

Making Change Visible

Evaluating Efforts to Advance Social Participation in Health



An Implementer's Resource



With support from the Robert Wood Johnson Foundation
Global Ideas Fund at Charities Aid Foundation America

This Resource was developed and authored by a team of people with professional experience in implementing and evaluating social participation in health in different countries globally. Their names and primary organisational affiliations are: Rene Loewenson (project lead), Training and Research Support Centre (TARSC); Sarah Simpson, EquiAct; Ruth Dudding, Athens City County Health Department; Francisco Obando, independent consultant, and Peter Beznec, Center for Health and Development Murska Sobota. Additional support was provided by Teri Larson, editorial consultant; and Maria Masotyia, researcher, TARSC.

The authors reviewed literature, studies, websites, guidance documents, and methods toolkits to develop and refine the contents of this Resource. The team interviewed people with diverse areas of expertise and experience working on the evaluation of SPH in different settings (termed 'key informants' in the text) to add further information and experience, and regular rounds of peer review feedback and guidance from those implementing participatory health improvement programs.

Acknowledgements

The project team gratefully thanks the peer reviewers: Josie Williams, Roberta Delgado, Matt Leighninger, Kari Boyle, Megan Buskirk, Sharri Lynne Oliver, Megan Inada, Ann Hwang, Bill Wagner, Roberta Waite, Beth Tanzman, Maurine Gilbert, Vanessa Ivie, Barbara Kaim, Pia Vracko, Renee Hodin and Susan Mende. We also thank the colleagues who gave key informant interviews: Tatjana Buzeti, Juan Pablo Orjuela Mendoza, Roger Skies, Elizabeth Harris, Edward Andersson, Richard Crespo, and Marilyn Wise. We are very grateful to Melissa Thomas, of Project Hoffnung and Ohio University, for sharing information on her work with Amish and Mennonite women in the Appalachian region of Ohio.

All graphics and photographs are appropriately credited and used either with permissions, under creative commons licenses, or GNU Free Documentation License. Our thanks also to the International Federation of Red Cross and Red Crescent Societies, which permitted use of cartoons from its [Project/program monitoring and evaluation \(M&E\) guide](#).

Finally, thank you to our colleagues at the Robert Wood Johnson Foundation Global Ideas Fund at Charities Aid Foundation America (CAFA) for their financial support. The views expressed herein are those of the authors and do not necessarily reflect the views of the RWJF and CAFA.

Cite as: Loewenson R, Simpson S, Dudding R, Obando F, Beznec P (2021) Making Change Visible: Evaluating Efforts to Advance Social Participation in Health, An Implementer's Resource, TARSC

Co-ordinated and produced by Training and Research Support Centre (TARSC), 2021

Making Change Visible

Evaluating Efforts to Advance Social Participation in Health



An Implementer's Resource



With support from the Robert Wood Johnson Foundation
Global Ideas Fund at CAF America

Making Change Visible: Evaluating Efforts to Advance Social Participation in Health

Welcome!

If you are responsible for—or engaged or interested in—advancing social/community participation in health in your local area, we developed this resource for you.

Around the world, people like you are taking charge of and engaging around their own health and the health of their communities. They are participating in a range of decisions and actions that improve health, including promoting equitable, fair, and effective use of resources for health.

For purposes of this publication, we're calling you, our readers, 'implementers' because you are implementing a health intervention that integrates social participation. You may more readily recognize yourselves as health practitioners, community leaders, local managers, program directors, or something similar. You may work for any one of a variety of for-profit or non-profit institutions, including health systems, insurance providers, government agencies, community-based organisations, foundations, or other.

This resource is also useful for those who work with implementers, including health system managers; academic researchers; program planners, facilitators, and trainers; and people in government agencies and non-profit organisations interested in building and supporting thriving communities. These professionals may have a role in designing and evaluating work on social participation in health, in facilitating its implementation, or in using its findings. This Implementer's Resource may also be helpful for funders who support programming in this area.

You may know social participation in health (SPH) by another name, such as 'community engagement in health' or 'community participation in health.' While there are many different terms used, we define social participation in health as: people's individual and collective power and meaningful involvement in shaping the conditions, decisions, and actions that affect their health and health services.

There are a variety of resources available on how to organise SPH, but there is limited guidance on how to evaluate its effectiveness. This publication fills that gap for those in a position to make decisions or take actions to advance SPH. This resource is thus not about how to implement SPH in your community, but rather how to evaluate your efforts on SPH. There are general resources on monitoring and evaluation, and some of the methods and tools in this Resource draw on that general body of knowledge, but we apply it to helping you answer the question: *what differences are our SPH efforts making?*

This Resource will help you and your colleagues conduct a *baseline assessment*, creating a critical reference point at the start of your SPH program that will help you plan your work and enable you to track changes as they are achieved. It will guide you in carrying out a *performance evaluation*, which will tell you how well the SPH intervention is performing as you are implementing it and if it is producing the intended actions and outputs within the desired time frames. Finally, it explains how to conduct an *outcome or impact evaluation*, assessing the changes achieved, directly and indirectly, as a result of the SPH intervention.

Contents

Part 1

Introduction.....1.1

Setting the scene: the contribution of social participation in health1.2

- What is social participation in health and what role does it play?
- How can we tell what difference SPH makes in health?
- What role does evaluation play in SPH?
- What skills and resources do we need?

Taking values and ethics into account1.9

Part 2

Establishing a Baseline2.1

Establishing a baseline and a theory of change2.2

- What is a theory of change and how do we develop one?

The evidence to include in a baseline assessment2.4

- What evidence do we include on SPH?
- How do we decide what to collect and from where?

Methods for a baseline assessment 2.10

- What methods can gather evidence on communities and their conditions?
- What methods can gather evidence on stakeholders?
- What methods are used to gather evidence on services?
- How do we ensure the quality of the evidence?

Organising, communicating, and using the findings..... 2.18

Planning for challenges 2.21

Part 3

Assessing Progress in Implementing the SPH Intervention.....3.1

Assessing whether SPH work is on the right path3.2

The evidence to include in a performance evaluation.....3.2

Methods for a performance evaluation3.4

- How do we assess changes in the context?
- How do we assess experience or acceptance of the intervention?
- How do we assess the inputs, outputs, organisation, and performance?
- How do we assess how effectively funds and other resources are being used?
- Can we do these methods online?

Organising, communicating, and using the findings 3.10

- How do we organise the information?
- How do we report on the progress?

Planning for challenges 3.13

Part 4

Assessing Outcomes and Impacts after an Intervention4.1

Assessing the changes from SPH interventions.....4.2

- When do we do an outcome or impact evaluation?

The evidence to include in an outcome or impact evaluation4.3

- What measures do we use to assess cost benefit?

Methods for an outcome or impact evaluation4.6

- How do we assess changes in context, inputs, actions, and outputs?
- How do we assess changes in the participants and beneficiaries?
- How do we assess outcomes?
- How do we assess impacts?
- How do we measure the cost benefit of the intervention?

Organising, communicating, and using the findings 4.13

- How do we show the outcomes and impacts of the intervention?

Planning for challenges 4.17

- Reflecting with the team

Part 5

Worksheets, Resources and Next Steps5.1

Next steps5.2

Overview of methods, tools, and their uses 5.3

Glossary.....5.7

References5.9

Resources for more information and support 5.12

Worksheets: 5.13

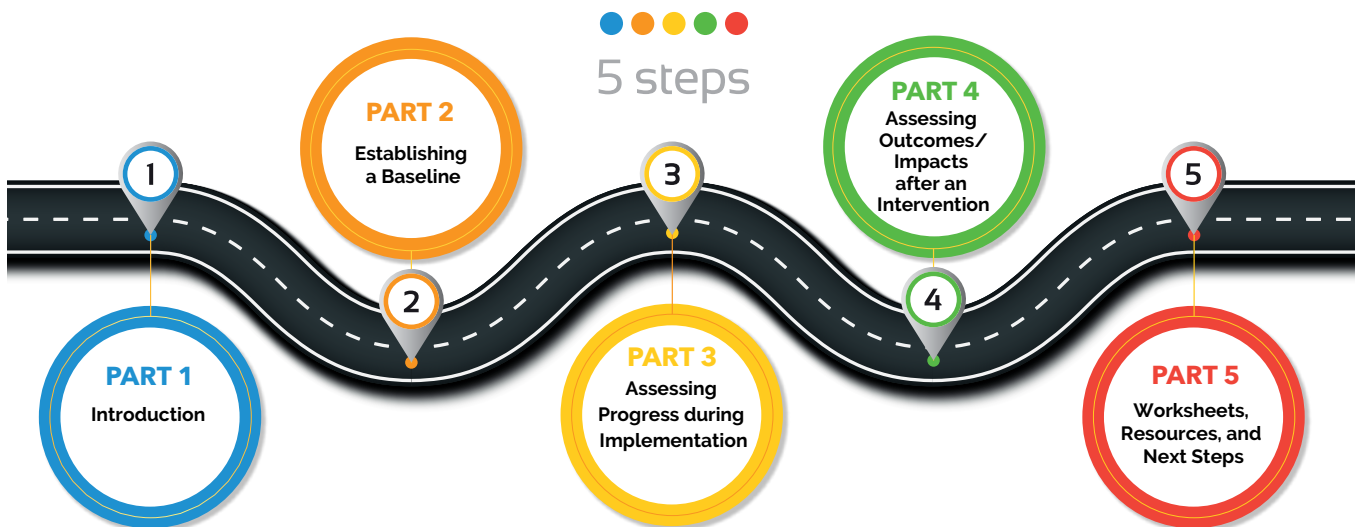
How to use this Resource

We recommend that, first, you read through the Implementers' Resource from beginning to end, to provide yourself with an overview of the different stages and types of evaluation and methods. This is especially helpful if you have little to no experience with evaluation. We suggest that you then work through the resource in sequential order, as it presents a full evaluation process from the beginning to the end of an intervention.

Navigating the document

The Implementers' Resource contains five parts as shown on the navigation roadmap below.

We have tried to make it as easy as possible to navigate this resource. In the Contents on the previous page, you are able to access each section or page by clicking on the headings. There are also tabs at the top of every page for easy access to any of the five parts.



Reference to worksheets appear throughout, with the full worksheets provided at the end of the Resource. They will take you and your colleagues through practical exercises that clarify the information and help you practice the skills described in the text. Links to worksheets are located at the ends of various sections, assuming you will want to complete them after you have read the relevant text. You may also decide to use them as an entry point into a particular topic. For example, you and your team may choose to read and complete as much as you can of a particular worksheet. After this you may then read the relevant text in order to help you finish the worksheet.

We designed the resource to be easy to read and use. It contains lots of visual cues and tips, and it divides information into separate sections that correspond with various phases of evaluation. Parts 2, 3 and 4 each contain a table that summarizes the methods and tools covered in that section. [Part 5 contains a table](#) that summarizes all the methods and tools in all three parts. There are also links between related pieces of information across the different sections to help you connect similar concepts and processes. We did this so that users like you and your colleagues can dip in and out of the Resource as needed—to refresh your

memory, to answer a specific question, to find a particular example, or to pull out a worksheet exercise. We hope you find the resource both informative and easy to navigate.

'How to' information and guidance



Yellow text boxes like this one feature practical 'how to' information and guidance.

More resources



This icon indicates links to more comprehensive guidance for methods described.

Real-world examples



Green text boxes offer real-world examples of social participation in health.

Worksheets



Orange text boxes alert you that a worksheet is available on the topic just covered.

Definitions



This icon signifies the definition of a key term used in the text. The terms are also compiled in the [glossary in Part 5](#).



