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shapinghealth

Exchanging on social power in health

Evaluating efforts that build social power and participation in health systems

BRIEF 3: Methods used for participatory evaluation

In this *Brief 3* we outline, with links for further information, the methods that can be used in different stages of participatory evaluation of social participation and power in health.

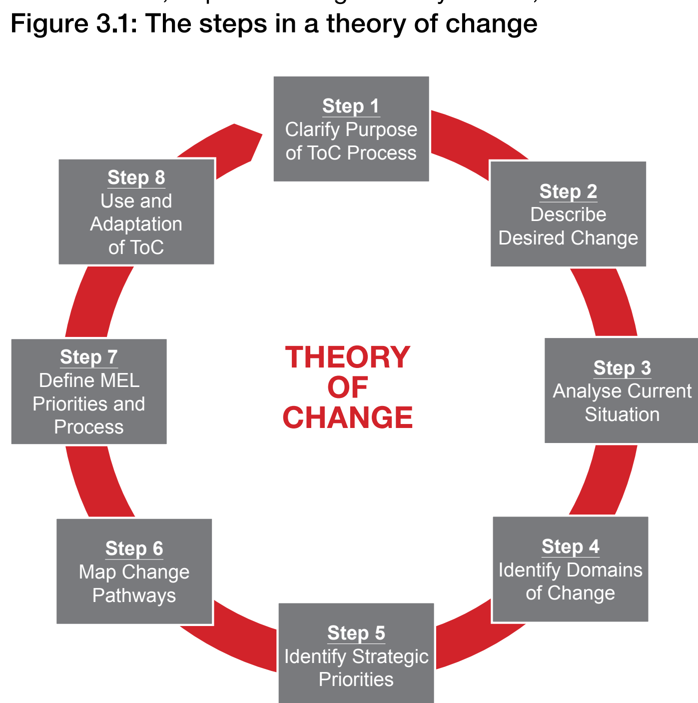
Methods for testing theories of change

The concept of a theory of change (ToC) was introduced in *Brief 1* as a tool for both planning and evaluation. Developing a ToC is like forward storytelling. It expresses and shares participants' hopes, expectations and assumptions, to draw and engage people in conversation on them.

The stepwise approach used to develop a ToC shown in *Figure 3.1* explores:

1. *In Steps 1 and 2:* What is the desired change, why and for whom?
2. *In Steps 3 to 5:* An analysis of the system and the current situation:
    - A context analysis of the current situation and stakeholders, of power and gender dynamics, and
    - The domains, drivers of, opportunities and priorities for change.
3. *In Step 6:* The pathways of change:
    - Who and what needs to change to realise the longer-term desired change?
    - How do we think the change process might evolve from where we are now?
    - What assumptions are we making about the needs, interests and behaviour of stakeholders and about cause-effect relations in the change pathways?
4. *In Step 7:* The processes and measures to use to monitor, review and evaluate implementation
5. *In Step 8:* The strategic options and plans to organise the intervention and roles in the TOC and produce the desired changes.

Figure 3.1: The steps in a theory of change



Source: van Es et al., 2015 p34 used under creative commons license. MEL = Monitoring, evaluation and learning

Using a TOC can be useful for explicitly addressing the framework, process and methods for monitoring, evaluation and learning, to document the change process, to identify what to monitor and how, and when and how to revisit the change process to reflect on what works and the learning gained (van Es et al., 2015).

These steps act as a basis for ongoing process evaluation and summative evaluation. They also facilitate a critical revisiting and evaluation of the thinking applied in the change process, as one element of realist evaluation noted in *Brief 1*.

