-risk population who have multi-faceted problems within the local determinants of health (i.e. social, financial, and cultural). Lifestyle, family dynamics, and risk behaviours all have the potential to affect pregnancy and, consequently, the future of children and their families within the Saskatoon region. Public health policy related to providing the best care and services to this high-risk group can be advanced through an ongoing evaluation and relevance of HMHB to the community.

Bell Woodard and Edouard (1992:188) discussed HMHB's development and ongoing success: "Community involvement in program planning, the use of native and non-native community health workers, the provision of social support and the tangible health benefits of the program contributed to its success in attracting women for service."

DESCRIPTION

Healthy Mother Healthy Baby was designed to meet the needs of "hard to reach" high-risk pregnant women who are unlikely to utilize other prenatal services (Bell Woodard and Edouard, 1992). Prenatal outreach workers, maternal child community health nurses, and a nutritionist function as a team to provide individualized counseling through home visits and group sessions. Service is often directed at alleviating adverse issues, including smoking, low-income status, poor nutrition status, and substance abuse. Clients receive free prenatal vitamins, iron, Lactaid, milk coupons, and assistance with transportation to medical visits (e.g. bus tickets). A community health nurse assesses all clients, and then either a nurse or prenatal outreach worker provides care throughout pregnancy.

The program provides a variety of prenatal classes: single parent classes, expert information (e.g. legal advice), and special hospital tours for immigrant women. Healthy Mother Healthy Baby recently tried a drop-in class and had a nurse available to provide information in the storefront of a local mall. They also offer a "Collegiate Program" to all of the identified pregnant teens and secondary and post-secondary school-aged women (14-22 years) in Saskatoon.

The Healthy and Home Program visits all postpartum women shortly after being discharged from the hospital. This early discharge program also sees Healthy Mother Healthy Baby clients, but every client also gets at least one postnatal visit from a HMHB community health nurse approximately two weeks after the baby is born. Occasionally, more visits are necessary.

There are many community organizations with which HMHB partners to provide optimal service, including: Food for Thought Program of the Canada Prenatal Nutrition Program; Family Support Centre; Saskatoon Community Clinic; KidsFirst; Saskatchewan Institute for Prevention of Handicaps; Healthy and Home; Saskatoon School Board; Addiction Services; Salvation Army; and Social Services (**Appendix B**).

OTHER PROGRAMS

The Healthy Mother Healthy Baby program was unique when it began, and appears to have remained distinct. Many programs across Canada now provide services to high-risk pregnant women. Most of these are under the auspices of Health Canada's Canada Prenatal Nutrition Program (CPNP). There are currently 350 CPNP projects across Canada. Additionally, First Nations and Inuit Health Branch (FNIHB) in Inuit and First Nation reserve communities fund over 550 CPNP projects.

CPNP's goals are similar to those of HMHB:

- CPNP funds community groups to develop or enhance programs for vulnerable pregnant women. Through a community development approach, CPNP aims to reduce the incidence of unhealthy birth weights, improve both the infant and mother's health, and encourage breastfeeding.
- CPNP enhances access to services and strengthens inter-sectoral collaboration to support the needs of pregnant women facing risky conditions. As a comprehensive program, services include food supplementation, nutrition, health, and lifestyle counseling, support, education, and referral (Health Canada, n.d.).

In Saskatoon, CPNP is offered through the Food for Thought program. It provides cooking classes in combination with mandatory prenatal education at various locations throughout the city. Education is in a group format, but if staff are concerned about a woman's understanding of the material, they will refer her to HMHB for individual instruction and prenatal classes.

The Canada Prenatal Nutrition Program, of which Food for Thought is a member, has an evaluation process that includes appraisal of many of the same components and activities as HMHB. The items include individual outcome and program evaluation information. Because both of these services are now part of the same portfolio within Saskatoon Health Region and will share the same office space, joint evaluation activities might save time and produce more comprehensive responses that management can use in program planning.

Ontario's Healthy Babies Healthy Children (HBHC) is a comprehensive program that offers all families with new babies information on parenting and child development and delivers extra help and support to those families who would benefit.

The program began in 1998 and involves:

- screening/assessment for pregnant women through prenatal programs or by their doctors, all new mothers by nurses in hospital or by midwives, and families with children up to age six by the parents themselves or by their doctor;
- a phone call from a public health nurse offering information and a home visit to every new mother shortly after her baby is born;
- home visit services by a public health nurse or lay home visitor for families who would benefit; and
- referrals to community services, such as breastfeeding, nutrition and health services, play and parenting programs, and child care services, for all families with children up to age six (Ontario Ministry of Health and Long Term Care, n.d.).

The research team talked to 6,222 families, 3,526 public health nurses and lay home visitors, and others who are familiar or involved with HBHC. They also conducted in-depth studies to ascertain the program's workings in twelve public health units.

Two freestanding, inner city prenatal outreach programs, Sheway in Vancouver and Breaking the Cycle in Toronto, have been developed in the last ten years. Each offers extensive drop-in and outreach services to mothers and children.

Sheway was established in 1993 and provides comprehensive health and social services to pregnant women and women with infants less than eighteen months of age and are dealing with drug and alcohol issues. They provide meals, food bags, contraception, STD testing, immunizations, baby food and clothes, alcohol and drug addiction counseling, and community referrals. Sheway operates 24-hours-a-day in a stand-alone clinic located in Vancouver's Downtown Eastside.

The *Evaluation Report of the Sheway Project for High-Risk Pregnant and Parenting Women* (2000) describes in detail the program and the evaluation process that took place over a three-month period in 1998. The report includes a profile of women accessing services, birth outcomes, and outcomes for women (e.g. HIV and Hepatitis C testing, substance use, housing concerns, services accessed, experiences with violence, connection to social supports).

Breaking the Cycle was developed in 1995 by key stakeholders in Toronto to address increasing concerns about risk behaviours during pregnancy. It is an exceptional early identification and prevention program for pregnant and/or parenting women who live in high-risk circumstances, such as substance abuse, homelessness, violence, poverty, poor health and nutrition, and unstable environments. It offers a variety of programs and assessments for women and children up to two years of age. Breaking the Cycle collaborates with the Centre for Addiction and Mental Health in Toronto on research and evaluation projects.

Programs in Nova Scotia, Edmonton, and Calgary provide physical monitoring and “bed-replacement” homecare for antepartum women who experience medical problems such as Pregnancy Induced Hypertension and Premature Rupture of the Membranes. These cities also have CPNP programs that attend to high-risk mothers in the community. The Nova Scotia Reproductive Program also has one inpatient Clinical Nurse Specialist who provides care to high-risk clients with social problems.

While this was not an exhaustive search, an identical program to HMHB was not found (**Appendix C**). Programs that are part of the CPNP follow that program’s evaluation process. Other than Sheway and HBHC, other programs that were contacted did not have further evaluation material.

FRAMEWORK AND PHILOSOPHY

Harm Reduction

The Harm Reduction Model (HRM) is the philosophical framework for the Healthy Mother Healthy Baby program. This model is used in addiction programs throughout the province. The Harm Reduction Model represents a shift from traditional legal concerns about substance abuse to public health principles of least harm to the individual. The model uses a value-neutral and humanist approach that focuses on reducing the immediate consequences and health risks caused by substance abuse, rather than on the abuse behaviours. While the model recognizes that abstinence is the ideal, it accepts alternatives that reduce harm to individuals at risk (Cheung, 2000; Marlatt, 1998). During focus group sessions, staff seemed unaware of the Harm Reduction Model, although much of their practice, as they described it, is consistent with the model’s beliefs.

Service Delivery

Staff essentially use an assertive outreach approach. This is evident in staff’s efforts to locate and provide service to clients, some who do not have telephones, and others who move frequently or live in precarious situations. Home visits and prenatal intervention have been shown to be effective and efficient in improving outcomes for high-risk children (Korfmacher et al, 1998). Bray and Edwards (1994) describe a similar case management approach by outreach workers in the prenatal care of Hispanic women, which they describe as an example of primary health care being accessible and acceptable to the community. Improved prenatal risk scores—both physical and psychological—were seen in a group of rural women who received home visits by public health nurses (Schmitz and Reif, 1994).

CLIENTS

The women seen by HMHB are considered to be high-risk, vulnerable, and in need of intervention to promote optimal pregnancy outcomes. The database developed by Roots and Wings is able to generate some statistics for the program. HMHB has been

entering their own data since April, 2003 but have not yet analyzed any of the data. As **Table 1** shows, there has been an increase in the number of teens in the program since its inception. The development of the collegiate program may be credited for this increase. There percentage of Aboriginal women attending the program has decreased. This is likely because the program initially focused solely on Aboriginal women, but is now available to any pregnant woman in need.

Table 1. Client Profile.