Mural on awareness of violence against women, Chile © Fundación EPES, 2016

Part 1: Introduction

What you will find in Part 1

Introduction

1.1

Setting the scene: the contribution of social participation in health	1.2
Taking values and ethics into account	1.9



An evaluation story in Amish and Mennonite communities

Ohio is home to two of the world's largest Amish and Mennonite communities. Among women under 60 in these communities, breast cancer was the leading cause of death. Barriers to breast cancer screening services were identified, including local beliefs about health and health care, the need to travel long distances to access services, and language. In 1997, [Project Hoffnung](#), working with and steered by community-based coalitions in the region, [began providing cancer outreach](#) to the Amish and Mennonite communities, providing a bridge between local community cultures and breast cancer care. The project team, comprised of community members and health workers, provided information, free mammography screenings, and follow-up support to help women prevent and manage breast cancer. Local communities saw the need to evaluate their progress and outcomes and mobilised funding for this. Amish and Mennonite team members brought an understanding of the communities and their cultures to the team, which also included non-Amish members from rural Ohio and Ohio University. The team planned its evaluation of the intervention.

We will follow the team's story through each part of this resource to see how the evaluation was designed and implemented, and how results were communicated.

Part 1: Introduction

Setting the scene: the contribution of social participation in health

We live in a time of increasing expectations for improved health and health services. It is also a time when social and economic inequalities and socio-political choices and systems are raising unprecedented risks for health, including through pandemics and climate change. Our technical knowledge is advancing, but these challenges highlight that to improve health we also need to understand and intervene on the social factors that affect health and to evaluate how these factors contribute to improvements in health.

What is social participation in health and what role does it play?

Social participation in health (SPH), also termed community engagement in health, draws on shared values and goals. It develops literacy, practices, and capabilities in communities to improve the conditions and services that affect health. It brings community needs, priorities, and capacities into planning and deciding services and makes services accountable to communities. It encourages services to use community-based and population health approaches, especially at the primary care level. [Chile's shift to a biopsychosocial family and community health model](#) is an example of this.

A community is any group of people who share some of the same characteristics, such as location, age, race, ethnicity, ability, experience, interests, or other commonalities. SPH doesn't necessarily mean that everyone in the community should participate, but that everyone has the opportunity to do so.

SPH has various features that reflect the important role people play in improving health:

- It is **intrinsic to people's identities**, reflecting their social values, rights, and democratic goals.
- It **engages people's rights, capacities, and power** to participate in and influence decisions that affect their health.
- The power and impact people have in directing resources to promote health—or to address ill health or its causes—contribute to **equity in health** and fair use of available resources.
- It **involves communities, families and clients of health services** in sharing

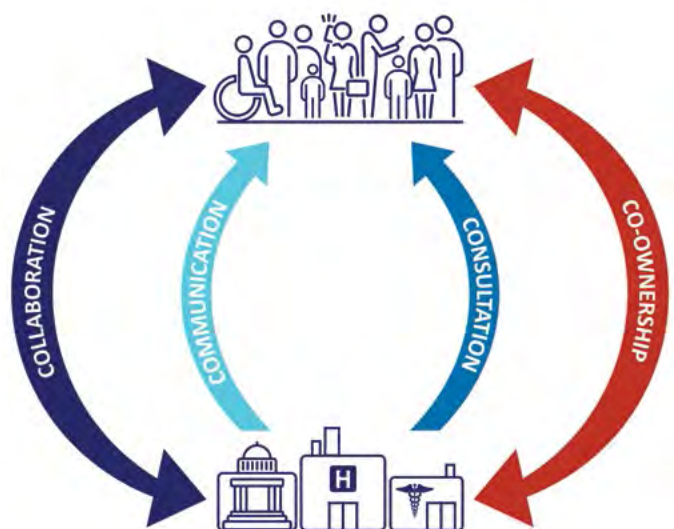
information and resources; in decision-making and actions that contribute to the quality and effectiveness of health services and that improve health.

- It takes place at **different levels of the health system** and involves varying forms of information sharing, consultation, collaboration, joint action, joint decisionmaking and co-ownership between the health system and the community.

SPH is visually represented in different ways. Ladders have been used to show increasing levels of participation, while flow diagrams, such as *Figure 1a*, show the connections between different forms of participation.

SPH may be initiated from within the community or by outside institutions. It takes place within formal and informal structures, such as health committees and social meetings. It also results from formal processes, such as accreditation standards (like those described below), and informal processes, such as social networks.

Figure 1a: A flow diagram of participation



COLLABORATION	COMMUNICATION	CONSULTATION	CO-OWNERSHIP
<i>Organization cooperates, jointly designs and participates</i>	<i>Organization shares information</i>	<i>Organization seeks information</i>	<i>Organization shares decision-making</i>
Examples include:	Examples include:	Examples include:	Examples include:
Advisory or quality improvement committees	Newsletters and ads/emails to promote services	Key informant interviews	Strategic planning committees
Skill-building training for patients	Health fairs	Surveys	Governance board membership for patients
		Listening sessions and Focus groups	

Source: Hodin et al., 2020:7

SPH may be open to everyone, such as through public meetings or gatherings, or participation may require a formal invitation to a closed session. It may be claimed by social networks through protest or legal and political action. It may be applied in a single event, like a budget hearing, but also in sustained processes, such as those used to manage the functioning of systems



Standards for authentic community engagement in the USA

In the USA, the federal Centers for Disease Control and Prevention (CDC) established principles for community engagement that informed the [Public Health Accreditation Board's standards](#) for what constitutes authentic or meaningful community engagement. These standards refer to relationships of trust built through working *with* not *for* communities. This means working in community-based settings, co-creating solutions with formal and informal community leaders and organisations as well as those community members who choose to participate. It involves listening to key community concerns, including those raised by rarely heard voices, and building shared understanding, expectations, and priorities for collaborative action. It implies awareness of historical contexts, social differences, power imbalances, and previous attempts at engagement, including the lessons and tensions that were raised. The CDC's principles state: *Remember and accept that collective self-determination is the responsibility and right of all people in a community. No external entity should assume it can bestow on a community the power to act in its own self-interest* ([Minnesota Department of Health](#), 2018: 23-25).

SPH takes many forms and functions at varying levels of inclusiveness; intensity of engagement; and influence on decision-making, conditions, and systems.

The [Shaping health](#) consortium of institutions, which worked on SPH in different countries, identified some shared principles (Loewenson et al., 2017). These principles suggest that meaningful SPH:

- Draws on community experience, knowledge, activism, and leadership.
- Involves people collectively assuming control over their lives, changing the power relations that play a role in health towards collective forms of power and self-confidence.

- Flourishes best when grounded within community settings, such as schools, markets, workplaces, sports venues, and other types of gathering spaces; and when supported by health care services that are holistic, comprehensive, people centred, and population health focused.
- Enables two-way interactions between the discussions in informal and formal spaces.
- Uses participatory processes to gather, analyse, discuss, and share community information, evidence, and knowledge in planning and decision making.
- Leads to co-determination and shared plans, actions, and resources.
- Requires facilitation, time, and consistent effort.
- Uses strategic review and evaluation to show progress in health and outcomes and build learning from action.

This Implementer's Resource is not about implementing SPH in your community. There are many other resources for this, such as those developed by [Shaping health](#). This resource is about evaluating SPH interventions. We do not focus on one particular form, intensity, or degree of SPH or community engagement. We recognize that the details vary from place to place. Instead, we present diverse methods and tools so that you may choose what best fits your own context and activities.

We do focus, however, on SPH interventions that are organised and implemented in local (district, municipal, state) health systems and focused on the *collective* participation of groups of people in their health systems, rather than on individual patients in their own health care.

How can we tell what difference SPH makes in health?

Investing resources into SPH or any type of intervention requires due diligence and generates tough questions.

- How do we know whether SPH efforts are producing positive changes?
- How do we know what SPH interventions will make the improvements we intend?
- How do we assess which SPH interventions work best in our community and health systems?

The stories overleaf, which come from very different settings, show how SPH can lead to improved health and health services in communities.



Health gains in a community-controlled health service in Australia

In Australia, the Looma Healthy Lifestyle SPH intervention helped prevent diabetes, obesity, and cardiovascular disease in an Aboriginal community. These outcomes were better in the population serviced by a community-controlled Urapuntja Health Service than in other areas. While SPH cannot substitute for the delivery of essential services, it was acknowledged to have contributed to these improvements, ([Rowley et al., 2000](#)).

Bogota, how are we doing?

In a multi-stakeholder initiative in Bogota, Colombia, a survey was used to assess the quality of child health services from the community's perspective, and findings were published as a report card with recommended improvements. The process increased the transparency of local government and informed official dialogue around measures to improve services. The initiative was sustained for over 17 years and improved the transparency, accountability, and delivery of and access to public services ([ELLA, 2012](#)).

Gains from participatory budgeting in Russia

A participatory budgeting and planning initiative in St. Petersburg, Russia, demystified the city budgeting process for the public. It identified new resources for social programs and proposed budget changes to address local priorities for education and care of people with disabilities. The proposed changes were integrated into the city budget. The process provided a forum for public debates on local government priorities and led to increased awareness of and input into the city's strategic planning ([Vinogradova, 2002](#)).

SPH views active citizenship and co-determination as a right in democratic systems and as an expectation in an increasingly literate society. Socio-economic inequalities and prejudices can deprive many in society of the right to participate, generating distrust and frustration. The more stratified and unequal a society, the more important it is for people to have some voice in their health and health services. SPH may be abandoned during crises such as epidemics, but these are in fact times when social action is most needed.

SPH processes are usually complex, making it difficult to attribute changes to particular actions. Those involved may be cautious about the motivations of those assessing the effects of their SPH efforts.



Source: UNESCO, 2009:2-3

It is important, however, to share evidence regarding positive changes and learning from SPH practice, especially when the practice is innovative. Evidence of progress can build confidence in the innovation and can also show where to make improvements. It can show whether resources are being effectively used to achieve desired goals and provide feedback to communities and others who have contributed.

Different stakeholders may have different reasons for wanting to assess the impact of SPH:

- SPH implementers may ask: *Is the process working? How can it be improved? Are we achieving the aims? What caused the changes?*
- Local community members, including residents, may want to know: *Did SPH make a difference to my health and to the quality of services we receive? Was the effort I made fair and useful? Are we being listened to?*
- Managers may ask: *Are the SPH efforts contributing to overall system goals? Do they meet the objectives for formal reporting?*
- Funders may want to know: *Was best use made of resources for the outcomes achieved?* Standards authorities, such as the [National Public Health Accreditation Board](#) or the [Patient-Centered Outcomes Research Institute](#), may ask: *Did the interventions meet our standards for community engagement?*
- Academics may ask: *What generalisable learning and knowledge can be shared?* (Aslin and Brown, 2004)

As one key informant observed, policies often propose things people can do to be healthy, *but do not consider the barriers that exist for certain groups to actually carry out those healthy actions*. Early dialogue with communities and other key groups can help to build a shared understanding of their different concerns, issues, assumptions, and constraints. The example below shows how one evaluation listened to and integrated

concerns from communities, providers, and funders, to produce evidence that would show the value of the SPH intervention.

Assessing SPH efforts helps to clarify plans and goals for the range of people involved. It can build accountability as work progresses and improve practice by sharing learning on what works.



An evaluation story on showing the returns from investing in community health workers, USA

Community health workers (CHWs) are found in many countries. These community-based lay workers facilitate participation of local residents in health promotion and prevention. In the tri-state area encompassing seven counties in Kentucky, Ohio, and West Virginia, chronic conditions, such as diabetes and heart disease, are costly for households and public providers, especially when people visit hospital emergency rooms for problems that could have been managed earlier or prevented. [CHWs, deployed as an SPH intervention, can improve management of chronic diseases](#). They can promote healthy eating, physical activity, and early use of primary care services—all of which help reduce the need for more costly emergency services. Unfortunately, insurers generally do not cover the costs of these inputs. An evaluation by the Marshall University Chronic Care team of a local CHW intervention sought to persuade Medicare, Medicaid, private health insurers and health care providers to invest in monthly payments for outreach and education services provided by CHWs.

The evaluation team learned from people working in Ecuador that the process starts by listening to what people talk about, what's important to them, and understanding and respecting their culture. *Baseline work is about putting your walking shoes on and getting to know the people*, said one of the team members. The team began their baseline evaluation by meeting with and listening to local stakeholders, including CHWs and payers (funders). They reviewed evidence on chronic health problems in the area, including how patients were using services and what was reimbursable by insurers. This provided baseline information on the most costly conditions on which CHWs could have the greatest impact. The team hoped that eventually the performance and outcome evaluations would demonstrate how use of CHWs creates cost savings by reducing acute care visits—thus, convincing insurers to pay for services provided by CHWs.