A comprehensive step by step guide for how to implement each one of these steps can be found at www.theoryofchange.nl/sites/default/files/resource/hivos_toc_guidelines_final_nov_2015.pdf

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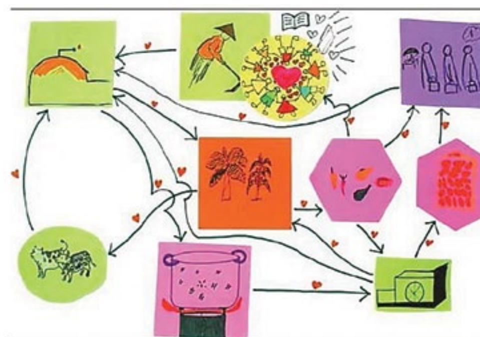
Box 3.1 Using a theory of change for youth led promotion of adolescent sexual health

The Illinois Caucus For Adolescent Health (ICAH) provides peer-led education for youth and promotes youth leaders as experts of their own sexual health education. The image below shows ICAH's visual for their ToC. It visualizes the work they are doing to disrupt systems by i. reducing stigma and shame around youth sexuality, ii. increasing safe relationships and environments that promote positive self-perception, iii. increasing opportunities for youth decision-making and leadership within family, school, and healthcare iv. increasing respectful youth and adult partnerships v. increasing access to culturally-relevant, youth-friendly sexual healthcare information and vi. increasing sex-positive, inclusive, developmentally appropriate information around health, identity, and rights. ICAH uses this ToC in implementing and reviewing their work and encourages others to use hashtags from their ToC. For example, their adult accomplice training has stages of training with topics like "Youth Voice" and "No Shame," that link topics directly to their ToC.

Source: Illinois Caucus for Adolescent Health 2018, used with permission.

As the ICAH work shows, a visual can make a ToC more engaging to return to different stages of a process, and enable those involved to build shared ownership and understanding of the process. A **rich picture**, such as that adjacent, has been used in some settings to raise, communicate, engage with and draw links between the different perceptions and ideas thinking of those involved (van Es et al., 2015). They can be used to represent the current situation and the desired change, as a "before and after". Detailed instructions for using rich pictures can be found at www.managingforimpact.org/tool/rich-picture-0.



Source: van Es et al 2015 p 26 under creative commons license

The next sections describe the methods used to address evaluation questions such as those raised in *Brief 2*, to assess changes in the situation, processes, practices and in outcomes and to test the theories of change framing work on social participation and power in health.

Methods for assessing changing needs, capacities and conditions

Current conditions and how they change can be presented and mapped in a range of approaches, revisiting findings over time to add new information or to identify differences:

- **Picture codes** are single pictures that reflect situations, conditions or problems that can be used for triggering discussion on conditions, system performance, causes, and actions to be taken. They are often helpful in raising and discussing sensitive or buried issues, such as on sexual and reproductive health services, or responses to substance abuse (Loewenson et al 2014).
- In **participatory mapping**, those involved draw one or more maps of the physical and social conditions in the setting for interventions.

This includes risk and hazard maps, as described in ‘Barefoot Research: A Workers’ Manual for Organising On Work Security. Various forms of mapping exist: social mapping of social characteristics; asset mapping, wellbeing mapping; vulnerability mapping to identify disadvantaged groups and rights mapping.

- A **transect walk or participatory observational surveys** add information and observations to these maps. Transect walks are systematic walks across the community allowing participants to see a range of features, resources and conditions in the area. Maps may be added to at different stages of evaluation and review processes to present new, complementary information (Loewenson et al 2014).

Discussion of a social map, Zimbabwe F Machingura 2006

Maps that communities have generated collectively tend to have a greater degree of acceptability, ownership and usefulness for future courses of collective action (Banerjee and Bharadwaj 2011).