Client Profile	1984/85*	1986/87*	1988/89*	2000	2001	2002
Avg. Age	Not recorded			Unknown		
Teen (13-19) %	21	26	26	42	35	35
20-35	Unknown			55	62	61
>35				3	3	4
Single %	16	20	21	Unknown		
Smokers %	62					
Alcohol %	23					
Aboriginal %	64			50	50	49
Caucasian %	Unknown			29	29	28
Immigrant %				5	6	7
Other/Unknown				16	15	17

*Source: Bell Woodard and Edouard (1992). The 1984-1989 numbers include all women who took singles prenatal classes but were not necessarily in the HMHB program.

Referrals

As **Table 2** demonstrates, the program currently receives an average of 590 referrals per year, and they engage and provide service to 485 (82.5%) of these women. The average number of clients referred to the program has increased by 9% since the 1984-1989 periods. The most notable shift is an almost fourfold increase in the number of women who self-referred. Word of mouth about the program and women who are attending during subsequent pregnancies may be the reason. However, doctors refer fewer than half as many women compared to the previous period. This decrease may indicate a need to educate physicians about the program and its mandate.

The average wait to be placed in the program is an estimated 2 to 3 weeks, although this information is not presently tracked. There are usually 150 women in the program at any given time. Each nurse or prenatal outreach worker (POW) carries a caseload of 20-30 clients.

STAFF

When the program was created, it included three Aboriginal outreach workers. There are now a variety of staff of different ancestry, including prenatal outreach workers with various backgrounds, such as social work, nursing, and nutrition (see **Table 3**).

Table 2. Client Referrals.

Client Referrals	1984/85*	1986/87*	1988/89*	2000	2001	2002
Self %**	18	25	28	58	68	67
Doctor %	8	15	14	7	5	4
Friend/Family	Not recorded			8	7	5
Other %	29	27	41	19	11	14
School %	Not recorded			8	9	10
Community nurses/workers %	45	34	17	Not recorded		
Previous HMHB client %	Not recorded			Not recorded		
TOTAL (N)	416	530	68	579	573	614

Engaged in program	Not recorded	476	478	503
Length of wait for program (days)	Not recorded	Not recorded		

*Source: Bell Woodard and Edouard, 1992. Taken from The 1984-1989 numbers include all women who took singles prenatal classes but were not necessarily in the HMHB program.

**Client may have heard about the program from others but phoned in herself to access service.

Table 3. Staff.

Title	Staffing	Personnel
Manager	1 FTE	Annette G.
Public Health Nurse	2.4 FTE	Sue V. Gloria M. Edna B.
Prenatal Outreach Workers	5 FTE	Colleen B. Tammy W. Agnes F. Edna N. Rocchina F.
Collegiate Nurses	2 FTE (.25 FTE of each position is public health)	Kathy B. Enid J.
Nutritionist	11.5 hrs/week	Jackie V.
Secretary	1 FTE	Liz K.

RESOURCES

Healthy Mother Healthy Baby receives financial and administrative support from the Saskatoon Health Region. During this project, the program became part of the new Primary Care Services portfolio. This portfolio also includes two of HMHB's community partners: Food for Thought and KidsFirst. The Food for Thought program will soon relocate office space to the HMHB office site in the Sturdy Stone Centre. Staff regard this as a positive change for both programs.

PROGRAM LOGIC MODEL

The Program Logic Model (PLM) creates a diagrammatic representation of a particular program. Development of a PLM can help clarify the objectives and articulate the activities of a program, and can increase Healthy Mother Healthy Baby's readiness for evaluation (Dwyer and Makin, 1997; Langevin et al., 2001).

Staff was actively involved in PLM development. Two staff focus groups were convened to discuss goals, target population, short and long-term objectives, and program activities. Dialogue included measurable outcomes and criteria that might be used in their practice or overall program evaluation.

GOAL

Staff were very clear that they had previously spent considerable time determining their mission statement and were not ready to make changes to it:

To promote optimal pregnancy outcomes and healthy lifestyle choices by providing support and education to individuals in the context of their family and community.

The focus groups examined, rather than attempted to revise, the mission statement. The first part of the statement describes PLM's goal. The second part includes how the goal is achieved, and is discussed in this report's Activities sub-section.

TARGET POPULATION

The target population includes women whose pregnancies are in jeopardy because of substance abuse, family violence, poverty, illiteracy, recent immigration, or other circumstances of risk. Collegiate-aged (14 to 22 years) pregnant women who are attending any of the collegiates in Saskatoon are also included in the program.

OBJECTIVES

Determining which objectives are long-term or short-term can prove challenging. This was no different for HMHB staff. While the time that women are with the HMHB program is limited to the length of the pregnancy and some postnatal visits, staff are clear that they want their interventions to have an impact on the health of the mother and her

family beyond their limited HMHB exposure. The result is two long-term objectives: increase mother's capacity to maintain healthy lifestyle and have a "Healthy Mother Healthy Baby."

Long-term Objectives

One staff member expressed her vision about the impact on the health of the babies in HMHB: "I want to know if the children of our mothers finish high school compared to children of other single mothers." Staff stated that they believe it important to help women make healthy choices about drinking, smoking, and nutrition, and to continue to decrease risk behaviours and activities beyond the borders of the program. They stated that this might take a few pregnancies to establish trust and develop the relationship necessary for the change to take place. The ability to increase a woman's capacity to maintain the gains made during pregnancy (e.g. decreased smoking) is seen as an important outcome of HMHB. The ability to access community resources to support healthy decisions is seen as an important component of this long-term objective.

All staff members were clear that the purpose of their program is to help ensure the healthiest possible outcome for both mother and baby, hence the name, "Healthy Mother Healthy Baby." This includes improved outcome measures such as: improved nutritional status, decreased involvement in high-risk behaviours and activities, increased number of doctor visits, decreased complications of pregnancy, and less time spent in intensive care.

While staff members agreed that it would be optimal for objectives to be client-centered, they reported that it would be difficult to set individual targets and objectives with a majority of their clients on the first visit. The objectives for individual clients often change throughout the program. Staff believed strongly that many of the program activities and objectives were generic and are therefore directed to helping clients take ownership of their own health care, while also promoting optimal pregnancy outcome.

Short-term Objectives

Short-term objectives identify the tasks needed to help women achieve the two long-term objectives.

ACTIVITIES

Program components are viewed as activities or sets of activities that have a direct impact on program targets and are intended to lead to the attainment of program goals (Langevin et al, 2001). Many of the staff have worked in the program for a long time. As Benner (1984) describes, it is often hard for senior workers who work intuitively to articulate how they achieve their goals at work. Initially, HMHB staff had a similar struggle. Six major activities were identified: Linkages, Advocacy, Support, Programs, Education, and Supplements.

- **Linkages** include inter-sectoral collaboration, case management, and referrals to community resources.
- **Advocacy** is primarily for the mother and baby. Staff maintains confidentiality on all fronts unless there is danger for the mother or children in the family, as mandated by law. They provide assistance with transportation through bus tickets to doctor visits, and occasionally staff will take mothers for appointments to ensure that they attend.
- **Support** includes listening, counseling, and problem solving with clients.
- **Programs** include assessments and screening during home and school visits, prenatal classes, school program, parenting program in conjunction with Nobody's Perfect, breastfeeding program, and Hotline.
- **Education** involves resource development as well as individual and group teaching with clients. Nursing students have also recently started to participate in the program's education initiatives.
- **Supplements** include milk coupons, Lactaid, iron supplements, and vitamins. Staff also encourage participation in Good Food Box and the Food for Thought programs.

RESOURCES

Much of HMHB's activity occurs in women's homes or schools. Staff members commented that the Sturdy Stone Centre is a less than ideal location for their clients. There was, for a time, a storefront operation in the Confederation Mall that provided some drop-in information and prenatal classes. Some staff saw an all-inclusive drop-in centre in the core area as one way to increase service to the hard-to-reach clients.