The team also needed to build providers' confidence in CHWs, convincing them to take the time to refer their patients to a CHW or chronic care team. To help initiate the process, a philanthropic organisation took on the initial costs of the CHW program. During this phase, the team regularly collected and reported on data on hospital and emergency visits and on other health care indicators and patient practices, and shared [stories from CHWs](#). During quarterly meetings, the team reported on this performance evaluation and shared stories of successful CHW interventions—all of which helped insurers and providers to build trusting relationships.

The quarterly meetings showed the evaluation team that payers cared most about realizing cost savings related to high-cost procedures, while providers cared most about improving health outcomes, such as reductions in blood pressure levels and acute emergencies. The evaluation gathered evidence related to both priorities. CHW activities generated USD6000 in monthly savings due to reduced acute emergencies and emergency/hospital visits. A single CHW working with 20 high-utilising patients could save USD120 000 per year against their annual cost of USD30 000. The team checked this savings calculation with two insurers. The evaluation demonstrated both the positive impacts on patient health and cost savings, and revealed that CHWs essentially pay for themselves and then some.

These results were shared with the CHWs, health providers, and funders. The evidence supported the wider development of a CHW workforce in the tri-state area. It brought payers and providers to the same table to explore payment structures that support community-based care for high utilizers through an impact investment model. By publishing the results in the CDC's [Preventing Chronic Disease](#) journal, the evaluation team was able to disseminate information about CHWs more widely and inspire broader application of the model and its evaluation in other states. An impact investment model has been used by Medicare for other interventions and is an established payment structure.

Source: Interview, R. Crespo, Marshall University, 2020; Rural Health Information Hub, 2020

What role does evaluation play in SPH?



Evaluation is a systematic and analytic inquiry. It aims to obtain information about what is taking place and why, to inform review and planning while work is underway, and to identify whether and how the actions contributed to the intended changes.

Most people likely think of evaluation as something that happens at the end of a program or intervention to assess its impact. However, as shown in *Figure 1b* below, evaluations have many other roles. An evaluation occurs in tandem with an SPH program, progressing through key steps, to play a role in providing information to plan, assess the performance of and progress in the SPH intervention, to inform course corrections and to review and show its outcomes.

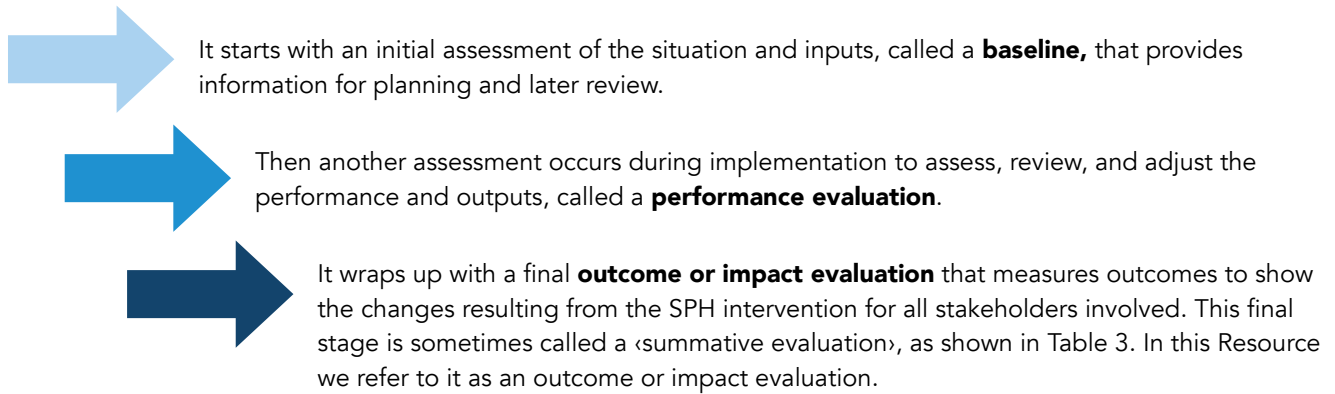


Figure 1b

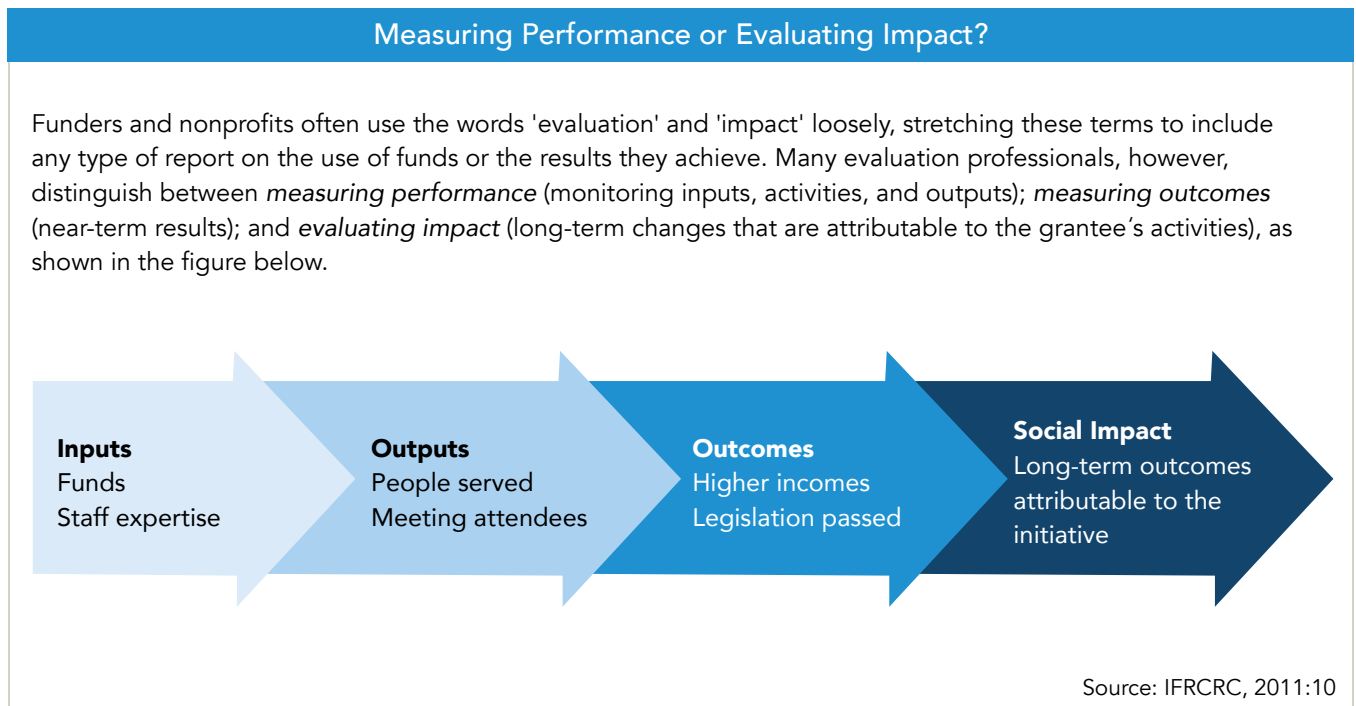


Table 1a shows the different stages of evaluations, as well as when they take place in an intervention and the role that each plays. In this resource, we refer often to these three stages and have structured the resource around them.

While the figure and table suggest that you can work through these different stages in a logical, sequential manner, this is not always the case. In complex systems, as with many SPH interventions, a performance evaluation may raise issues that call for new baseline evidence, while an evaluation of outcomes may require further performance review to understand what contributed to the changes. We discuss this further in [Part 3](#).

Table 1a: Different stages of evaluations, when they are done and their roles

Stage of a process	Type of evaluation	Its role or purpose	Information gathered
At the start of an intervention	Baseline assessment	Provides information to plan programs and for later comparisons for evaluations.	Context, conditions, actors, and systems that need to be considered or monitored
During implementation	Process or performance evaluation	Determines whether a program is being delivered as intended to the targeted recipients. Can also assess intermediary outcomes that it intends to achieve.	Inputs, or the resources for the activities and or the actions taken; and outputs, or what was delivered
When the intervention is finished or has been ongoing for a substantial period	Summative evaluation	Informs judgments about whether the program goals and objectives were met	All of the items above and below that are relevant to the goals
	Outcome evaluation	Focuses on the observable changes or outcomes that a program is expected to achieve.	Outcomes, or changes, without assuming that the intervention caused them
	Impact evaluation	Examines the changes produced that can be attributed to the program and identifies factors that caused the changes	Impacts, or the changes, particularly those caused by the intervention, and factors that led to them

Sources: NIH, 2011; Lennie et al., 2011; Perrin, 2012

At every stage of an intervention and evaluation, it is important to 'keep an eye' on **equity**, that is avoiding unfair or preventable differences in health among population groups. The social, gender, economic, and other inequalities found in communities affect people's participation in, uptake of, and benefit from SPH interventions. *We, thus, need to go beyond numbers and obtain evidence on inequities in ways that are enabling for disadvantaged groups. We need to do this during the baseline evaluation to help design the intervention, and during subsequent evaluation phases to assess how well the intervention is reaching and leading to changes for different groups.*

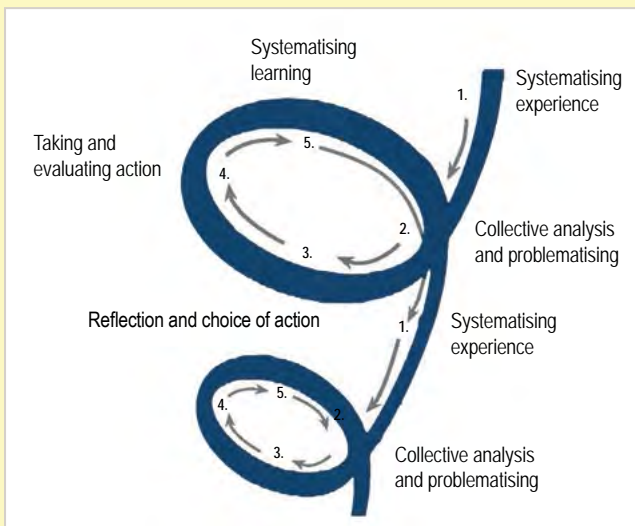
As the intention of a relevant intervention is to promote SPH, it is also pertinent for the evaluation of that intervention to be participatory. This implies involving those directly affected by the intervention in the evaluation. They should have the opportunity to participate in drafting the questions, and in gathering, interpreting, and reporting the evidence. Involving affected communities from the start can yield evidence that is not accessible to others. It brings a context-relevant lens to interpretation of evidence, can spark ideas and dialogue, and leads to better uptake of findings. We discuss how to do this in subsequent sections.

i Participatory action research (PAR) is one form of **participatory evaluation** where communities and local implementers take on the role of researchers.

As shown in *Figure 1c*, participants draw on and validate local experience and analyse it to identify problems and their causes. PAR has enabled the active involvement of more disadvantaged/excluded groups, using accessible methods that start with their own experiences.

This is used to plan, to take and review action, and to learn from it. The process engages with the lived experiences of and builds collective power amongst those involved. It can thus contribute to equity (Loewenson et al., 2014).

Figure 1c: the PAR cycle



Loewenson et al., 2014:13



Go to worksheet 1.1: With your team, identify the different stakeholders who may be interested in or may benefit from your SPH evaluation and discuss what they may want to know.

What skills and resources do we need?

Evaluations can make people anxious about what may be demanded of them. You may want to assess your SPH work, but you may also be worried whether you have the time, skills, and resources to do it effectively. Are any of the myths below keeping you from evaluating your SPH work?



Myths that stop people from doing evaluations

Myth: Evaluation is a complex science and I don't have time to learn it. No, evaluation is a practical activity. If you can manage a project, you can implement an evaluation.

Myth: Evaluation is an event to get over with and then move on. No, it's an ongoing process and you are already doing many of the necessary activities.

Myth: Evaluation is a whole new set of activities and we don't have the resources. No, most of the activities are standard management activities that your organisation needs to do.