The changing positions, roles and interests of social groups involved in processes can be assessed in a number of ways:

- The various forms of **stakeholder and network analysis** and various forms of **power analysis** introduced in *Brief 2*, when repeated, can identify changes in the presence, interests, power, networking, relations and influence of critical actors. The tools for implementing these analyses are described for example in online ODI resources. An analysis at inception creates a baseline from which change can be assessed, with participant observation and semi-structured questionnaires and in-depth interviews adding information and focus group discussions; forums or public debates supporting interpretation (UNESCO 2009).
- **Venn or chapati diagramming** consists of a series of interrelated circles that indicate the relationships, status in the community and the interactions between social groups/ actors or institutions. The size of the circle indicates importance and its position and distance from the central group/ institution and other circles indicate the relationship with central and other actors. It provides a means of mapping, reviewing and discussing the relationships between actors and services, such as patterns and preferences in use of services, information flows between services and communities and other relations in health systems. (Loewenson et al 2014).

Methods for assessing performance and process

There are a range of participatory approaches for assessing performance and process outcomes during and after implementation, covering the processes for planning, implementing, organising and delivering actions and services. *Table 3.1* overleaf shows some of the questions asked about participatory practice, as one element of the questions for review set in Step 7 in building a theory of change. (Nabatchi 2012).

Beyond the assessment of quantitative outputs and milestones in programmes, people’s perceptions of the performance of programmes can be gathered through **indepth interviews, focus groups and round tables.**

Case studies can be used to explore particular areas of practice in more depth. Other methods include **observation**, such as of the dynamics of groups, **portfolio reviews** of work produced and use of **journals and diaries** by those involved to record their activities, involvement and experiences (UNESCO 2009).

Life histories, narratives and storytelling use structured stories to represent experiences of and changes in practices, and to review cycles of improvement (Loewenson et al., 2014).

Spider-grams as visual tools are used to identify and analyse relationships between actors in and elements of processes. The spider ‘body’ is the issue of focus and the legs the different factors that affect it. The separation of factors (legs) enables discussion, ranking of and analysis of links across factors, and diagrams may be compared across different social groups.

Table 3.1 Evaluating practice

Evaluation Area	Main Question	Data Sources
Program Organization		
1. Program Implementation and Operation	Was the participatory program implemented and does it operate as designed?	Archival, Program Staff
2. Directives, Guides, and Standards	Do program directives, guidelines, manuals, and standards provide sufficient information for program administration and use?	Archival, Program Staff
3. Delineation of Staff and Participant Responsiblilities	Does the delineation of staff and participant responsibilities reflect the design of the participatory program and enable its smooth operation?	Archival, Program Staff
4. Sufficiency of Staff	Are the number, type, and training of staff adequate to meet the operational needs of the participatory program?	Archival, Program Staff
5. Coordination and Working Relationships	Have effective collaborative relationships been established to carry out the objectives of the participatory program?	Archival, Program Staff, stakeholders, Observation
Service Delivery		
1. Access	Are potential participants aware of the program and do they have access to the program?	Participants, Program Staff
2. Neutrals/Facilitators	Are neutrals/facilitators effective in the participatory program?	Participants, Program Staff, Observational Data
3. Procedural Understanding	Do program staff and participants understand how the participatory program works?	Participants, Program Staff
4. Issue Selection	Are appropriate issues being discussed in the participatory program?	Participants, Program Staff, stakeholders, Observation
General and Process-Specific Outputs	What are the general outputs from the participatory program? What are the outputs specific to the goals and objectives of the participatory program?	Archival
Specific Program Features	What uniquue features of the participatory program should be assesed?	All data sources possible depending on features assessed
Intervening Events	What events may have influenced the implementation and operation of the participatory program?	Observation, Program Staff

Source: Nabatchi 2012 p23

These methods enrich the evidence and analysis of processes involving participation and power in health, particularly in the manner in which the engage with the experience of those directly involved and improve the quality and credibility of the findings. As noted by Preskill and Jones (2009) in their step by step guide on soliciting input from stakeholders in the design of evaluation, these methods for direct engagement of those involved are an important means to support the relevance and credibility of the findings and the useful assessment of impact.