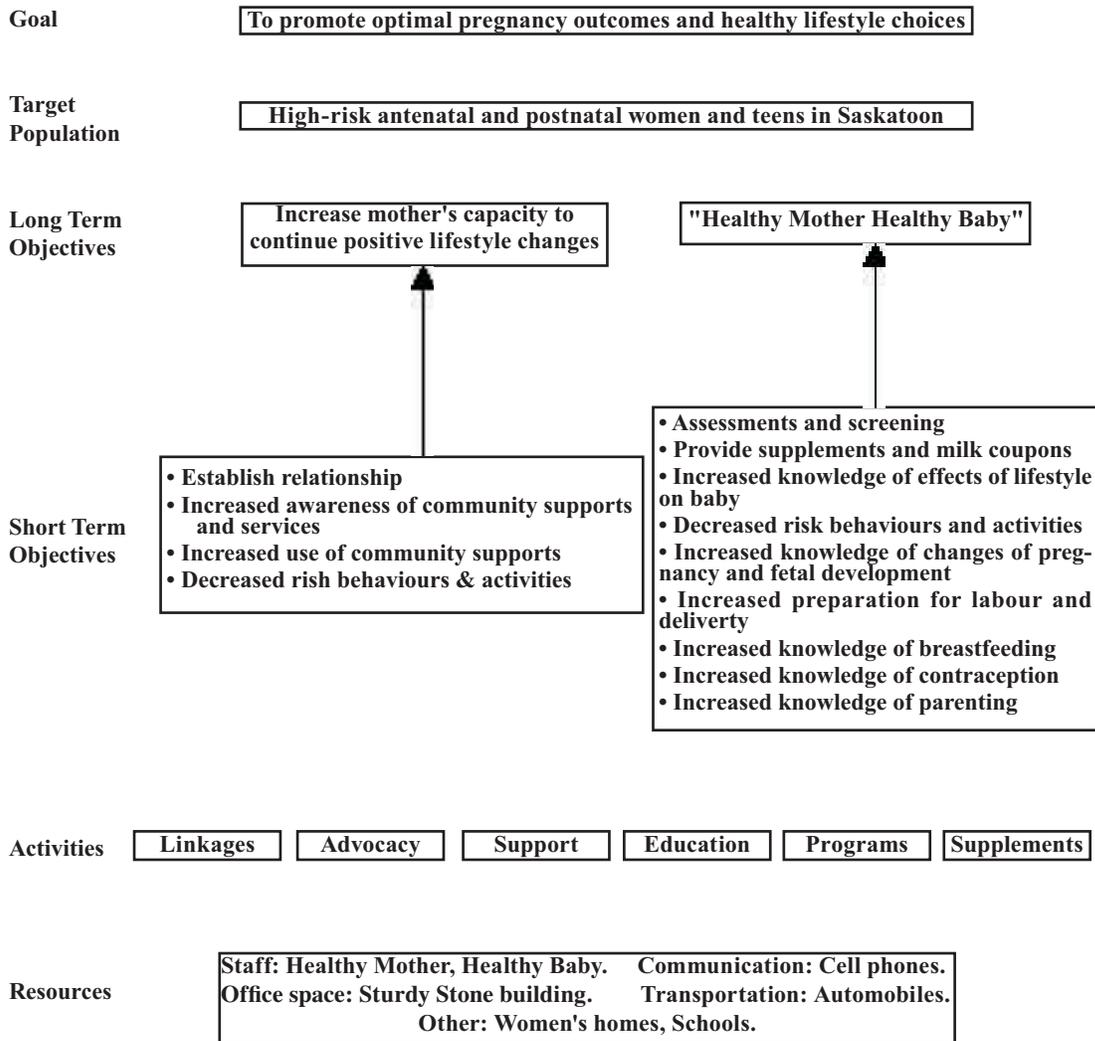
A draft Program Logic Model containing all of these elements was posted in the coffee-break area of the HMHB office for one week, with an invitation for staff to add comments and suggestions (**Appendix E**).

COMMUNITY PARTNER AND CLIENT RESPONSES TO PROGRAM LOGIC MODEL

The PLM was shared with HMHB clients and partners for further validation. A series of questions that focused on HMHB perceptions and experiences of clients and community partners were used to guide the interviews (**Appendices F and G**). The interviews were conducted in the participant's work place, the program site (e.g. Westside Clinic, Royal West Collegiate), or client's home. It took between 10 to 20 minutes to complete.

While the interviews' intent was to assess the draft PLM's accuracy in HMHB's practice, this process inadvertently resulted in some program evaluation. The findings and responses are summarized in **Tables 4 and 5**.

Figure 1. Final Program Logic Model



COMMUNITY PARTNER RESPONSES

Twelve community partners were interviewed: Healthy and Home (staff meeting); Food for Thought; Open Door Society; Family Support Center; Nutana Collegiate; Fetal Alcohol Syndrome Program; KidsFirst; Nobody’s Perfect; Addiction Services; Community Clinic; Joe Duquette High School; and Bethany Home (**Appendices B and F**). **Table 4** summarizes the responses of community partners.

There were some services of which the community partners were unaware, such as transportation assistance to doctor’s visits and the parenting and breastfeeding programs. Partners were interested in finding out more, and stated that they would follow-up to discuss further joint programming options. Two requests by community partners for copies of the PLM were referred to the program manager.

A few community partners questioned the long-term objective, “Increase mother’s capacity to maintain healthy lifestyle.” They stated that many women were not living healthy lifestyles. HMHB staff wanted to ensure that women continued to make the healthy lifestyle choices that they were taught during the program, and the PLM was changed to reflect this intention (see **Figure 1**).

CLIENT RESPONSES

Responses to client questions (**Appendix G**) were elicited from 19 participants of the HMHB program (**Appendix D**). Focus groups were held after school at Royal West Collegiate and during the last session of the Food for Thought program at Westside Community Clinic (2 and 12 participants, respectively). Five pregnant/postnatal women were interviewed individually in their homes (one was unavailable). The PLM was explained to the women in simple terms, paraphrasing where needed. This included drawing the model on the blackboard to ensure that the women understood each element. Client responses are summarized in **Table 5**.

During their focus groups, staff stated that they thought that the main reasons that women come to HMHB are for milk coupons, information about labour and delivery, and support. It was evident during the interviews that this very small group of clients believes that HMHB, as described in the PLM, not only meets many of their needs, but also leads to healthier pregnancy outcomes.

Based on their direct involvement in the program, some community partners suggested a few changes to the PLM. These changes are incorporated into the final version of the Program Logic Model (**Figure 1**). Overall, there was consistency between the staff depiction of the goals, objectives, and activities of the PLM and the perception of community partners and clients.

To ensure its ongoing relevance, it is suggested that HMHB staff review the Program Logic Model every few years.

EVALUABILITY ASSESSMENT

This section describes the evaluability assessment and proposed evaluation parameters of the Healthy Mother Healthy Baby program.

Evaluation has two components: process and outcome. Process evaluation determines if the program is delivered to its target population as intended, while outcome or impact evaluation includes measurement of the indicators that the program is accountable for improving. The HMHB Program Logic Model identifies objectives and activities that are open to both types of evaluation.

The evaluation topics contained within the evaluability assessment framework are based on four broad categories that need to be addressed in any program evaluation

Table 4. Community Partner Responses to Draft Program Logic Model

Question	Responses
Is HMHB meeting its goal?	Yes: 12 No: 0
Is your target population the same?	Yes: “Definitely”; “we are more (specialized/different time frame) but same clients” (5); “a lot of overlap” (2); “ours is everyone, theirs is specific” (3). No: 0.
Are your long-term objectives the same?	Yes: 7 “similar although theirs are more specific to decrease use” “longer period of time”; “we don’t target a group, ours is everyone (i.e. men)” (2); “yes, as relates to parenting skills”. No: “ours is very short-term connection” (1)
Do you receive any of the same or similar services from a different group? Who?	Yes: “Public health nurses after the baby is born” (2); “a few crossover with KidsFirst but not much”; “doctor”; “Food for Thought”; “Parenting from the Family Support Center or Westside clinic”; (2) “Overlap but different partnerships not necessarily duplication”; “Nobody’s Perfect”. No: 6
Do you have any of the same services/activities?	Yes: “Education” (3); “Advocacy” (5); “Support” (2); “Referrals”; “Assessment and screening”; “definitely-home visits but different focus, social vs. pregnancy related”; “screening but no supplements”; “some overlap for a very short period, which is good”; “group education vs. individual”; “Depends on situation”. No: 5
Are there any claims of activities/goals etc. that they do not meet? What don’t they do?	Yes: 0. No: 11. “Wouldn’t know” (1)
How does HMHB fit with your organization?	“Very well”; “Excellent, team work for outreach”; “longstanding, part of the organization that we can count on”; “Good partnership, very supportive of resources, tested a brochure”; “Good continuum (of care)” (4); “share office-charts-communication”; “complementary” (3). There were no negative comments.
General Comments	“Really appreciate support and partnership”; “Mutual respect and understanding”; “Question knowledge about co-dependency”; “Not good that some clients have to wait for service” (2); “Nurses a wealth of information”; “Invaluable program-community work for young parents and outreach attempts that they make”; “Often the only support for these young girls”; “depend on the continuity and regularity of nurse attending (school) really notice when she is not there”; “wonderful program that reaches a lot of women”; “Flag sheet not getting to us consistently”; “Don’t always know if client has gone through program”; “Can tell which teens have been through program”; “Nursing students are good”; “feedback from HMHB clients (to our organization) is good”.

Source: See Appendix F.

(Langevin et al, 2001): (1) Rationale/Relevance; (2) Design and Delivery; (3) Impact/Success; and (4) Alternatives/Cost-Effectiveness.

Table 5. Client Responses to Program Logic Model Draft and Questions.

Question	Responses
How did you hear about HMHB?	“Day Care”; “Doctor”; “Family member/Friends” (6); “Previous Client”; “Food for Thought”.
Is HMHB meeting its goal? (Draft PLM)	Yes: All agreed. No: 0
Are all of those services/ activities available to you?	Yes: “Bus Tickets”; “Support”; “Vitamins”; “Referrals”. No: 0
Do you get any of those services elsewhere?	Yes: “KidsFirst, it is good that they both visit me. I need it”. No: (0) “Oh God, No!”
Is there anything that they are not doing for you that you need and cannot get elsewhere?	Yes: “Take you places”; “Groups and places to get together with each other”; “Prenatal/postnatal exercises”; “Aquasize”; “Programs for singles”; “Programs for women who are older”. No: (4)
What did you hope to gain from the HMHB program?	“Support” (2); “Knowledge about parenting” (2); “Pregnancy info” (3); “Information about baby”; “Milk coupons” (4); “Vitamins”; “Nutrition information”.
How well does HMHB meet your needs?	“Very well” (2); “Good” (6).