Myth: There's a "right" way to do an outcome evaluation. What if I don't get it right? No, each evaluation process is somewhat different, depending on the needs and nature of your organisation, programs, and issues. Start simple and learn as you go.

Myth: Funders will accept or reject my evaluation plans. No, enlightened funders will work with you to suggest improvements.

Myth: I know what my clients need. I don't need outcome evaluation to tell me this. You may not know what you don't know about community needs. An evaluation helps you and your organisation to be aware of these needs. (McNamara, 2017).

Don't let these myths put you off evaluation! It will take time and resources, as does work on SPH, but it is possible to plan and implement an evaluation in a way that fits your resources, time, and capacities. This resource outlines a range of methods that can be done in creative ways by local health teams and communities.

[According to an online evaluation guide](#) aimed at non-profit organisations with very limited resources: 20% of the effort usually generates 80% of results. Avoid making things too complex! Instead, start now, start small, and grow as you are able.

Many of the skills you use to plan, organise, and implement SPH interventions are also useful for evaluating them. Facilitation skills are key and include the abilities to ask questions and to draw out and capture ideas and perspectives. Facilitators need to be able to build consensus around analysis and learning. They need to have cultural sensitivity, respect for diversity, and an ability to resolve conflict. They need to be able to see things through the lenses of others and be sensitive to hidden agendas on the one hand, and voices that are not being heard on the other hand. They must have enough authority to keep processes on track and diplomacy to include as many different people in the discussions as possible, especially those who may be less confident, powerful, or outspoken.

Your team will also need a mix of different language skills and experiences. Choosing a project name and logo can help to generate co-operation and a feeling of being part of a shared process amongst diverse team members. You may also need to engage outside help for some skills, such as in survey design, data analysis, and budget management. Knowledge of economics, the law, and communications is usually needed. One key informant commented that recruiting help from outside experts can bring a new, unbiased view and credibility to the evaluation project. The same interviewee also noted that anyone who comes in from the outside needs to thoroughly understand the program goals and *walk through the program with the team*.



There are [guides on how to be a good facilitator and processes to build facilitation skills](#).



Go to worksheet 1.2: With your team, discuss the evaluation-related knowledge, skills, and capacities you and your colleagues already possess, as well as those you still need and how to fill the gaps. You may return to this as you clarify plans for the evaluation.

Taking values and ethics into account

SPH efforts are informed by the values of equity, solidarity, and mutual respect. Evaluations of SPH work may be expected to uphold the same values. There are standards for ensuring that evaluations are conducted legally, ethically, and with regard for the welfare of those involved, especially people in vulnerable situations. These standards include the following.

- **Utility standards** ensure that the evaluation meets the information needs of intended users.
- **Feasibility standards** ensure that the evaluation's scope and methods are realistic.
- **Accuracy standards** ensure that evaluations employ valid methods.
- **Ethical standards** ensure that everyone involved, especially marginalised groups, are fairly treated and protected from harm, that they provide informed consent, participate voluntarily, and are informed of the results (NIH 2011).



Evaluating health with Aboriginal and Torres Strait Islanders

An evaluation framework was developed to assess policies, programs, and services for Aboriginal and Torres Strait Islander people in Australia. Key elements of the evaluation included Aboriginal involvement in setting the contract, determining ethical standards and data ownership, designing the evaluation, keeping evaluators accountable to the community, partnering in the implementation, and sharing knowledge and feedback (Kelaher et al, 2018).



You can find useful templates (such as informed consent forms) in the [Real People Real Data Toolkit](#).



Ethical principles for evaluation of SPH interventions

Consider the following when designing and implementing SPH evaluations.

- Be transparent about ownership of the process and seek fair representation from all stakeholders as early as possible in decisions. Be transparent regarding available resources, roles, demands, and constraints. As much as possible, aim for understanding and consensus on decisions and seek feedback on outcomes from everyone.
- Respect different forms of knowledge, including local knowledge acquired through lived experiences, specialised knowledge based on expertise, and strategic knowledge from politicians and community leaders.
- Ensure honesty, accuracy, and quality in the collection of evidence. Do not adjust or exclude evidence that might conflict with program objectives.
- In data collection, uphold the principle of do no harm. Respect that certain information can endanger or embarrass respondents, and seek to maximize the benefits and reduce any unnecessary harm that might occur. Report any wrongdoing that may harm others.
- Implement evaluations in ways that are responsive, participatory, and fair. Find ways to consult and involve beneficiaries and build local capacities. Avoid allowing one set of interests to dominate others.
- Protect the confidentiality of individual and personal data, including through secure data analysis, and storage.
- Give clear explanations of ethical issues so they are understood by all participants.
- Ensure inclusion and fair representation, and avoid exclusions, such as on the basis of language or logistics. Do not rely on group leaders to nominate participants or on self-nominations. Ensure effective communication in accessible languages.
- Ensure that the processes are fair, open, inclusive, and accountable and follow the principle of free, prior, and informed consent (FPIC). Allow people to give or withhold consent to a process that may affect them and to negotiate the conditions under which it will be designed and implemented. Explain that participation is voluntary and that participants may, without prejudice, withdraw at any time or choose not answer any question.
- Ensure that participants are fairly compensated for transportation costs and/or provided with refreshments, but that they are not paid for their answers or involvement.
- Ensure that those involved agree to the public release and dissemination of results, including the contents, format, and timing of the release.
- Ensure that stakeholders can provide comment and voice any complaints about the work, with a process for reviewing and responding concerns/grievances.

Sources: Aslin and Brown, 2004; Jackson and Kassam, 1998; IFRCRC, 2011; Brown, 2013; FAO, 2016



Herder Community Survey, Eastern Steppe Mongolia . USAID Biodiversity & Forestry under CC

Part 2: Establishing a Baseline

What you will find in Part 2

Establishing a Baseline	2.1
Establishing a baseline and a theory of change	2.2
The evidence to include in a baseline assessment	2.4
Methods for a baseline assessment	2.10
Organising, communicating, and using the findings.....	2.18
Planning for challenges	2.21



An evaluation story in Amish and Mennonite communities, continued...

Let's return to the team evaluating the SPH intervention in the Amish and Mennonite communities in Ohio. The team's first step was a baseline assessment. A team member said, *the first thing we did was see what was out there*. The team needed to know the burden of breast cancer and to better understand the local risk factors. The baseline found out what community members [thought and wanted to know, and how they wanted to access services](#). The assessment was participatory, guided by an advisory group of all key stakeholders, and used tools from the Transformative Participatory Evaluation Model of the [Patient Centered Outcomes Research Institute](#). The assessment also sought to measure knowledge and behaviour regarding breast cancer screening, which funders hoped to see change in, and indicators of power and shared leadership that the team saw as important for the change. The findings were used to develop a more culturally appropriate program, one that would take religious and community values and conditions into consideration. The assessment helped persuade local health authorities to support the comprehensive mobile services that the community preferred. The information gathered would be useful later in assessing whether the program was engaging and making a difference in these communities. We will pick up this next stage of the story in Part 3 of the Resource.

Part 2: Establishing a baseline

Establishing a baseline and a theory of change

To measure if and how well your SPH efforts are progressing, you need to know your starting point. Gathering evidence on the current situation provides a baseline to inform discussions on desired changes, including how to achieve them and how to measure success.



A baseline assessment provides information about the conditions that exist before a program or intervention starts. It provides a reference point against which you can measure changes achieved during and at the end of a program or intervention.

A baseline assessment is usually done before the intervention begins. As noted in the example featuring CHWs in [Part 1](#), it is a process of listening and learning. It not only provides evidence for use in planning and later assessing change, it also helps in understanding and engaging with the different people and interests involved in the SPH intervention. It can help to identify any potential problems or conflicts and elicit ideas for and build confidence in the feasibility of desired changes. SPH programs and processes do not, however, always have distinct beginnings and endings. In this case, a baseline assessment can be done when a change or innovation is being introduced into an existing program.

The evidence collected in a baseline assessment can convince local authorities and funders of the need for and feasibility of an intervention, as shown in the Los Angeles example in the next column. A baseline assessment gathers evidence, but also stimulates communication around what change is possible, what success would look like, and what actions and roles could achieve success.

What is a theory of change and how do we develop one?

Consciously or not, we develop ideas or theories about what will produce the changes we seek in different areas. It starts with being clear on what success will look like or what changes we seek to achieve. These goals may differ among stakeholders, which makes it important to discuss and reconcile any differences at the outset. Involving people who are directly affected can build social momentum for and understanding of the SPH intervention, and of its limitations. When discussing how to achieve the desired changes, we make assumptions based on many factors, including our beliefs and perceptions.



Gathering data to make the case in Los Angeles

In 2015, the Los Angeles Department of Parks and Recreation in California undertook a baseline needs assessment as a first step toward addressing health equity and engaging county residents in decisions about public parks and recreation resources. A steering committee appointed by the county guided the work. A public engagement expert trained over 300 facilitators and community organisations in the county. Following extensive outreach, the needs assessment data was gathered from thousands of county residents through community workshops held in 188 study areas between December 2015 and February 2016. When presented publicly, the findings were so compelling that the county board of supervisors put a parks funding measure on the ballot in November 2016. Due in large part to the extensive community engagement during the assessment as well as the effective dissemination of public information, the measure was passed with nearly 75% of voters supporting it. The measure provides the county's public parks with about \$94 million annually. ([NRPA, undated](#))

The evidence we gather can test these assumptions and support planning. The steps in an intervention that lead to a change can be organised within a table to show the sequence of activities and components. They can be presented as a flowchart, a table, or a road map, as shown in the photo.



A roadmap on steps and plans to strengthen participation
©CESFAM MT Calcuta, Santiago, Chile 2016



[Better Evaluation \(2014\)](#) provides further information on how to develop and present logic models.

Logic models (also called logframes) imply that change takes place in a logical and predictable sequence of steps over time. SPH processes, however, are usually complex and often unpredictable. One way to think about such complex interventions is to develop a *theory of change*. Theories of change have been used in SPH work in many different settings, such as the examples below. Theories of change help to identify and frame a diversity of pathways that may lead to desired changes.



A theory of change helps us to think in an organised way about our assumptions and the pathways we think will lead to change, especially in unpredictable and complex processes. Developing a theory of change engages stakeholders in conversations on their hopes, expectations, and assumptions.

The stepwise approach used to develop a theory of change is shown below.



Steps to develop a theory of change

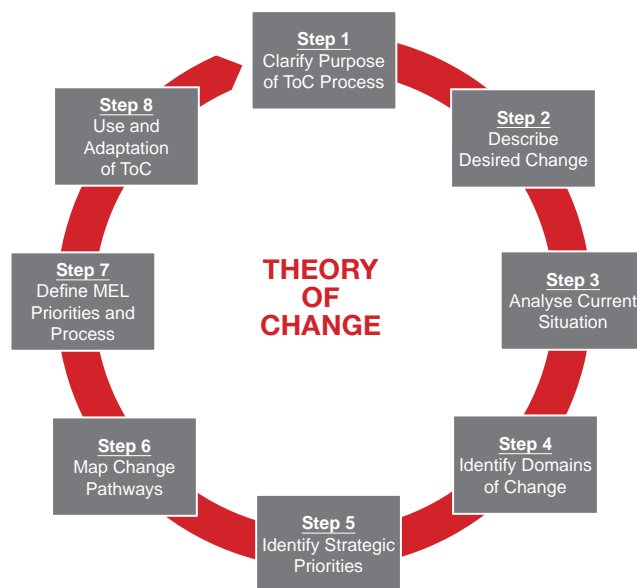
The key steps are shown in *Figure 2a*.

- Steps 1 and 2 ask *what is the desired change and why is it needed and for whom?*
- Steps 3 to 5 uses context analysis to identify the drivers of, as well as opportunities and goals for change.
- In Step 6, the pathways of change are identified, including:
 - Who and what needs to change?
 - How might the change process evolve from where we are now?
 - What assumptions are we making about the needs, interests, and behaviours of different stakeholders and about cause-effect in the change pathways?
- In Step 7, we identify processes and measures to monitor, review, and evaluate implementation
- In Step 8, we set plans to implement the intervention (Van es et al., 2015).



van Es et al., (2015) provide a [comprehensive step-by-step guide](#) on how to develop a theory of change.