Box 3.1: Using storytelling as a method for evaluating practice

The Global Giving Story Project has collected and mapped tens of thousands of stories about people and organizations that produced a change. It uses digital technology to aggregate community stories and provides a means to create a continual feedback loop of information flowing in to support review and adjustment of interventions. The California Endowment fosters storytelling approaches to program evaluation that includes tools such as visual documentation, scrapbooking and story theatre.

Given many factors, facilitators and intervening events likely to be affecting practice, there are also methods for participatory identification of those factors that are most influential in or important contributors to the observed changes.

Well-being ranking, preference ranking, matrix ranking and matrix scoring are various participatory tools used to prioritise or provide relative weighting issues. Wellbeing ranking in its most common form starts with social mapping on the ground to identify households. These are then written on individual cards. Small groups sort the cards into piles (three or four pile sorting) according to whatever categories of features (eg wealth) or wellbeing (eg: self-confidence) they decide upon. **Pair wise ranking** provides a method to compare each item on a list with the other items on the list in a systematic way. Each choice is compared with all others, one by one. Both the final ranking and the information shared contribute to learning (Loewenson et al., 2014). You can read further on how to these methods at http://pubs.iied.org/pdfs/G01675.pdf.

Methods for assessing changes in outcomes

As noted in *Brief 2* the outcomes in processes of social participation and power may be related directly to these social dimensions, as an intrinsic goal in itself, and may also relate to health and health system improvements. The outcomes may be immediate reactions or learning outcomes, intermediate changes in practice or longer term institutional and situational changes (Othieno 2011). What is measured and found depends therefore on the timing of the evaluation.

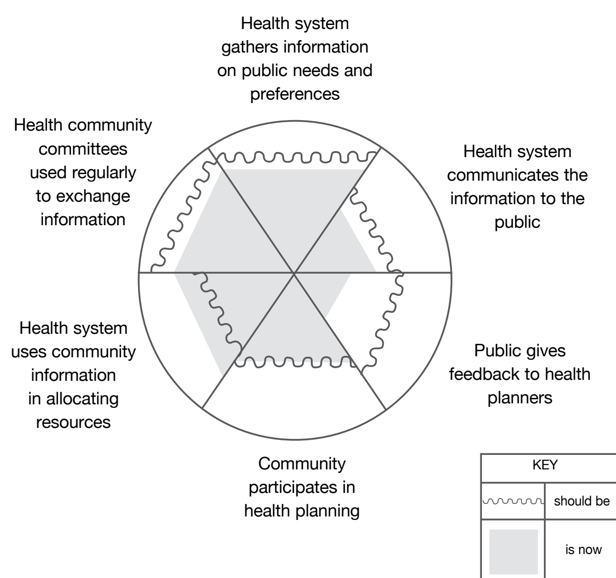
The areas and questions asked in assessments of outcomes would be included in Step 7 of setting a theory of change. They include, for example:

- What was actually implemented?
- Who did the programme serve (disaggregating the different groups)?
- What else was going on that could have affected the outcomes (other programmes, factors)?
- What short, medium and long term intended outcomes and impacts can be documented, with
- what strength of evidence?
- Can these be sustained? What is the evidence for this?
- What positive and negative unintended or unexpected effects happened? To what extent
- were these potentially under the control of the programme? (Perrin 2012).

The evidence on outcomes may be gathered through quantitative measures of health and wellbeing, of system performance or of institutional practices, depending on the issue in focus. These may be assessed from time trends in routine and survey data, as well as the key informant, focus group, observational and narrative methods described earlier. As for other aspects of change, in processes for social participation and power in health, these measures are enriched by approaches that allow for more direct collective reflection and validation by those directly involved. There are further methods for doing this:

A **wheel chart** can be used for collective review of a range of outcomes, which if repeated over time provides a quantitative means of assessing change. Participants draw a blank wheel chart and mark each "spoke" on the wheel with points from 1 to 5, with 1 nearest the centre. Each segment is labelled with the feature under inquiry, such as the outcomes or process change intended, dimensions of participation and so on. Participants collectively assess the level of the outcome. For each segment of the wheel, they discuss *the situation / outcome* and decide on the level. Once they've decided, they shade the area of the segment to show this (See *Figure 3.2*).