Source: See Appendix G.

Note: Not everyone in the group discussions answered each question individually. Therefore, the yes/no responses do not equal the total (N=19).

Staff were asked to make their suggestions based on the goals, objectives, and activities of the program. The results of these discussions are included in this evaluability assessment. It reviews these broad categories and summarizes them in **Table 6** where they are relevant to the HMHB program.

EVALUATION METHODS

The following evaluation methods, as described in the evaluability assessment, may be adapted by HMHB to complete the evaluation process:

- **Administrative File Review.** This is a review of the various files and statistics that the program manager keeps, some of which may be presented in an annual report (e.g. number of referrals received and completed, budget, expenses). Staff or management complete this portion of an evaluation. Data entered into the Roots and Wings database may be helpful to this process.
- **Program Documentation Review.** This is similar to the administrative file review, but includes program documents such as client files and educational materials.

- **Literature Review.** As HMHB was established over twenty years ago, there may be other approaches useful to their clients. A literature review may help update program activities, and can be conducted by the manager, students, or staff. Inclusion of material gained through attendance at conferences or from other programs needs to be reviewed before adding it to the program.

- **Client Satisfaction Survey.** These are an important part of a program evaluation and are frequently used in health care. During interviews, clients reported a high level of satisfaction with HMHB and, in particular, the staff.

A client satisfaction survey completed at the final postnatal visit would provide feedback on program effectiveness in meeting their needs. Mail-in surveys may be less successful in this population. Instead, a short evaluation tool for clients to complete during the final interview might be effective (**Appendix I**). Staff might engage in another activity away from the mother (e.g. with the baby) to allow her to complete the survey in privacy and then put it in a sealed envelope to increase confidentiality.

- **Post Program/Follow-up Survey.** Management could commission or have staff complete a retrospective telephone study or follow-up home visit of HMHB clients. It is likely that external funding would be required for such a post program/follow-up survey.

- **Expert Panel/Opinion.** Besides their community partners, there are many expert resources available to help HMHB in this review (e.g. Continuing Nursing Education, Addictions Services, Public Health, Saskatchewan Institute for Prevention of Handicaps). During this project, contact was made with various organizations across Canada. These experts were quite willing to share program information (**Appendix C**).

- **Focus Group.** This is an interview with six to eight people who are selected for their knowledge or perspective on a particular topic (Langevin et al, 2001). For example, clients of the Food for Thought and the Royal West Collegiate programs were involved in a focus group for a review of the PLM. Similar types of focus groups could be used to evaluate various aspects of the program.

- **Tools.** These would measure HMHB's impact in reducing risk behaviours and activities or provide an accurate account of time spent in engaged in the activity. Revision of the assessment and discharge forms would promote retrieval, and thus measure the amounts of alcohol and drugs in an efficient and effective way.

Clients could be asked to complete questionnaires that measure their knowledge of lifestyle on baby, pregnancy and fetal development, labour and delivery, breastfeeding, parenting, and awareness of community resources prior to developing individual objectives and targets for the home visits or referral to prenatal or parenting classes.

Table 6. Evaluability Assessment.

Issues/Questions	Indicators	Data source	Method
1. Rationale: To what extent is the HMHB program relevant?			
1.1 Is there a need for this type of program?	<ul style="list-style-type: none"> • Number of pregnant women requiring support, education • Expert opinion 	<ul style="list-style-type: none"> • Number of referrals and those receiving care • Expert opinion 	<ul style="list-style-type: none"> • Administrative file review
1.2 Is there empirical evidence to demonstrate the effectiveness of this intervention?	<ul style="list-style-type: none"> • Evidence of causal relationship between this type of program and the improvement of perinatal outcome • Expert opinion 	<ul style="list-style-type: none"> • Literature on programs for high risk women • Comparison of like programs 	<ul style="list-style-type: none"> • Literature review • Internet search • Contact other programs
1.3 Is the program relevant to the needs of clients?	<ul style="list-style-type: none"> • Degree to which the program framework meets the needs of the clients • Expert opinion 	<ul style="list-style-type: none"> • Literature on programs for high risk women • Identified needs of the clients • Community Partner opinions 	<ul style="list-style-type: none"> • Literature review • Client intake review • Meet with partners
2. Design and Delivery: Is the program designed and delivered effectively?			
Design			
2.1 Is the program design based on the principle of effective community-based high-risk prenatal programming	<ul style="list-style-type: none"> • How much the program manual adheres to the principles of high risk prenatal care • Expert opinion 	<ul style="list-style-type: none"> • Literature on the principles of effective prenatal outreach care • HMHB program manual • Expert opinion 	<ul style="list-style-type: none"> • Literature review • Program documentation review • Policy Manual • Expert panel
2.2 Do any of the program activities fail to contribute to the attainment of the program's objectives?	<ul style="list-style-type: none"> • Activities that do not contribute to the attainment of program objectives • Program staff opinion • Manager opinion • Expert opinion 	<ul style="list-style-type: none"> • Number and type of activities that do not contribute to the attainment of program objectives • Job evaluations • Client outcome scores increase (issues 3.2, 3.3, 3.5) 	<ul style="list-style-type: none"> • Staff focus group • Job evaluations • Client outcome scores (issues 3.2, 3.3, 3.5)
2.3. Are appropriate high-risk prenatal assessment measures used to collect information?	<ul style="list-style-type: none"> • Degree to which the program assessment measures reflect current knowledge Expert opinion 	<ul style="list-style-type: none"> • Literature on high risk prenatal assessment • Compare with other similar programs • HMHB intake assessment • Expert opinion 	<ul style="list-style-type: none"> • Literature/other programs • Program documentation review • Expert panel

Table 6. Evaluability Assessment (cont'd).

2.4 Are there enough staff to meet the client needs?	<ul style="list-style-type: none"> • Client opinion • Staff opinion • Manager opinion • Compare with other programs 	<ul style="list-style-type: none"> • Client • Staff • Manager • Other similar programs 	<ul style="list-style-type: none"> • Client satisfaction survey • Focus group • Staff/Manager
Delivery			
2.5 Is the program available at the appropriate literacy level and in languages other than English?	<ul style="list-style-type: none"> • Staff opinion • Expert opinion • Resource materials used 	<ul style="list-style-type: none"> • HMHB program manual • Educational material • Client feedback • Staff evaluation • Expert opinion 	<ul style="list-style-type: none"> • Program documentation review • Experts e.g. Open Door, First Nations, Patient Education Dept.
2.6 Is the program being delivered in a culturally sensitive manner?	<ul style="list-style-type: none"> • Client opinion • Staff opinion • Expert opinion 	<ul style="list-style-type: none"> • HMHB program manual • Educational material • Client evaluation • Staff evaluation • Expert evaluation 	<ul style="list-style-type: none"> • Program documentation review • Focus group-clients • Experts e.g. Open Door, First Nations
2.7 Is the program being delivered to the target population?	<ul style="list-style-type: none"> • Number of clients identified with high-risk prenatal needs 	<ul style="list-style-type: none"> • HMHB risk assessments • Community Profiles 	<ul style="list-style-type: none"> • Administrative file review • Community Profile reviews
2.8 Are HMHB staff delivering the program consistent with the principles of harm-reduction, capacity building, and high-risk prenatal programs	<ul style="list-style-type: none"> • Degree to which the program is consistent with harm reduction and high-risk perinatal programming 	<ul style="list-style-type: none"> • Literature/material on the principles of effective high-risk perinatal programs • Staff 	<ul style="list-style-type: none"> • Literature review • Client survey • Focus group: staff, clients, community partners • Expert panel
2.9 Are staff trained to deliver the program?	<ul style="list-style-type: none"> • Staff credentials • Staff opinion • Manager opinion • Expert opinion 	<ul style="list-style-type: none"> • Personnel files • Ongoing continuing education • Staff/Manager • Partner/Expert 	<ul style="list-style-type: none"> • Administrative file review • Staff reviews • Partner/expert review • Manager
2.10 Are clients satisfied with the services received?	<ul style="list-style-type: none"> • Client opinion • Number of referrals from non-professionals 	<ul style="list-style-type: none"> • Client satisfaction • Referrals from friends/family 	<ul style="list-style-type: none"> • Process evaluation • Client survey • Administrative file review • Focus groups
3.0 Impact to what extent do the program activities contribute to the attainment of the program objectives? All of these are outcome evaluation components.			
3.1 Are risk behaviours decreased?	<ul style="list-style-type: none"> • Use of drugs, alcohol and smoking • Client opinion 	<ul style="list-style-type: none"> • Client risk behaviours • Intake and discharge forms 	<ul style="list-style-type: none"> • Client survey • Comparison of intake and discharge data

Table 6. Evaluability Assessment (cont'd).