Figure 2a: The steps in a theory of change



Source: van Es et al., 2015: 34 used under creative commons license. MEL = Monitoring, evaluation and learning



Using a theory of change to establish a baseline for and plan SPH work

In the USA, the non-profit organisation Engage for Equity (2020b) used a theory of change to identify the pathways, outputs, and outcomes for building community-based partnerships. The organisation analysed the context and defined two pathways for how practices could lead to outcomes. The first, termed the partnership pathway, identified relationships and capacities for collective empowerment. A second structural pathway set out the resources, funding, and community involvement that contribute to the systems and capacities. The two pathways are combined to create the desired changes.

Also in the USA, the Illinois Caucus For Adolescent Health (ICAH) developed a theory of change around helping youth leaders serve as experts in their own sexual health education. The accompanying photo shows the drivers ICAH identified in its theory of change. The drivers were used as hashtags in social media posts and key themes in training (ICAH, 2018).



As for all steps in the evaluation, pay attention to social groups that may be more disadvantaged and more marginalised. Identify what barriers these social groups may face in following the pathways of change that link your activities to your goals. Will the pathways be the same for all?

It is best to develop a theory of change and baseline assessment before the SPH intervention starts. If an intervention is already in progress, you can identify a start date for the intervention and, at that time, gather baseline evidence on conditions from records and key informant interviews and add this to information on the current situation. The goals identified as part of the theory of change will align with the evaluation outputs and outcomes on which you need to gather baseline evidence for later comparisons.



Go to worksheet 2.1: With your team, set goals for your SPH work, including identifying what you already know about the situation, your assumptions, and your theory of change. Identify what evidence you need to collect in the baseline assessment.

The evidence to include in a baseline assessment

The baseline assessment takes place in Step 3 of the theory of change process shown in *Figure 2a*. While the specific evidence gathered depends on the SPH intervention and location, there are common types of information to include in any baseline assessment.

Information gathered in a baseline assessment includes evidence on:

- The context.
- The community.
- The conditions affecting health (also termed determinants of health), and the available services, their budgets and functioning, and how they are perceived by workers and users.
- The stakeholders.
- The level and quality of SPH.

Each of these areas is elaborated below, except the level and quality of SPH in (e), which is discussed in the next subsection.

- The **current contexts** that influence the SPH work and the intended changes include:

- The population involved*, including its diversity, geography, political and cultural participation, education levels, social inequality, inclusion, networking, and history.
 - The institutional setting*, including its history, leadership, personnel, processes, resources, and partnerships of key institutions, and how this differs for different social groups.
 - The socio-political conditions*, including the relevant political histories; trust relationships between governments, stakeholders, and different groups in the community; current policies and where they are made; and the laws, and decision-making processes.
- The **community** affected by and involved in the work refers to people living in one area or with common conditions or interests. You need to gather evidence on the people, and the distribution of age, gender, ethnicity, indigenous nature, tenure, incomes, and other key features needed for keeping an eye on equity, as well as the geographical boundaries and features of the area covered. Depending on the SPH intervention, the baseline will also gather evidence on people's living, working, family, and community conditions, as well as their food sources and diets, experiences, knowledge, interests, perceptions, and priorities. It may include information on relationships within and beyond the community; links to relevant services and organisations; and the assets, capacities, weaknesses and challenges of different social groups.
 - Perceived and measured levels of **health and their determinants** relevant to what you seek to improve. This includes interaction with, and coverage, performance, quality, and experience of **health services** that the SPH efforts are seeking to improve. The baseline should collect how these different measures are experienced or perceived by the different social groups in the community to be able to plan for and assess equity.



The National Association of City and County Health Organisations' [Mobilizing for Action through Planning and Partnerships \(MAPP\)](#) provides tools to collect health and health service information.

- The baseline gathers information on the **stakeholders and processes** that will be directly or indirectly affected either positively or negatively by work on SPH. Information is also gathered on stakeholders and processes that play an enabling or obstructing role in, or may otherwise influence the changes that results from the work on SPH.

Later in this section, we explain how to conduct a stakeholder analysis. The evidence gathered on stakeholders may include their purposes, interests, capacities, roles, communication channels, governance, networks, and relationships with other institutions, communities, and authorities. A participation matrix, like the blank one below, can help you identify which stakeholders to involve in your team or advisory group at each stage of SPH implementation and evaluation.



A **stakeholder** is any person or institution (including services and state, community, or private institutions) with an interest in an issue, whether that interest is financial, moral, legal, personal, community-based, direct, or indirect.

Example of a stakeholder matrix with blank cells to fill

Stage	Stakeholders to involve	Stakeholder features
Setting goals		
Designing the SPH intervention		
Implementing the intervention		
Performance evaluation		
Impact/outcome evaluation		



Go to worksheet 2.2a: We will complete Worksheet 2.2 in two parts. For this part, identify with your team the key features of the context, community, and stakeholders for the SPH intervention and its evaluation.

What evidence do we include on the level and quality of SPH?

Given our SPH focus, baseline assessments always include information on social participation in health as it currently exists in the community where you are implementing an SPH intervention, particularly those areas the intervention seeks to change. The specific SPH indicators on which you will gather evidence

depend on the intervention and the context in which it is being implemented. *Table 2a* provides a number of areas of SPH, and particular features within those areas, that may be included in a baseline assessment. You don't need to include all of them! You may select only relevant measures, taking the context, intervention, and goals into account.

Table 2a: Key areas of SPH that can be measured

All areas below are as applied to the community or social group involved

KEY AREA	SPECIFIC ELEMENT, FEATURE
Inclusion/ voice/ representation and communication	<ul style="list-style-type: none"> • Extent to which participants in SPH reflect the social group/community in terms of socio-economic, ethnic, racial, cultural, educational, sexual orientation, gender, age, geographical, and political diversity; and organisational affiliation • Extent of recruitment and retention of new members • Extent to which all voices are heard and valued; level of communication and coalitions within and across different groups in the community • Sense of trust, reciprocity, and cohesion in the community • Level and inclusion of formal and informal networks/civil society organisations • Integration of social values and beliefs
Knowledge/ self-consciousness/ capacity	<ul style="list-style-type: none"> • Level of understanding of the issues in and goals of the intervention • Involvement in conceptualising, establishing the goals of, planning, implementing, and reviewing the performance of the intervention • Levels of learning in different groups; perceptions of the benefits of SPH • Community/social group capacities and knowledge, including from experience • Self-confidence and belief in the group's ability to produce desired changes

Table 2a: Key areas of SPH that can be measured (Continued)

KEY AREA	SPECIFIC ELEMENT, FEATURE
Leadership/ agency/ self esteem	<ul style="list-style-type: none"> • Whether SPH was externally motivated or self-determined by participants • Changes in people's confidence in their abilities to analyse and bring about change and influence decision-making • Levels of community roles, responsibilities, and collaboration in health • Level of supportive formal/informal community leadership • Levels of community/group co-operation and involvement in action • Level of supportive formal/informal community leadership • Levels of community/group co-operation and involvement in action
Interests/ self-determination	<ul style="list-style-type: none"> • Response to goals, interests, motivations, risks, benefits of different groups • Self-perceptions of levels of control, autonomy, authority, and use of own resources • Levels of perceived and actual institutional and individual corruption • Rights; presence of anti-discrimination policies(eg. gender, sex, race, identity) • Institutional level at which decisions are taken • Perceived benefits and challenges of participation, particularly SPH
Power/influence	<ul style="list-style-type: none"> • Balance of power, including power over, power with, power to, or power within • Distribution of power within and across the community and between actors • Levels of conflict/tension/friction between stakeholders and with services • Levels of co-management of programs/processes, including use of evidence from the community/social group and their influence in decision-making • Perceived value of and impact of working together
Process	<ul style="list-style-type: none"> • Organisation of, time for, enabling process of, and flexibility in participation • Diversity of methods, sharing of evidence, and collective validation • Real/perceived levels of participation in processes, ranging from manipulating to informing, to consulting, to forming partnerships, and to co-determining • How permanent or temporary the processes are for SPH • Level of communication between institutions and communities; perceptions of openness and extent of open sharing of information between stakeholders • Perceived legitimacy of processes and procedures • Levels of stakeholder consensus around and satisfaction with decisions
Organisational issues relevant to SPH	<ul style="list-style-type: none"> • How clear and formally agreed the tasks, roles, and collaboration are • Level of formality and inclusiveness of the SPH mechanisms • Level of responsiveness, accountability, and transparency of services and institutions on their functioning and decisions • Organisational links and networking between different social groups/partners
Resources	<ul style="list-style-type: none"> • Level of budgets and resources provided relative to SPH program costs • Level of shared control over resources for SPH programs • Level of public revenues and resources that reach or are within the community • Identified cost benefit and value for money (from prior assessments)

Abelson et al., 2003; Wallerstein, 2006; NIH 2011; Loewenson, 2016; NAAEE, 2017; Butterfoss, 2006; Abelson and Gauvin, 2006; Engage for Equity, 2020b; Tachhi and Lennie, 2014; Public Agenda, 2019

Which features from *Table 2a* you choose to measure and how you measure them depend on your local context and the details of your SPH intervention. As a reminder, choose only those measures that are most relevant to your SPH intervention's inputs, activities, and goals, including how you want to assess its performance

and outcome. *Remember to gauge if and how any measures may be affected by existing [inequities](#) between different population/social groups.*

The experiences on the next page, from the USA and Australia, illustrate the choices involved in measuring SPH.



Measuring SPH in different settings

Euclid, Ohio has a Creating Healthy

Communities program on healthy eating and active living. A key informant in the program noted that *the most compelling and useful information comes from ... the stories or experiences of the people who are affected by the issue*. Listening to peoples stories exposes how SPH is perceived, including the barriers to it. It shows what really matters to people and what animates them, especially, notes the key informant, if you hear the same features appearing in many such stories. These experiences reveal priorities for SPH, including identifying: key spaces, such as sports facilities; how secure or safe people feel; how racial or other forms of discrimination have affected people; and how people have organised around these issues affecting SPH.

One particular social group are community health workers. They may be members of particular social/cultural groups. In an experience shared by a key informant, [the SmokeCheck Project in New South Wales, Australia](#) identified that success in smoking cessation among Aboriginal and Torres Strait Islander communities depended on programs designed with and for Aboriginal people and delivered primarily by Aboriginal Health Workers (AHWs). The SPH measures related to the capacities (knowledge, skills, and confidence) of AHWs, as well as the trust that their communities had in them and the authority conferred on AHWs by local health care services to deliver interventions on smoking cessation. The SmokeCheck project trained AHWs and other health professionals and used an intervention and control group to evaluate whether the knowledge, skills, motivation, and confidence of those participating in the training had increased compared to that of others that had not had the training (NSW Health, 2010).

Many of the indicators you may want to measure are difficult to measure with numbers. Counting the number of community members involved in an activity can be misleading when the change depends on the quality of the activity. Many measures, such as an SPH intervention's degrees of inclusiveness, intensity, and influence need to first identify the current levels within a range. There are different ways of assessing this. One method is using a five- or seven-point Likert scale, discussed in [Part 3](#). Speedometers or spider diagrams, both shown in the adjacent box, are other options for assessing the levels of key measures in baseline, performance, and impact assessments.