Figure 3.2 Wheel chart of change in outcomes



Source: Loewenson et al 2006 p55, used with permission

The wheel chart can also be used to reflect the level intended for an outcome, or *what the situation should be*. This can be marked in each segment with a squiggly line (as in the diagram). The space between the two markings creates a clear visual picture of the gap between what the situation should be (squiggly line) and what it is now (shaded area). The levels may also be quantified, to give a measure of the difference. After the chart is completed it is 'interviewed' ie groups discuss the differences over time or between areas to review what is driving – or blocking- the change (Loewenson et al 2006).

A further method for such collective review of progress against goals has been through mapping the outcomes on progress markers. This has been adapted from the Outcome Mapping approach by Earl et al. (2001). Progress markers are selected at the time of identifying action plans in terms of what participants would:

- *'Expect to see'* (usual situation)
- *'Like to see'* (improved situation)
- *'Love to see'* (more ideal situation) progress markers.

They are then used to monitor progress towards the desired outcomes of actions. Regular meetings are held to assess progress and discuss the obstacles to overcome or opportunities to tap. In the adjacent example from Lusaka, Zambia, the filled table shows how far the different progress markers jointly set by community and service personnel have been achieved (Mbwili Muleya et al., 2008).

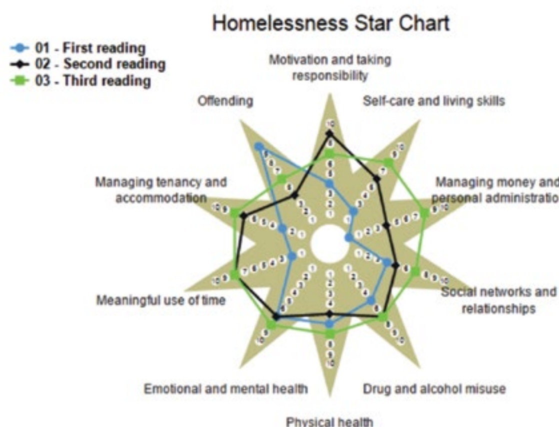
Table 3.3: Example of progress markers, Zambia

Problem: Inadequate Information And Communication On Planning Progress							
EXPECT To See Progress Markers		Progress Monitoring					
		CLINIC A			CLINIC B		
		1	2	3	1	2	3
1	HC staff meetings with CMs having schedules, agendas & minutes		Started/Ongoing	Done	Done	Done	Done
2	HC staff & CMs disseminating or sharing information on planning and any other current issues		Started/Ongoing	Done			Done
3	HC giving CMs feedback on planning activities and any other current issues as soon as it is received		Started/Ongoing	Done	Done	Done	Done
LIKE To See Progress Markers							
1	HC providing necessary materials & simplified guidelines to CMs on planning process		Started/Ongoing	Done			
2	HCs & CMs beginning the planning cycle activities without being prompted by higher level						
LOVE To See Progress Markers							
1	75% of HWs conversant with planning process						

Key: Done ■ Started/Ongoing ■ Not Started/not done □

Source: Mbwili Muleya et al., 2008 p17, used with permission

Figure 3.4 Outcomes Star



Source: © Triangle Consulting 2010-2016 in D'Ambruoso et al 2017

An 'outcome star' can similarly be used to assess progress against goals, across up to ten dimensions, as shown in *Figure 3.4*. The star can be used as a visual representation for internal discussion and review of progress and for external reporting. It can be complemented by qualitative methods, such as stories to tell people's accounts of how the actions taken and support services provided have affected change in areas such as trust and dignity for those involved (D'Ambruoso et al., 2017).