<p>3.2 Are prenatal care activities increased?</p>	<ul style="list-style-type: none"> • Number of prenatal classes attended • Number of doctor visits • Engaged in positive behaviours 	<ul style="list-style-type: none"> • Staff statistics • Prenatal class assessment • Doctor visits • Nutritional status 	<ul style="list-style-type: none"> • Client survey • Nutritional status reports • Administrative file review • Program file review
<p>3.3 Is knowledge of pregnancy, birth-related issues, and healthy behaviours increased</p>	<ul style="list-style-type: none"> • Level of knowledge of pregnancy, birth-related issues, and healthy behaviours 	<ul style="list-style-type: none"> • Outcome indicator • Client knowledge increase (pre-post program) • Staff notes 	<ul style="list-style-type: none"> • Program documentation review
<p>3.4 Are goals achieved?</p>	<ul style="list-style-type: none"> • Goals accomplished • Staff opinion • Client opinion 	<ul style="list-style-type: none"> • Process/outcome • Intake and discharge notes • Staff notes • Client opinion 	<ul style="list-style-type: none"> • Program documentation review • Client survey
<p>3.5 Are healthy life-style changes?</p>	<ul style="list-style-type: none"> • Continued healthy lifestyle choices 	<ul style="list-style-type: none"> • Client opinion • Community partner opinion 	<ul style="list-style-type: none"> • Post-program follow-up
<p>4. Alternatives Are there more effective methods for achieving the objectives of the HMHB program?</p>			
<p>4.1 Are there services already provided in the community for high-risk prenatal women?</p>	<ul style="list-style-type: none"> • Existence of similar programs in the community • Comparison to other jurisdictions • Manager/staff opinion • Community partners 	<ul style="list-style-type: none"> • Community program documentation / comparison • Literature review • Manager/staff 	<ul style="list-style-type: none"> • Program documentation/ literature review • Community Partners / Manager Committee
<p>4.2 Is HMHB as effective as other similar programs offered in the community for high-risk pregnant women?</p>	<ul style="list-style-type: none"> • Impact of HMHB program as well as other community substance abuse programs for high-risk pregnant women • Expert opinion 	<ul style="list-style-type: none"> • Client outcome scores • Outcome studies of other community programs: e.g. Food for Thought, KidsFirst • Expert 	<ul style="list-style-type: none"> • Program documentation review • Documentation review of other programs • Expert opinion
<p>4.3 Can any of the program activities be achieved more cost effectively?</p>	<ul style="list-style-type: none"> • Cost of activities compared to cost of similar community program activities • Expert opinion 	<ul style="list-style-type: none"> • Budget for HMHB and similar programs • Opinions of <ul style="list-style-type: none"> - Staff - Staff from other similar programs - Manager - Experts 	<ul style="list-style-type: none"> • Administrative file review • Focus group: program staff • Manager • Contact other similar programs • Expert panel

Staff members stated that they often had difficulty establishing goals and objectives early in the relationship. Such tools may help identify areas of need for care and education. This process would also determine if clients have increased their knowledge because of participation in the program.

The Roots and Wings project provided HMHB with an SPSS program. Data is continually entered and can be analyzed to provide trends and client profiles that staff, partners, and senior management will find helpful in program planning and evaluation.

EVALUATION IN PRACTICE: THE PROGRAM LOGIC MODEL

While data collection for any evaluation should be as non-disruptive and efficient as possible for both staff and clients, it is nevertheless crucial for the program to collect the appropriate data to determine if HMHB is meeting its long and short-term objectives through its various activities: Education; Support; Supplements; Advocacy; Programs; and Linkages.

Long-term Objectives

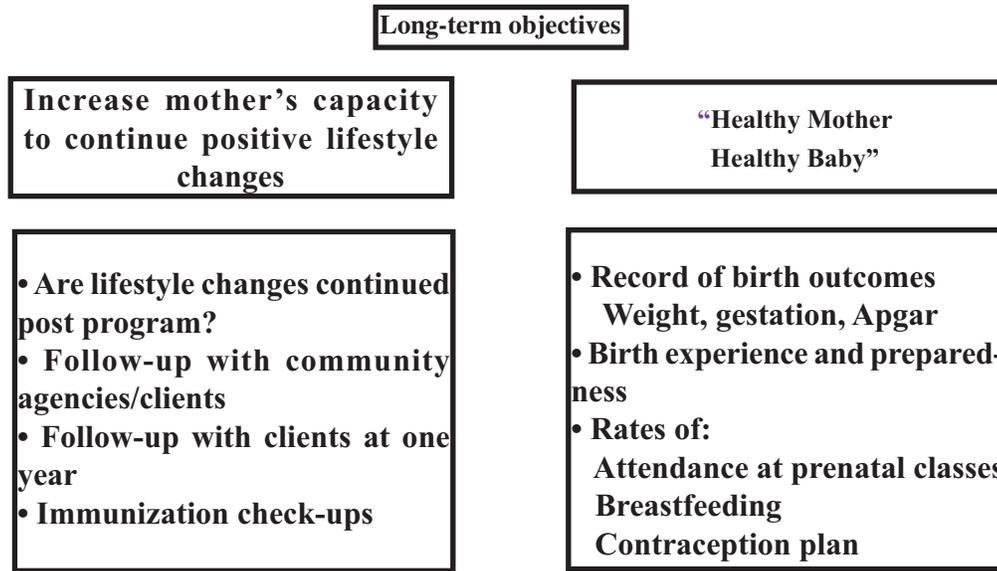
Evaluation of long-term objectives may be difficult. The first objective—increasing the mother’s capacity to continue positive lifestyle changes—would involve a follow-up with the community agencies or clients themselves to see if they have continued their lifestyle changes. For example, mothers often attend immunization clinics, which may offer an opportunity for ongoing evaluation. This long-term goal is similar to that of KidsFirst and Food for Thought. As some clients participate in both programs, there may be an opportunity for collaboration in evaluation activities.

The “Healthy Mother Healthy Baby” objective can be evaluated through birth outcomes (e.g. gestation, Apgar scores, birth weights). Clients would also be asked about their birth experience and how prepared they felt. Attendance rates at prenatal and parenting classes, breastfeeding, and a plan for contraceptive use could be incorporated into an evaluation at the final discharge meeting with the clients. This information would be entered into a database for ongoing monitoring of program effectiveness in meeting this objective (see **Figure 2**).

Short-term Objectives

Staff saw decreased participation in risk behaviours and activities as an important short-term objective. Client self-reporting and staff observation are two ways that HMHB could evaluate this objective. While decreased Fetal Alcohol Syndrome (FAS) rates and increased school performance might better reflect decreased participation by the mothers and the impact on the lives of their children, such an evaluation is out of HMHB’s realm without additional research resources. The evaluation of the KidsFirst program may again prove informative.

Figure 2. Long-term Objectives.



Existing intake forms for tobacco, drug, sniffing, and alcohol use start with closed-ended questions that give the client the option to halt further assessment. However, to assess if HMHB is achieving its short-term goal of decreasing risk behaviours and activities, it is therefore essential to have a better method to determine and document the amount of engagement and reduction in those behaviours (e.g. smoking, drugs, sniffing).

Fetal Alcohol Syndrome: A role for professionals in providing early intervention and other support for women (Saskatchewan Provincial Alcohol and Drug Services Working Group, 2002) is a document designed to improve interview practices for maximum effectiveness in early identification of alcohol abuse. These techniques could be readily applied to all substances used by HMHB clients. Consultants at the Fetal Alcohol Syndrome Program and Addictions Services within the Saskatoon Health Region is a resource revising intake and discharge tools and interviewing processes to increase early identification and reporting of substance use.

Activities

The following HMHB activities are amenable to evaluation:

- **Education.** HMHB presently tests its learning material on clients and through other agencies (e.g. Open Door) to ensure that all materials are up-to-date and consistent with messages delivered by the staff and community partners. A patient education or knowledge transfer specialist may be helpful to ensure relevance for this population. Testing materials for client understanding through focus groups and pre- and post-tests will ensure that materials are suitable and serving their purpose. Pre- and post-tests can help establish if the educational material of the program is actually increasing knowledge.

- **Support.** A Client Satisfaction survey that includes listening and counseling activities will help determine if support is being achieved. Measuring pre- and post-program risk behaviours and activities will help determine if the support is helping women engage in healthier activities and behaviours. One staff member said that she used to get upset when a client would return to the program during subsequent pregnancies. She saw it as a failure of herself and of the program, but after many years she understood it as a sign of success, that they have established trust with the client who is continuing to engage in the service, and as an opportunity to further help the family.
- **Supplements.** Records of the number and type of supplements used by clients determine use. Staff members report that they sometimes need to educate women to use the milk for themselves while pregnant and not to give it to their children. Follow-up documentation will assist evaluation of the effective use of supplements.
- **Advocacy.** While staff believe that one of their main activities is advocacy, this may be harder to measure than other activities. One major HMHB method of referral is via family/friends. If clients do not believe that staff is maintaining confidentiality and advocating for themselves and their baby, it is expected that they would not recommend the program to others. Most of the mothers interviewed for this report indicated that they had heard about the program through friends or sisters. The number of women who return to HMHB during subsequent pregnancies is another indicator that clients believe the program advocates for them.
- **Programs.** Ongoing record-keeping of programs and visits provides attendance data, but there is still a need for assessing the impact and relevance of these. Evaluation of prenatal classes, home visits, and other programs will provide information for ongoing planning and resource allocation.