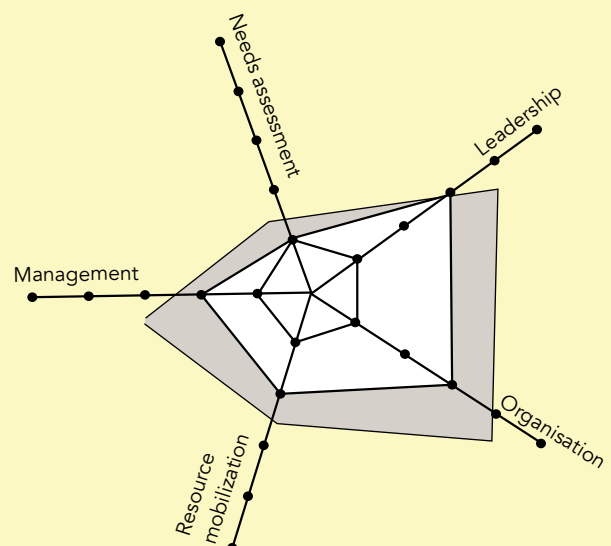
Assessing levels of SPH

A **speedometer, or 'Speedo'** is a participatory way of measuring performance of key SPH dimensions. A large illustration of a speedometer, displaying 0-100, is produced for each feature being assessed. The dimension being measured is displayed on the speedometer (see graphic). Participants, either individually or collectively, set the current level by locating the dial between 0 (indicating *not at all*) to 100 (indicating *fully achieved*). This exercise can be repeated for performance and impact evaluations ([Burns et al., \(2004\)](#)).



Used with permission of University of West England; originally published in Burns et al., 2004 (see reference list for full details)

A **spider diagram** can be used to assess the changes in the levels of different dimensions of SPH, such as leadership, organisation, resource mobilisation, and management (see graphic below; [Rifkin et al., 2007:12](#)). A set of questions was developed to assess where to place the mark in each of the five legs. The inner line reflects the baseline for each dimension, while the outer line reflects a post-intervention assessment of a greater or lesser level, with the shaded area showing the change. A pentagram in the centre ensures no mark is placed there because all communities have some degree of participation. The indicators are descriptive; they do not represent absolute levels of participation, for example, but enable discussion on how participation is changing.



How do we decide what to collect and from where?

Once you have identified the indicators to measure, you should think about what evidence to collect on them and where to find that evidence. Review your indicators carefully to choose those that are feasible, given time and resources.

i When you discuss evidence collection with your colleagues, think about:

- What is most relevant and specific to the changes you are expecting to achieve;
- Your collective vision/definition of what success looks like;
- What evidence will be most simple, meaningful, and useful;
- What is easiest and most credible for communities and stakeholders to interpret and use;
- What evidence is unambiguous and clearly defined;
- What indicators can be consistently tracked over time; and
- What is sensitive to change and easy to collect (van Es et al., 2015).

Discuss suggested indicators with community leaders and members, implementers, managers, and funders to hear their views on what you are proposing to collect. Credible evidence is the raw material of a good evaluation. If the evidence is viewed as valid and relevant to stakeholders' questions, they will be more likely later to accept and act on the conclusions.



The **validity** of a measure tells us how well it measures what we intend it to measure.

Bias occurs when validity is affected by a variety of factors, including researcher perceptions; tools used; inclusion or exclusion of potential participants; and errors in data collection, processing, or analysis.

When you are unsure about a measure's validity, you can test it by collecting the same information in different ways. You can then **triangulate** the findings to see if they are the same or different. For example, you may gather information on service uptake using data collected by the service delivery facility or using data gathered via a community survey. Another example: you can ask people in different areas for their perceptions of how polluted the air is, and you can also give local people simple air pollution monitors to measure it

themselves. Mixing different types of evidence provides a more comprehensive understanding of the situation and helps to avoid bias when interpreting findings.



Primary data is evidence that you collect directly from the source.

Secondary data is evidence that has already been collected from the source by someone else who makes it available to you. Using secondary data can save time and expense.

You may choose to use primary or secondary data. As the cartoon shows, if the data already exists as secondary data, you don't need to collect it, but you should ensure that it is relevant, reliable, and credible. For example, using facility data may exclude people who do not use the facility's services, such as migrant workers or people who are homeless. If you use evidence from a survey conducted for a different program, check whether it covers the relevant population, institutions, conditions, or services. Much routine data does not adequately disaggregate (separate) evidence to show differences/potential inequities between areas or social groups, especially at local levels. You will need to collect primary data when relevant, reliable, and credible secondary data is not available.



Secondary data can come from different sources:

- a. Census surveys and vital statistics provide demographic and population data.
- b. Regular household and other surveys provide information on a range of variables. It is critical to know the size, timing, and definition of indicators in these surveys to judge their relevance.
- c. Compiled reports of routine and financial data are collected by services, insurers, and agencies.
- d. Reports from state and local governments may provide information on institutional policies, programs, capacities, past evaluations or performance records, and financial data.
- e. Local stories and media provide information on context, experiences, and perspectives.

If secondary sources don't provide the needed information, then the baseline assessment can be used to collect primary data. Be sure to collect only what is necessary. If you are not sure, review your theory of change or brainstorm with your colleagues around evidence gaps that need to be addressed.

When collecting primary data, you should think about the following considerations.

- **Who to collect data from** (this is known as your population sample). If you are doing surveys, then obtain guidance from statistical experts on how many people to include and how to choose your sample. You may choose your sample *randomly*, so everyone in the population has an equal chance of being included, or *purposively*, to ensure inclusion of particular groups or areas of focus, or a mix of both. You can *stratify* your sample, which means categorising and including defined numbers from different subgroups in the population so that you can later analyse them separately. When using the participatory tools described later in this section, the right number of participants depends on the chosen method. Many participatory methods are more likely to be effective if the number of participants is below 30, but you can include larger numbers if you organise people into smaller subgroups. For a community meeting, you may issue an open invitation, but for a focus group it is better to purposively include representatives of particular social groups, including marginalised groups. Always consider the sensitivities of different groups and if they first need separate groups to effectively participate?
- **Numbers or stories?** The evidence may be quantitative or qualitative and is often both.



Quantitative data is numerical and can be measured, such as the volume of drinking water people consume. **Qualitative data** may be visual, verbal, or counted (but not measured), such as reported perceptions or preferences, seasonal calendars, prioritized needs, or interactions between services and people.

Statistical techniques are used to analyse quantitative data. For qualitative data, we examine, compare, contrast, and otherwise interpret themes and patterns. Qualitative data often explains the 'why' and 'how' behind the 'what,' which is measured through quantitative data. Both forms provide useful evidence.

- **Direct and indirect indicators.** The data collected may directly reflect whatever it is we want to measure, such as monthly immunisation uptake. Conversely, sometimes we may only be able to use an indicator that indirectly represents (or serves as a proxy) for what we really want to measure. For example, service uptake data may be used as an indirect indicator of the accessibility of those services. We aim for direct indicators, but may use indirect indicators when the former are difficult to collect.
- **Assets and capabilities.** It is useful to understand not just the problems, but also the assets and capabilities that communities, stakeholders, and institutions bring to SPH processes, including what is already working well. For example, we can use appreciative inquiry to collect evidence on the assets and capacities of communities or institutions



Appreciative Inquiry is a systematic search for what gives 'life' to an effective system, organisation, or community. It uses open and energising questions to identify what an organisation, or community does *well*, rather than what it does badly. The questions in an appreciative inquiry aim to strengthen a system's potential, such as: *What has been the most helpful part of the program?* ([Sero et al., undated](#)). Appreciative inquiry explores assets and capacities in communities that can be integrated into SPH interventions.



The [Appreciative Inquiry Commons](#) has extensive resources on how to carry out an appreciative inquiry and examples of the method.

- **Equity and diversity.** Wherever possible, the baseline assessment (as well as later evaluation stages) should seek to disaggregate the evidence collected to describe and understand the differences between social groups and areas. Don't rely only on totals or averages. People in communities differ in terms of their incomes, races, ages, residency status, disabilities, and other characteristics, including in their capacities. We need to assess these social differences in the baseline to be able to design an SPH intervention that addresses them, and to see later how the different groups participated in and benefited from the intervention.

While the SPH intervention may be intended to enhance equity, other programs or services that also intend to promote equity should be noted in the baseline.



Implementing a baseline equity assessment in Portland, Oregon

In 2011, a working group of the Urban League of Portland and the Office of Neighborhood Involvement developed an equity lens to help the city government address worsening disparities in employment, housing, health, and education. A baseline equity assessment was implemented to inform a racial equity strategy. It gathered evidence on gaps in program delivery, operations, service performance, and resource management. It identified points where equity goals could be incorporated and inequalities addressed in plans. The findings were reviewed together with community-identified needs and priorities to agree on action steps and their evaluation. You can read more on this initiative in [Portland's Partnership for Racial Equity 2011 Strategy Guide](#).

Equity is not only addressed by how the information is analysed. It depends also on how the data is collected and whether the collection process respects and meaningfully engages with the groups affected, particularly marginalised groups.

As one key informant noted, you need to give enough time for this, for people to express themselves and understand each other. This is especially important for those who may be more disadvantaged, as was discussed in the section on [ethical standards in Part 1](#).



You can listen to podcasts on [Durham's methods for evaluating](#) equitable engagement and on the methods used by [Change Lab's Denver Housing Authority redevelopment project](#) to engage diversity in its work. [PROGRESS-plus](#) identifies features for disaggregating evidence to capture diversity.



Go to worksheet 2.2b: With your colleagues, continue to identify what you want to include in your baseline assessment and the sources of that information, including what to do to ensure quality and equity.

Methods for a baseline assessment

There are many methods that can be used to collect different forms of evidence. You can choose those most appropriate and feasible for your setting, and can set up an advisory group to help in this. Many of the methods can be done in ways that involve community members, implementers, and other key stakeholders in the process.



Establishing an advisory council in Kentucky

In its [Community Engagement Resource Guide](#), the USA's National Recreation and Park Association describes a community advisory council whose members are identified through election, appointment, and open volunteering to ensure diverse representation from the community. Council members were informed about their terms, roles, and processes and discussed opportunities for input to processes and decisions. In Covington, Kentucky, the city asked for volunteers to join an 11-person park advisory group to analyse the current situation and prioritise redevelopment projects. The advisory group assigned a 'Park Potential Index' for redevelopment to be linked to community needs. The group communicated with neighbourhood stakeholder groups on feedback from communities, bringing community engagement into co-design and construction at the heart of capital development (NRPA, undated).

The table overleaf lists the baseline assessment methods presented in this section and their purposes. Similar information on methods used in subsequent evaluation phases is provided in [Part 3](#) and [Part 4](#), and the inclusive table in [Part 5](#) provides a summary of all the methods presented in this resource and how they are used across the three phases of evaluation.

This section provides a summary of the different options for gathering evidence, and the kind of information each can be used to gather. As noted earlier, the decision on what methods to use depends on the details of the SPH intervention, the context and community in which the intervention is set, and the time and resources available for evaluation. People who volunteer for participatory groups tend to have self-confidence and free time. You may need to think about novel ways to include people who may be less forthcoming or have less free time, such as younger people, migrants, people with disabilities, caregivers, members of minority groups, second language speakers, people who are homeless, people who work several jobs, and others.

Methods and tools for the baseline assessment

PURPOSE	METHODS	PAGE
Gathering evidence on communities, their contexts, and conditions	Surveys	2.11
	Interviews	2.12
	Focus group discussions (and meetings)	2.12
	Participant observations and diaries	2.12
	Picture codes	2.12
	Participatory maps	2.12
	Transect walks, participatory observational surveys	2.12
Gathering evidence on stakeholders and institutions	Stakeholder and network analyses, onion tool	2.13, 2.14
	Venn or chapati diagrams	2.13
	Stakeholder power analyses, community trade-offs assessments	2.13
	Social network analyses	2.14
	Relationship maps	2.14
	Power analyses, power maps	2.15
Risk analysis grids, forcefield analyses	2.16	
Gathering evidence on services	Service use maps, circle maps, venn diagrams	2.17
	Exit interviews	2.17
	Surveys, focus groups, participant observation	2.11, 2.12

Think about possible barriers to participation for different groups within the community. For example, if you are working with less literate communities or second language speakers, you may need to use more visual communication methods. If you need to gather numerical data, you may choose to conduct a survey, and depending on the survey's length and community members' level of online access, you may decide to use a digital survey application.

What methods can gather evidence on communities and their conditions?

Surveys involve anywhere from one to multiple questions and are administered by interviewers or completed by respondents on paper, online, or over the telephone. They elicit information on a wide range of topics, using a set order of fixed questions that may be multiple-choice, closed, or open-ended.