The **most significant change (MSC)** technique is a further form of participatory monitoring used throughout the stages of a programme to manage interventions that can also be used to assess outcomes. The process involves collecting significant change stories of who did what, when and why. The stories are collected by asking a simple question such as: ‘During time X, in your opinion, what was the most significant change that took place?’ The selected stories can be verified by visiting the sites of the described events. The most significant of these stories are then selected by panels of those involved through ‘searching’ for outcomes and change within agreed domains. The stories, domains selected and discussions on them are fed back to those involved and used to review against desired outcomes (Davies and Dart 2005). Unequal voices can be balanced in the process by making the information public for feedback and by having an option for an ‘any other changes’ domain in the selection to open up the breadth of change options. The method is further detailed at The ‘Most Significant Change’ (MSC) Technique: A guide to its use.

Many of these tools and those described in earlier parts of this brief can be used to explore the factors affecting outcomes. **Flow diagrams and maps** can link changes to a perceived causes, **diaries** can be used to describe the different experience of changes in different groups and **photographs** before, during and after interventions can be used to understand how changes over time affected outcomes (UNESCO 2009). Relationships across factors can be further explored through interviews and discussions of causal flow diagrams, to identify factors that have contributed to impacts. Methods such as matrix ranking and ‘spider’ diagrams can be used to assess the extent to which different actors and communities value particular outcomes.

These methods are often implemented by people more directly involved in interventions. This core group of heavily invested members of a community draw from and are seen to represent a larger group. For example, a student involved in a process may represent adolescents in his community. It is important to also include the perspective of this wider group. Some of the methods described (such as interviews, focus groups, story-telling, transect walks and progress markers) can reach out to and involve the wider community represented.

Feedback loops are a further way of drawing the perceptions of community members for participatory evaluation. The Constituent Voice Operation Cycle, shown in *Figure 3.5*, is one approach to giving the wider community a voice in evaluation. It does so through communicating findings to and collecting feedback from the wider groups and including this feedback in the analysis (Keystone 2016). A Feedback Toolkit provides further information on how this is implemented (Feedback Labs 2018).

Finally, Rogers (2012) presents methods for examining outcomes by exploring the counterfactual, or what would have happened in the absence of the intervention, including:

- **Difference-in-difference** that compares the before-and-after difference for the group receiving the intervention compared to the before-after difference for those who did not.
- **A logically constructed counterfactual** using the baseline to estimate the counterfactual.
- Matched comparisons where participants (individuals, organizations or communities) are each matched with a nonparticipant on factors that are thought to be relevant.
- **Multiple baselines or rolling baselines** that stagger implementation of an intervention across time and social groups to look for a repeated pattern in each community of a change in the measured outcome after the intervention is implemented, along with an absence of substantial fluctuations in the data at other time points, and
- A **general elimination methodology** where possible alternative explanations are identified and then investigated to see if they can be ruled out. (Roger 2012).

Figure 3.5 The Constituent Voice Operation Cycle

Source: Keystone Accountability 2016 p2 used with permission

This brief has outlined the methods and tools used in formative, process and summative / outcome stages of evaluation of social participation and power in health. As noted in the briefs, evaluation of social participation and power in health calls for "…radically rethinking who initiates and undertakes the process, and who learns or benefits from the findings" in a way that includes mutual trust and respect for the experience, skills and knowledge of all involved (IDS, 1998 in UNESCO 2009 p13). This brief has thus given most attention to methods that enable participatory evaluation, that collect evidence in ways that may be more accessible for community engagement and that may be part of an ongoing strategic planning, management, review that is itself sustained and participatory. At the same time others not directly involved, such as funders, policy makers, academics may also seek evidence of how effective efforts have been. *Brief 4* discusses how these approaches to evaluation of social power and participation in health can engage and interact with the motivations and valued outcomes of these wider actors.

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