Including a formal evaluation component with all existing and new programs will ensure optimum use of limited assets. A storefront prenatal class in a local mall, for example, was discontinued after a few sessions. A program evaluation by clients and staff would help determine the strengths and weaknesses of such endeavours and should be planned as part of any future program changes or additions.
- **Linkages.** Linking clients to other resources through referrals is an activity that helps achieve the short-term goal of increased awareness and use of community supports, and the long-term goal of increasing the mother's capacity to continue with positive lifestyle changes. Follow-ups with clients and community partners would help assess if this objective is achieved.

EXISTING EVALUATIONS

Many HMHB clients also attend Food for Thought, which completed an evaluation a few years ago and submits data to Health Canada on an ongoing basis. Healthy Mother Healthy Baby may be able to dovetail or adapt the evaluation materials in an efficient manner. There are also HMHB clients who participate in the KidsFirst program during and following their pregnancy. This program is in the process of developing evaluation criteria that may be useful to HMHB.

Appendix H is a draft evaluation adapted from Program without Walls and the Algoma Cooperative Children's Services. It includes client satisfaction (process) and outcome measures that may be further adapted and used for Healthy Mother Healthy Baby. The program outcome evaluation could be achieved if the client documentation is amended to include some of these criteria on entering and exiting. **Appendix I** contains a draft client satisfaction survey that addresses the process evaluation of the program.

DISCUSSION

HMHB invited this first step in the evaluation process. The program has shown openness to participation in research and incorporating research findings and new methods to improve practice (e.g. Roots and Wings). Staff meetings frequently include an in-service component. Staff are challenged with maintaining competency in a broad range of areas: family violence, addiction, prenatal care, breastfeeding, contraception, and parenting. They must also stay abreast of changes within the community, health region, or school programs that impact on their work. They may benefit from increased exposure to the Harm Reduction Model and capacity building in high-risk women.

Staff members voiced concerns about the future of some of the neediest families in the program after the final postnatal visit. KidsFirst in Saskatoon continues post-delivery home visits, but only when the mother has substance abuse problems and if the family lives in a targeted area of Saskatoon. There is no other home visit program for continued intensive support to other vulnerable families who have been participating in HMHB. The literature supports the ongoing use of home visits beyond the postpartum period when risk factors are still present (Schmitz and Reif, 1994; Vines and Williams-Burgess, 1994). This practice is employed in the Vancouver and Toronto programs, which extend outreach services and supplements into the child's second year.

It is recognized that HMHB has not engaged in any type of evaluation since 1991 (Bell Woodard and Edouard, 1992). To perform a self-evaluation, the program may wish for a short period to reallocate or request staff resources to focus on revision of existing materials and forms, and development of evaluation tools. A new documentation system created by the program staff was revised some time ago, but was not implemented.

SUMMARY

Healthy Mother Healthy Baby is a well-established, highly respected, robust program that has provided service to women during more than 8,000 pregnancies in the past 20 years. Clients and community partners who were contacted for this project all see the program as meeting its goal of promoting optimal pregnancy outcomes and healthy lifestyle choices in high-risk antenatal and postnatal women and teens in Saskatoon. However, a formal evaluation will produce valuable feedback to strengthen and improve the program.

RECOMMENDATIONS

The following recommendations are presented to reflect areas where HMHB can increase its impact as well as provide a foundation for further growth and future evaluation activities.

- (1) Continue to foster and maintain community relationships.
- (2) Introduce staff to capacity building concepts.
- (3) Increase education of and articulate the Harm Reduction Model in the program policies and procedures.
- (4) Develop specific outcome and process evaluation criteria within various HMHB programs.
- (5) Develop a documentation system that is amenable to tracking activities, interventions, and outcomes that combines narrative with easily retrievable information for evaluation of client behaviours (e.g. substance abuse) and program activities.
- (6) Analyze data and produce a report for staff, management, and community partners.
- (7) Develop a liaison with similar programs (e.g. Breaking the Cycle, Sheway).
- (8) Assess the relevance of CPNP evaluation tools presently in use by other programs (e.g. Food for Thought) for use/adaptation by HMHB.
- (9) Examine the feasibility of increasing the number of postnatal visits to clients not involved in the KidsFirst program.
- (10) Develop a simple client satisfaction tool that administered to each client upon discharge.
- (11) Review the intake process to try to reduce waiting list time.
- (12) Look for innovative ways to combine services with other community programs regarding hard to reach families.

- (13) Regularly review the Program Logic Model with staff and community partners.

WHERE TO START?

The recommendations and evaluation criteria within the report require an effort on the part of HMHB management and staff. However, there are experts in the community to help with these activities. The continuing education recommendations—(2) and (3)—could be included as part of regular staff in-services. Staff or management could draft policies and evaluation criteria and then review them at staff meetings to achieve recommendations (3) and (4). Assigning staff different aspects of the client forms may ease the pressure of meeting recommendation (5).

There may be a need for some external support to help with data analysis and the review of the existing evaluation tools. Sample evaluations have been included in **Appendices H and I** that could be adapted to help achieve recommendation (10). The program has been in place for a considerable time following the same policies and procedures. Sharing recommendations (11), (12), and (13) with community partners may help provide creative solutions. The PLM, policies, and other procedures can be flagged for regular review in the policy manual.

CONCLUSION

Healthy Mother Healthy Baby is a vital program that has helped many women in Saskatoon over the last twenty years. It has established an exemplary reputation for engaging and providing confidential outreach pregnancy services to high-risk vulnerable women. HMHB's challenge is to evaluate how it provides services, client outcomes, and develop creative solutions to issues that may surface in the evaluations. This may involve new and innovative partnerships and approaches to service delivery.

REFERENCES

- BC Ministry of Health and Ministry Responsible for Seniors. (1993). *Pregnancy Outreach Program*. Victoria, BC.
- Bell Woodard, G. and Edouard L. (1992). Reaching out: A community initiative for disadvantaged pregnant women. *Canadian Journal of Public Health*, 83(3): 188-90.
- Benner, P. E. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA.
- Bray, M. L. and Edwards, L. H. (1994). A primary health care approach using Hispanic outreach workers as nurse extenders. *Public Health Nursing*, 11(1): 7-11.

- Breaking the Cycle. (n.d). Online resource (<http://www.breakingthecycle.ca/evaluation.html>).
- Cheung, Y.W. (2000). Substance abuse and developments in harm reduction. *Canadian Medical Association Journal*, 162(12): 1697-1700.
- Dwyer, J .J. M. and Makin, S. (1997). Using a program logic model that focuses on performance measurement to develop a program. *Canadian Journal of Public Health*, 88(6): 421-425.
- Health Canada. (n.d). Online resource (http://www.hc-sc.gc.ca/dca-dea/programs-mes/cnpn_goals_e.html).
- Korfmacher, J., Kitxman, H., and Olds, D. (1998). Intervention processes as predictors of outcomes in a preventative home-visitation program. *Journal of Community Psychology*, 26(1): 49-64.
- Langevin, C. M. et al. (2001). An evaluation framework for the maison decision house substance abuse treatment program. *The Canadian Journal of Program Evaluation*, 16(1): 99-129.
- Marlatt, G. A. (1998). Basic principles and strategies for harm reduction. In Marlatt, G. A. (ed.). *Harm reduction: Pragmatic strategies for managing high-risk behaviours*. New York.
- Ontario Ministry of Health and Long Term Care. (n.d). Online resource (http://www.health.gov.on.ca/english/public/pub/ministry_reports/healthy_babies_report/hbabies_report.html).
- Poole, N. (2000). Evaluation report of the Sheway project for high-risk pregnant and parenting women. Vancouver.
- Schmitz, K. and Reif, L. (1994). Reducing prenatal risk and improving birth outcomes: The public health nursing role. *Public Health Nursing*, 11(3): 174-180.
- Vines, S. W. and Williams-Burgess, C. Effects of a community health nursing parent-baby (Ad)venture program on depression and other selected maternal-child health outcomes. *Public Health Nursing*, 11(3): 188-195.

Appendix A. Proposed Timeline for Healthy Mother Healthy Baby CUI SR Project.