- Closed and multiple-choice questions present participants with a set of answers from which to choose. They may include questions that can be answered by choosing yes, no, true, false, or not sure.
- Open-ended questions ask participants to write down their responses in their own words. These may yield a lot of information regarding participants' views and perceptions, but they are harder to analyse.

Before they are finalized and used to gather actual data, draft survey questions should be pre-tested to make sure that they are clear and will elicit the intended

evidence. Surveys conducted by interview demand time and resources to implement and analyse, unless online survey tools are used.



Using surveys for baseline evidence for health interventions in India

[District Level Household and Facility Surveys](#) (2002-2004) were used, in 2005, to establish the National Rural Health Mission in India, including as a baseline for monitoring and evaluating its interventions. The Mission's SPH interventions include the Accredited Social Health Activists (ASHA), which work to improve women's health-seeking behaviours. District level surveys, which assess the use of public health services and people's perceptions about the quality of these services, are done regularly and provide core data for ongoing monitoring. They also point to areas where additional information should be gathered ([Central Statistical Office India, 2015](#)).

Individual interviews with key informants from the community and services representatives can be a quick and less resource intensive way to collect evidence and perceptions on the current situation. Interviews have more open content, with a limited number of questions and different questions for different stakeholders. They require a content or thematic analysis on the findings that look for common ideas, evidence, or themes across responses.

Group interviews and **focus group discussions** of between 5 and 30 participants with specified characteristics (such as age range, occupation, residence) are another less costly way of gathering information from more people than individual interviews, but they do demand skills to encourage equitable participation and implement a content or thematic analysis on the findings. A pre-set topic is explored over a longer time (often several hours) through a limited number of questions. Facilitators ask probing follow-up questions. Paying attention to issues that animate a majority of people in a public meeting can help expose local views and perceptions.

i The [Real People Real Data Toolkit](#) developed by the Consumers Health Forum of Australia helps to capture and analyse community narratives of health, illness, and the health system to inform and guide decision-making by government agencies, and health services and consumer organisations. Stories provide deeper understanding of and community perspective on what lies behind quantitative data, such as why inequalities persist and what needs to be done to overcome them.

Surveys and interviews can be combined with qualitative techniques, such as **participant observation**, **keeping diaries**, recording oral or life histories, writing poems or songs, making timeline drawings or calendars, or taking and sharing and photographs. In one example, community members who felt too shy to talk in front of a group used Whatsapp to share a picture or a recorded message so their evidence could be included in discussions. Photovoice combines photography with social action to show, discuss, and act on community members' conceptualizations of their circumstances. It can show the community's strengths and problems from their own lens and promote dialogue about these features. [A Hamilton Community Foundation manual provides steps on how to implement a Photovoice program.](#)

Maps are used to design interventions and can be revisited later to add new information. The following are examples of mapping approaches.

- **Picture codes** are pictures that can be used to trigger discussions on conditions, system performance, problem causes, and actions to be taken. They are often helpful in raising and discussing sensitive or buried issues, or those that need to respect personal privacy, such as on reproductive health services or substance abuse. An example of their use can be found in Activity 11 in [Organising Peoples Power for Health](#).
- In **participatory mapping**, those involved draw one or more maps of the physical and social conditions in the intervention setting. This includes risk and hazard maps, as described in [Barefoot Research: A Workers' Manual for Organising on Work Security](#). Various types of information can be mapped, including: social characteristics, community assets and wellbeing, vulnerabilities, [rights](#), and the distribution of vulnerability.
- A **transect walk or participatory observational survey** adds observations to these maps. Transect walks move through the area to observe and record key features, resources, and conditions. [Observation tools \(page 52\)](#), used with a schedule or checklist, can help to understand how services or other processes are currently working.

These various forms of mapping can be helpful to show inequalities.



Discussion of a social map, Zimbabwe F Machingura, 2006

What methods can gather evidence on stakeholders?

As noted in Part 1, different stakeholders play different roles in the pathways for change and in evaluations. They also have different agendas and may need to be engaged in different ways. Various forms of **stakeholder and network analysis** and of **power analysis** are used to gather baseline evidence on the presence, interests, agendas, capacities, power, networking, and influence of different actors and their roles. [Stakeholder analysis](#) provides one way

of identifying these different groups and the power relationships between them. It can be used to determine who the program will affect, both positively and negatively. Primary stakeholders are *directly* affected or influential, while secondary stakeholders are *indirectly* affected or influential. Their influence and importance are ranked between 1 (maximum influence/importance) and 6 (minimum influence/importance). The ranking can be done by a mixed stakeholder group.

An example of a matrix is shown in *Table 2b*:

Table 2b: Sample stakeholder analysis matrix

Stakeholders	Interests in relation to the program	Position on program goals	Importance for program success (1-6)	Influence over the program (1-6)
Primary stakeholders				
Women	Improved provision of early child development services	Positive	1	3
Children	Stimulation of learning; health monitoring	Positive	2	6
Secondary stakeholders				
Local civil society	Health and wellbeing in disadvantaged communities	Depends on priorities	3	3
Insurers	Funding of health care	Depends on cost benefit	4	2



You can read more on how to do a stakeholder analysis in [online ODI resources](#).

Chapati diagramming, also called Venn diagramming in participatory tools, uses a series of interrelated circles to indicate relationships between stakeholders, groups, specific social networks, and institutions (as shown in the adjacent photo), with the method shown in Activity 21 of [Organising People's Power for Health](#). The size of the circle indicates its importance for the central group/program, while its position and distance from this central circle shows how connected it is to it. These diagrams visually express the relationships between actors and services, and are used, for example, to assess patterns in the use of services or in the information flows between service providers and community members. Venn diagrams are participatory, not costly, and relatively easy to implement.

Stakeholder power analysis and influence mapping show the power different stakeholders have and how it changes over time. Stakeholders are listed and a two-dimensional grid is used to identify power imbalances.

Chapati/venn diagram of services for maternal health (around a focal point 'Sara'), Liberia



TARSC, 2016

Stakeholders may be individuals, specific officials, leaders, institutions, defined common interest groups, or networks. Stakeholders are mapped by their level of interest on the vertical axis and their power on the horizontal, as shown below (Mathur et al., 2007).

Prioritization Matrix

A. High interest, little power	B. High interest, great power
C. Low interest, little power	D. Low interest, high power

While this calls for good facilitation skills, it is also a straightforward tool to implement. A [community trade-offs assessment](#) compares the interests and power of stakeholders directly involved in the SPH intervention and those external to it. It is used to discuss different priorities and how to address them in the intervention (Vermeulen 2005).

The **onion tool** is a simpler visual tool used to analyse the actors that influence change. The outer layer contains the positions people take publicly. Underlying these are their interests, or what people want to achieve from a particular situation. Finally, at the core are the key needs to be fulfilled.

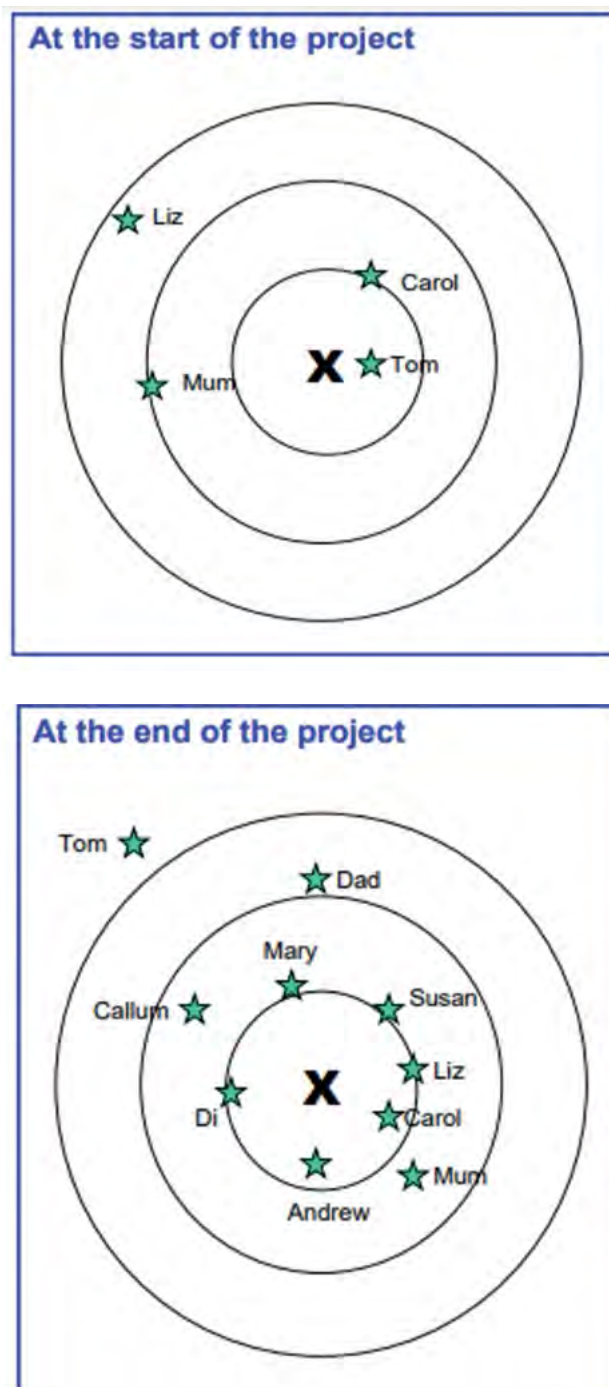
[Social Network Analysis](#) describes and analyses interactions amongst particular actors. It assesses social relations and network characteristics, such as how central the network is to an issue, and how strong or weak the ties are between the different social groups involved in health initiatives, or between the groups and agencies that support or block initiatives. It may assess the strength, sustainability, and impact of community partnerships. The strength of the different connections may be assessed on the basis of their frequency of interactions, or some other metric of interest. The connections are usually displayed as a visual graphic of interacting entities, depicting the interactions and the strength of each.

One way of doing this is with [relationship maps](#), also known as social network maps. They are simple to do and useful if your outcomes are about building or improving relationships or building support networks (see *Figure 2b*). Step 1 finds out the relationships each user has when they first come to the service (the baseline). In a one-on-one meeting, or in a group setting, you give your service user a relationship map and some sticky stars (or dots or pen marks). The X in the centre of the circle represents the service user and they place the stars representing different stakeholders in one of the concentric circles around the X. The closer the service user places the star to the X, the closer the relationship between them (top map). To review changes they complete the process again (bottom map). You can review the maps by asking:

- *Are you happy with this situation?*
- *If not, how do you want this to change?*
- *Are there any relationships that you would like to be different?*

Social networks, including online networks and those generated through social media, have been assessed to explore the relationships and levels of participation by different groups, and their perceived role and value for participants. These assessments have also been

Figure 2b: Relationship maps



Source: Figures from Evaluation Support Scotland's Method Sheet: Relationship Map. Adapted from The Relationship Map developed by Personal Futures Planning and Circles of Friendship inspired by Judith Snow

made using online tools, such as [Kumu](#), an online social network analysis tool (see others [listed in Wikipedia](#)). These online mapping tools can help to visually show relationships, to map assets and their links to different groups, to identify key actors in networks, and to see how systems relate to each other. They need to be facilitated well and tailored to the specific purpose, and they demand digital access and familiarity with online platforms.

Beyond understanding the links and interests of different actors, mapping social power in health helps in managing processes, as discussed below, and understanding its role in outcomes.