Date	Objectives	Actions
May-July, 2003	<ul style="list-style-type: none"> • Understand the HMHB program • Compare to similar programs in other cities i.e.: outcome measures and evaluation tools • Develop Program Logic model and Evaluability Assessment 	<ul style="list-style-type: none"> • Meet with manager of HMHB • Senior management aware of project-new management 26 May • Spend time with staff and observe or participate in program activities • Review of program documents: policy and procedure manual • Review literature on Harm Reduction Read relevant reports • Internet search of similar programs • Contact Vancouver, Victoria, Sheway, Calgary, Edmonton, Halifax, Toronto • Review of literature on Program Logic Models and Evaluability Assessment • Focus group with staff • Post Draft Program logic model for manager/staff input • Meet with partners: Food for Thought, Westside Community Clinic, Social Services, Healthy and Home program staff, KidsFirst, Open Door, Collegiates, SIPH, • Contact Ethics officer, Saskatoon Health Region, J. Franko. • Focus groups with clients: Collegiate and Food for Thought, • Home visits
Ongoing	<ul style="list-style-type: none"> • Maintain progress 	<ul style="list-style-type: none"> • Consultation with faculty advisor and other faculty as appropriate
July	<ul style="list-style-type: none"> • Write report • Draft report to manager and faculty advisor 	<ul style="list-style-type: none"> • Compile data, complete model and assessment
August	<ul style="list-style-type: none"> • Final Report to CUI SR 	

Appendix B. Community Partners Consulted.

Community Partner	Contact
Healthy and Home, Saskatoon Health Region (group of staff at staff meeting)	Maureen Keith. Acting Supervisor 655-4613
Food for Thought, Canada Prenatal Nutrition Program.	Pam Woodsworth. Coordinator. 655-4650
Open Door Society	Eleanor Shaw. 653-4644
Family Support Center, Social Services	Wendy Maddin. Teen program. 933-7751
Nutana Collegiate	Brian Flaherty. Principal. 683-7580
Fetal Alcohol Syndrome Program, Saskatchewan Institute for Prevention of Handicaps	Holly Graham, Educator. 655-2312 Lois Crossman, Coordinator 655-2459
KidsFirst	Marcia Clark, Manager. 655-5804
Nobody's Perfect	Sue Haffey, Coordinator. 655-5399
Addiction Services, Saskatoon Health Region	Jan Frayling, Outpat. Manager 655-4100
Westside Community Clinic	Cheryl Hand, Manager of Nursing
Joe Duquette High School	Sylvia Raginski, Day Care Coordinator. 668-7490
Bethany Home, Salvation Army	Debbie Levitt. 244-6758

Appendix C. Other Programs/Resources Contacted.

Location/contact information	Program
<p>Rebecca Attenborough Co-ord. Nova Scotia Reprod. Program 5850 University Ave. Halifax, NS. B3H 1V7 902-470-6798/6607/6791 Rebecca.Attenborough@iwk.nshealth.ca</p>	<p>Home-based nursing care to high-risk antepartum clients who require ongoing medical monitoring in the community. One Clinical Nurse Specialist is available to see clients with social or substance abuse issues.</p>
<p>Roxanne Campbell HBHC Inventory Coordinator 590 Jarvis St, 3rd Floor Toronto, ON M4Y 2J4 416-338-2261 rcampbe@toronto.ca</p>	<p>Healthy Babies, Healthy Children (HBHC) is a prevention and early intervention initiative introduced by the Province of Ontario in January, 1998. The program provides support and services to families with children, prenatal to six years of age. The program has universal and high-risk target group components.</p>
<p>Margaret Leslie, Director, Early Intervention Programs, Manager, Breaking the Cycle 107-761 Queen Street West Toronto, ON M6J 1G1 416-364-7373 mleslie@mothercraft.org</p>	<p>Breaking the Cycle is a multifaceted intensive pre- and postnatal (to age 2 years) program located in downtown Toronto. A variety of programs, mentoring, and counseling related to addiction, mental health, Nobody's Perfect program, child development, and FAS screening. Lunch and transportation are provided. Offer women a Doula labour coach to attend prenatal visits with them and provide support them in labour.</p>
<p>Donna Wallace, Antenatal Mgr. Calgary Health Authority 403-781-1453/1210 Donna.Wallace@CalgaryHealthRegion.ca</p>	<p>Two programs. The Antenatal Community Care Program is for women with high-risk medical conditions (e.g. PTL, placenta previa, multiple gestation) who would otherwise be hospitalized. The Best Beginning Program is a CPNP program.</p>
<p>Roberta Parkes Capital Health – Edmonton 780-413-7974</p>	<p>Healthy Beginnings Antenatal Program is a “bed-replacement” program for medically at risk pregnancies. Health For Two is a CPNP program</p>
<p>Jeannie Dickie Karen McDougall Vancouver: Health Canada 604-666-6429 Karen_MacDougall@hc-sc.gc.ca</p>	<p>Healthiest Babies Possible Program is a CPNP-sponsored program.</p>
<p>Ministry of Health 1515 Blanshard St. Victoria, BC V8W 3C8</p>	<p>Provided evaluation material.</p>
<p>Sheway Project 369 Hawks Ave. Vancouver, BC V6A 4J2 604-658-1200 sheway@vrhb.bc.ca</p>	<p>Freestanding facility provides a wide range of assessment and intervention services to promote healthy pregnancies: free hot lunch Monday to Friday; food hampers with dry goods, fresh fruits, vegetables, bread, vitamins, and pre- and postnatal milk and juice vouchers; and maternity and baby clothes (when available). Sheway continues to provide services until child is 18 months of age. A “well baby clinic” provides doctor care, immunizations, formula, and baby food and diapers.</p>
<p>Greater Victoria Health Authority 250-385-8979</p>	<p>Best Babies is a CPNP sponsored program.</p>

Appendix D. Client Interviews.

Clients	Interviewees
Food for Thought, Canada Prenatal Nutrition Program	Group of 12 clients, all Aboriginal
Royal West Collegiate	Group of 2 students
Home Visits	One immigrant woman, 2 Aboriginal, 2 Non- Aboriginal throughout the city

Appendix E. Draft Program Logic Model.

***DRAFT* Program Logic Model – Healthy Mother Health Baby Program *DRAFT*
3 June 2003**

Goal To promote optimal pregnancy outcomes and healthy lifestyle choices

Target Population High-risk antenatal and postnatal women and teens in Saskatoon

Long Term Objectives Increase mother's capacity to continue positive lifestyle changes "Healthy Mother Healthy Baby"

Continue positive lifestyle changes • Exposure to risk behaviors & activities • Able to access health and community services • Health outcomes • Nutritional status • Skills to make healthy choices • Complications • Doctor visits • Self-esteem • NICU time • Long-term goals (school)

Short Term Objectives

- Establish relationship
- Increased awareness of community supports and services
- Increased use of community supports
- Decreased risk behaviours & activities

- Assessments and screening
- Provide supplements and milk coupons
- Increased knowledge of effects of lifestyle on baby
- Decreased risk behaviours and activities
- Increased knowledge of changes of pregnancy and fetal development
- Increased preparation for labour and delivery
- Increased knowledge of breastfeeding
- Increased knowledge of contraception
- Increased knowledge of parenting

Activities	Linkages	Advocacy	Support	Education	Programs	Supplements
	<i>Resource development</i>	<i>Listening Counseling</i>	<i>Provide vitamins, Lactaid</i>	<i>Mother, baby Transportation Confidentiality</i>	<i>Home visits Prenatal classes School visits Parenting/ Breastfeeding School programs Hotline</i>	<i>Referrals</i>
	<i>Clients</i>					
	<i>Students</i>					

Resources
Staff: Healthy Mother, Healthy Baby. Communication: Cell phones.
Office space: Sturdy Stone building. Transportation: Automobiles.
Other: Women's homes, Schools.

Appendix F. Community Partner Questionnaire.

The questionnaire is completed in conjunction with the *Draft Program Logic Model*, Healthy Mother Healthy Baby Program.

Group _____ Spokesperson _____ Date _____

Is Healthy Mother Healthy Baby is meeting its goal?

Is your target population the same?

Are your long-term objectives the same?

Do you do any of the same services/components/activities?

Do you receive any of the same or similar services from a different group/organization?
Who?

Are there any claims of activities/goals etc. that they do not meet? What don't they do?

How does Healthy Mother/Healthy Baby fit with your organization/Group?

General comments:

Appendix G. Client Input Questionnaire.

The questionnaire is completed in conjunction with the *Draft Program Logic Model, Healthy Mother Healthy Baby.*

Group _____ Number of clients _____ Date _____

How did you hear about Healthy Mother Healthy Baby?

Show PLM: Goal: Is Healthy Mother Healthy Baby meeting its goal as stated?

Are all of those services available to you?

Do you get any of these services elsewhere?

Is there anything that they are not doing for you that you need and cannot get elsewhere?

What did you hope to gain from the Healthy Mother Healthy Baby Program?

How well does it meet your needs?

Overall, do you think your pregnancy is going better because of Healthy Mother Healthy Baby Program?

Any other comments?

Appendix H. Sample Draft - Client Outcome and Evaluation Tool.

Adapted from Program without Walls and the Algoma Cooperative Children’s Services.

Healthy Mother Healthy Baby Program

You recently participated in the Healthy Mother Healthy Baby (HMHB) program; we are interested in how the program met your needs and what you got out of the program. To help us provide better service, please answer these questions and return to the program as soon as possible.

All responses are completely confidential and anonymous.

1. Your goals when you entered the program were:

Did you achieve these goals?

If no, why not?

2. Overall, how would you say things are for you now, compared to when you first came to the Healthy Mother Healthy Baby program? (Circle one)

much better somewhat better unchanged somewhat worse much worse

Because of the Healthy Mother Healthy Baby program:

	not at all	somewhat	very much
3. I know more about healthy eating	1	2	3
4. I know how to care for my baby	1	2	3
5. I ate better during pregnancy	1	2	3
6. I understand how drinking alcohol during pregnancy affects my baby	1	2	3
7. I know how to access more services for my family	1	2	3
8. I attended prenatal classes	1	2	3
9. I went to the doctor more often	1	2	3

10. I understand the effects of smoking during pregnancy on my baby	1	2	3
11. I felt confident breastfeeding my baby	1	2	3
12. I have more friends	1	2	3
13. I know more about birth control	1	2	3
14. I drank less during pregnancy	1	2	3
15. I understand the effects of taking drugs during pregnancy on my baby	1	2	3
16. I felt prepared for the birth of my baby	1	2	3
17. I felt able to care for my baby	1	2	3
18. I smoked less during pregnancy	1	2	3
19. I was able to make healthy lifestyle choices	1	2	3
20. I took fewer drugs during pregnancy	1	2	3
21. I understood what was occurring during labour	1	2	3

The program:

	not at all	somewhat	very much
22. My nurse/outreach worker gave the support I needed	1	2	3
23. The home visits are helpful	1	2	3
24. I used the supplements	1	2	3
25. I used the bus tickets	1	2	3
26. My nurse/outreach worker listened to me	1	2	3
27. I tell my friends and family to use Healthy Mother Healthy Baby	1	2	3

28. The thing I like best about Healthy Mother Healthy Baby is?

29. If I could change one thing about Healthy Mother Healthy Baby it would be:

30. How we might improve Healthy Mother Healthy Baby program?

31. Your age: _____ 32. Your postal code: _____

33. How old is your baby? _____ 34. How many children do you have? _____

35. How many times have you participated in HMHB? (Circle one) 1 2 3 4 Other _____

36. How did you hear about HMHB? _Friend _Family _Social worker _Teacher
_Doctor Other _____

37. Are you? _Aboriginal _Immigrant _Teenager _Other _____

38. Level of Education: _Some high school _Finished high school _Other _____

39. Family income: _Less than \$20,000 _\$20-29,000 _\$30-39,000 _More than \$39,000

40. Are you? _Single _Separated _Divorced _Common-law _Married

Comments:

Date: _____

Thank you for taking the time to complete this evaluation.

If you have any questions or are presently experiencing problems that you need help with please contact the Healthy Mother Healthy Baby program at 655-4600.

Appendix I. Sample Draft - Client Satisfaction Survey-Process Evaluation.

Healthy Mother Healthy Baby Program

All information on this survey is confidential and anonymous. It will be used only to make improvements to the Healthy Mother Healthy Baby program.

	Not at all	somewhat	very much
1. My nurse/outreach worker have the supportiveI needed	1	2	3
2. The home visits are helpful	1	2	3
3. I used the supplements	1	2	3
4. I used the bus tickets	1	2	3
5. I will tell my family/friends to use Healthy Mother Healthy Baby	1	2	3
6. The thing I like best about Healthy Mother Healthy Baby is?			
7. If I could change one thing about the program it would be:			
8. How we might improve the Healthy Mother Healthy Baby program?			
9. Your age: _____ 10. Your postal code: _____			
11. How old is your baby? _____			
12. How many children do you have? _____			
13. How many times have you participated in HMHB? (Circle one) 1 2 3 4 Other ____			

14. How did you hear about HMHB? Friend Family Social worker Teacher
 Doctor Other _____

15. Are you? Aboriginal Immigrant Teenager Other _____

16. Level of Education: Some high school Finished high school Other _____

17. Family income: Less than \$20,000 \$20-29,000 \$30-39,000 More than \$39,000

18. Are you? Single Separated Divorced Common-law Married

Comments:

Date: _____

Thank you for taking the time to complete this evaluation. If you have any questions or are presently experiencing problems that you need help with please contact the Healthy Mother Healthy Baby program at 655-4600.

THE CUISR MONOGRAPH SERIES

Bound copies of this and our other publications are for sale through our office and in downloadable pdf format <http://www.usask.ca/cuisr/Publications/Publications.html>.

- Amankwah, Dinah. (2003). *Integrative Wraparound (IWRAP) Process Training*. Saskatoon: Community-University Institute for Social Research.
- Avis, Kyla and Angela Bowen. (2004). *Postpartum Depression Support Program Evaluation*. Saskatoon: Community-University Institute for Social Research.
- Banks, Christopher. (2003). *The Cost of Homophobia: Literature Review on the Human Impact of Homophobia On Canada*. Saskatoon: Community-University Institute for Social Research.
- Banks, Christopher. (2004). *The Co\$t of Homophobia: Literature Review on the Economic Impact of Homophobia On Canada*. Saskatoon: Community-University Institute for Social Research.
- Berntson, Ron. (2003). *Peer Victimization Experiences in High School*. Saskatoon: Community-University Institute for Social Research.
- Bowditch, Joanne. (2003). *Inventory of Hunger Programs In Saskatoon*. Saskatoon: Community-University Institute for Social Research.
- Bowen, Angela. (2004). *Healthy Mother Healthy Baby: Program Logic Model and Evaluability Assessment*. Saskatoon: Community-University Institute for Social Research.
- Brown, Shardelle. (2003). *"We Did It Together": Low-Income Mothers Working Toward a Healthier Community*. Saskatoon: Community-University Institute for Social Research.
- Drechsler, Coralee. (2003). *Influencing Poverty Reduction Policy: Data Analysis*. Saskatoon: Community-University Institute for Social Research.
- Dressler, Mary P. (2004). *Aboriginal Women Share Their Stories in an Outreach Diabetes Education Program*. Saskatoon: Community-University Institute for Social Research.
- Fernandes, Neville. (2003). *Saskatchewan's Regional Economic Development Authorities: A Background Document*. Saskatoon: Community-University Institute for Social Research.
- Gold, Jenny. (2004). *Profile of an Inter-Sectoral Issue: Children Not In School*. Saskatoon: Community-University Institute for Social Research.
- Grosso, Paula. (2003). *Uprooting Poverty and Planting Seeds for Social Change: The Roots of Poverty Project*. Saskatoon: Community-University Institute for Social Research.
- Harlingten, Leora. (2004). *Saskatoon Charging and Disposition Patterns Under Section 213 of the Criminal Code of Canada*. Saskatoon: Community-University Institute for Social Research.
- Jackson, Maureen. (2004). *Closer to Home: Child and Family Poverty in Saskatoon*. Saskatoon: Community-University Institute for Social Research.

- Janzen, Bonnie. (2003). *An Evaluation Of The Federation of Canadian Municipalities Quality of Life Reporting System*. Saskatoon: Community-University Institute for Social Research.
- Kynoch, Bev. (2003). *The Brightwater Environmental and Science Project: Respecting Traditional Ecological Knowledge—The Soul of a Tribal People*. Saskatoon: Community-University Institute for Social Research.
- MacDermott, Wendy. (2003). *Child Poverty in Canada, Saskatchewan, and Saskatoon: A Literature Review and the Voices of the People*. Saskatoon: Community-University Institute for Social Research.
- MacDermott, Wendy. (2004). *Common Functional Assessment and Disability-Related Agencies and Departments in Saskatoon*. Saskatoon: Community-University Institute for Social Research.
- MacDermott, Wendy. (2004). *Evaluation of the Activities of the Working Group to Stop the Sexual Exploitation of Children*. Saskatoon: Community-University Institute for Social Research.
- Ofosuhene, Maxwell. (2003). *Saskatchewan River Basin-Wide Survey of Residents' Attitudes Towards Water Resources and the Environment*. Saskatoon: Community-University Institute for Social Research.
- Olfert, Sandi. (2003). *Quality of Life Leisure Indicators*. Saskatoon: Community-University Institute for Social Research.
- Reed, Maureen. (2003). *Situating Indicators of Social Well-Being in Rural Saskatchewan Communities*. Saskatoon: Community-University Institute for Social Research.
- Soles, Kama. (2003). *Affordable, Accessible Housing Needs Assessment at the North Saskatchewan Independent Living Centre*. Saskatoon: Community-University Institute for Social Research.
- Tupone, Juliano. (2003). *The Core Neighbourhood Youth Co-op: A Review and Long-Term Strategy*. Saskatoon: Community-University Institute for Social Research.
- Woods, Florence. (2003). *Access To Food In Saskatoon's Core Neighborhood*. Saskatoon: Community-University Institute for Social Research.
- Wright, Judith and Muhajarine, Nazeem. (2003). *Respiratory Illness in Saskatoon Infants: The Impact of Housing and Neighbourhood Characteristics*. Saskatoon: Community-University Institute for Social Research.