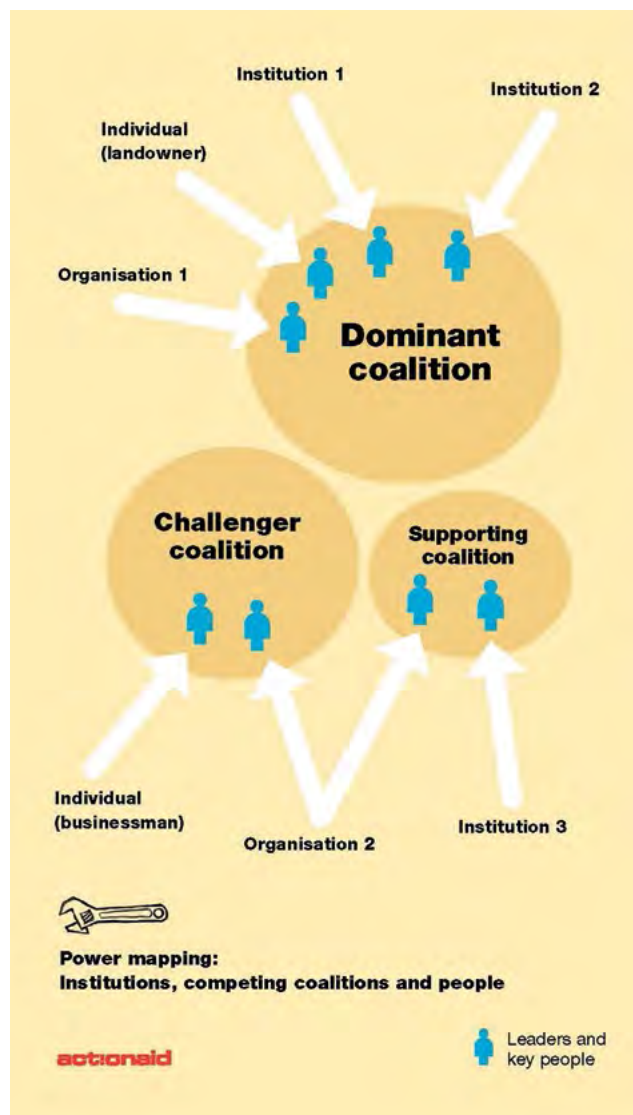
i A [One-Stop Participation Guide](#) describes ways stakeholders use power and how to engage with it:

- *Heavy-handed authorities*, such as government authorities, can be forceful in how they exercise power. This can undermine both SPH interventions and their evaluation. Take active steps to encourage their empathy and respect. Encourage them to buy into the ground rules of the participation process and accept that it is independent for good reason.
- *Dominating participants* can attempt to direct the assessment and intervention. Discuss with them why it is important to hear from everyone and how to enable this.
- *Biased practitioners* can bias the evidence. Encourage and create opportunities for debate and actively work against any one party being unfairly biased.
- *Intellectual dominators*—such as some specialists—can use complicated language in a way that suppresses others' input. Discuss accessible terms and processes.
- *Gatekeepers* are self-appointed leaders of civil society groups that can become bottlenecks to wider contact between practitioners and the community. Assess social networks and stakeholders to find ways of making wider links into communities (Common Ground, 2005).

Power analysis can be used to map and navigate the different dimensions of power and its role in strategies for change. In a matrix, it maps the actors, including any social networks, as well as their interests and fears, how they promote their interests, and how they take or block actions in ways that influence outcomes. It examines who functions as a gate keeper, such as by controlling access to influential people. Diverse methods may be used for power analysis.

If participants might respond better to a visual tool, then **power mapping** may be a good one to use. A map is used to show the power relationships among key stakeholders (see *Figure 2c*). The mapping is dynamic; it can be used to point toward action and repeated to show changes.

Figure 2c: Power mapping



Actionaid and HRBA, 2012:42, under creative commons

Stories about experiences of power can be used to analyse the sources, positions, expressions, and forms of power and how they are expressed.

You can also observe who determines the agendas of meetings, as well as who leads them and who speaks at them.

➤ Hunjan and Pettit (2011) provide further information in their online [Power: A Practical Guide for Facilitating Social Change](#). In another resource, [Actionaid and HRBA \(2012\)](#) give examples of ways of assessing and evaluating power.



Using power analysis for strategic action on the right to health in Denmark

A project in a disadvantaged area of Denmark used social network analysis to display participation and non-participation in community development and health promotion activities. The analysis identified community assets and capacities. It helped to mobilize resources and was used to evaluate the project's achievements. The project found that, in networks, both close interpersonal ties and more tenuous connections can be leveraged to foster cohesion and cooperation for health (Hindhede and Aagaard-Hansen, 2017).

Risk analysis grids can be used to inform discussions on the likelihood of occurrence and level of risks in engaging power (see Figure 2d). They can be used to choose actions to address identified risks, or to assess how risks have changed as a result of chosen actions.

Figure 2d: Risk analysis grid

Checking for Degrees of Risks	
<p>High degree of risk</p> <p>↑</p> <p>High risk: threatens future existence of organisation or group, endangers people's lives, or could lead to significant reversal on issue.</p> <p>Low occurrence: surprising if it happened in next x years/months.</p>	<p>High risk: threatens future existence of organisation or group, endangers people's lives, or could lead to significant reversal on issue.</p> <p>High occurrence: likely to happen in next x years/months or is occurring now.</p>
<p>Low risk: noticeable but little effect on our work.</p> <p>Low occurrence: surprising if it happened in next x years/months.</p> <p>Low</p>	<p>Low risk: noticeable but little effect on our advocacy.</p> <p>High occurrence: likely to happen in next x years/months or is occurring now.</p> <p>High likelihood of occurrence</p>

Actionaid and HRBA, 2012:49. Under creative commons

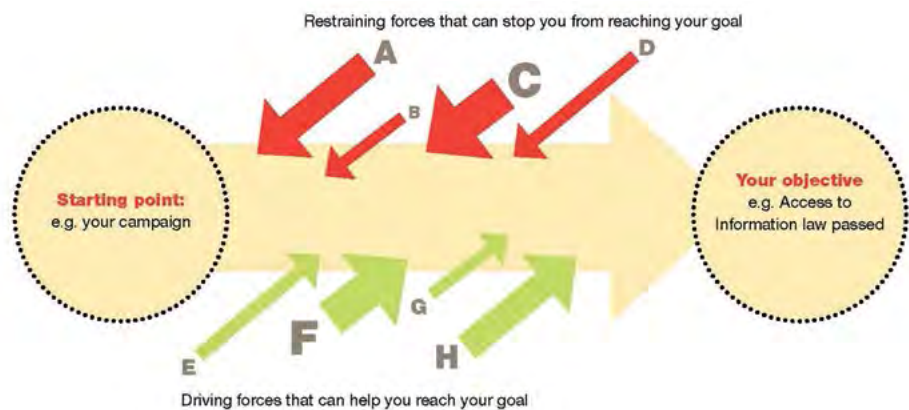


A forcefield analysis

is another type of risk analysis. It identifies the different forces that may influence the success of an intervention. Forces can be people, organisations, or events. They may support or block the intended changes or goals. A forcefield analysis helps to identify the strength of these forces. To create one, draw a horizontal time line with your starting point at one end and your goal at the other end, as in the graphic.

Above the timeline list all the forces (people, organisations, or events) that may block progress towards the objective, with an arrow for each. The thicker the arrow, the stronger that force. The closer the arrow to the timeline the closer it is to you or the intervention. Underneath the timeline list all the forces that support progress towards the objective, using arrows for each. As before, the thickness of the arrow and closeness to the line reflect the strength and proximity of the force. (Actionaid and HRBA, 2012).

Forcefield Analysis



Source: Ideas based on Lewin, K. (1951) Field Theory in the Social Sciences, New York; Harper and Row.

The forcefield analysis on the previous page allows you to consider which forces can be influenced and what strategies to use for doing this. Repeating this analysis at various stages shows how these forces change over time, and can be used to identify how SPH interventions change the forces at work.

What methods are used to gather evidence on services?

Some of the methods described earlier—surveys, individual interviews, focus groups, mapping—can be used to gather evidence on services, their functioning, and how they are perceived. Diaries, activity logs, calendars, and stories can be used for clients or service workers to describe their experiences of services.

Service use maps can help you understand which services people use and how. They can be done as concentric **circle maps**, where the service user lists the services they use most in the centre circle, services they use less often in the middle circle, and services they have heard of but never use in the outer circle. An **area map** is an actual map or one that people have drawn. People place sticky dots on the map at the places they go to use services.



You can find more information on how to implement service mapping at [Evaluation Support Scotland](#).

Exit interviews are a quick way to collect data on client satisfaction. You ask a set of questions about client experience and satisfaction with particular services as soon as the client leaves their consultation. These interviews provide a relatively reliable report of the experience, although clients may not report negative experiences while still on a service provider's premises. Researchers have found, however, that reported satisfaction in exit surveys is generally valid for questions about the behaviour of health personnel, infrastructure conditions, and supplies and services ([Sah and Kumar, 2015](#)).



More information on exit interviews is available at the Health Foundation's [Measuring Patient Experience](#).

The tools you choose to use in the baseline assessment may be used again for the next steps of performance and outcome evaluation, to compare findings with the baseline. [In Part 3, we discuss how some of these methods](#) can be done online, which may also be relevant for the baseline assessment.

How do we ensure the quality of the evidence?

There are many tools to choose from! Take your time and think about what best suits your purposes. You may also pre-test various options to identify the one that is most accessible to the people involved and to those collecting or facilitating the assessment, and that will elicit the highest **quality** information given available time and resources. Pre-testing helps ensure that the method you choose works for all social groups involved.

The quality of evidence is affected by how well the measures are defined, the design of the tools and data collection procedures, the training of those involved in data collection, and the management and routine checking of evidence for errors. If you collect too much evidence, perhaps more than you need, you may reduce the quality of what you collect. It is best to collect what is needed and most important.

Practically, aim for a level of quality that is credible for those stakeholders who will want to use the findings, including those in the community. Ensure that you include all key stakeholders throughout the entire evaluation process, from planning and implementing to analysing and sharing findings.

If issues are sensitive or if some groups have less confidence, as in discussions around adolescent sexual health, choose facilitators and methods carefully and allow enough time for participants to fully participate.



Quality refers to the appropriateness and integrity of information gathered. The better the quality, the more reliable and informative the evidence.



Engaging on tools and methods in Slovenia

In Slovenia's Pomurje region, community associations and various government sectors worked on a health and development agenda, prioritising actions that could improve health equity. A needs assessment was used to inform the actions to take. The activities were evaluated and [comprehensive efforts were made to assess the impact of the participatory interventions](#) on health and development. The evaluations used evidence from national health surveys and qualitative reports from services and community members over the seven years of the intervention. The evaluation found positive changes in the region including: increased consumption of fresh fruits and vegetables; reduced use of animal fats in cooking and consumption of unhealthy foods; reduced smoking and increased physical activity. The qualitative reports showed improvements in awareness and in intersectoral co-ordination and participatory decision-making (Bez nec et al., 2017)



Inaugural RAG meeting, Slovenia © CHD, 2012



Go to worksheet 2.3: With your team, complete the table in the worksheet by listing the indicators you plan to collect, the methods you will use for collecting them, and whether you plan to repeat them for the performance and/or outcome evaluations.

Organising, communicating, and using the findings



Data analysis is the process of converting collected data into usable information. It involves identifying trends, clusters, or other relationships between different types of data and then forming conclusions.

Descriptive analysis refers to describing the key findings of an evaluation, while interpretive analysis refers to drawing meanings, explanations, or causal relationships from the findings. It is useful to develop a **data management plan** to track what information will be collected and when—not only for the baseline, but also for the later performance and impact/outcomes evaluations.

The data management plan should also include details on the type of analysis that will be performed. It also helps to make clear upfront what evidence cannot be collected and why, and to be explicit regarding the limitations of the data collected.



There are five key stages involved in data management:

- Data preparation and verification;
- Data analysis;
- Data presentation; and
- Recommendations and action planning.

Throughout these stages, described below, it is important to identify any limitations and biases in the data that may arise due to challenges in the design and or implementation of the assessments.

a: Preparing and verifying data: *Quantitative data* needs to be checked and corrected. The data can be entered into a spreadsheet, missing data followed up on, and odd findings and outliers checked. It is always best to have two people doing these checks.

For *qualitative data*, whether captured as text, pictures, maps, or other visuals, identify and summarize the key points. This may involve synthesizing themes from long descriptions or highlighting critical statements, pictures, or other visuals.

In a thematic analysis, key points can be organised into categories, or themes, for further analysis, and outliers or otherwise contradictory findings can be checked.

b, c and d: Data analysis, presentation and discussion:

Quantitative data is organised in frequency tables, graphs, histograms, charts, bar charts, pie charts, maps, and/or pictograms, as shown in *Figures 2e and 2f*.

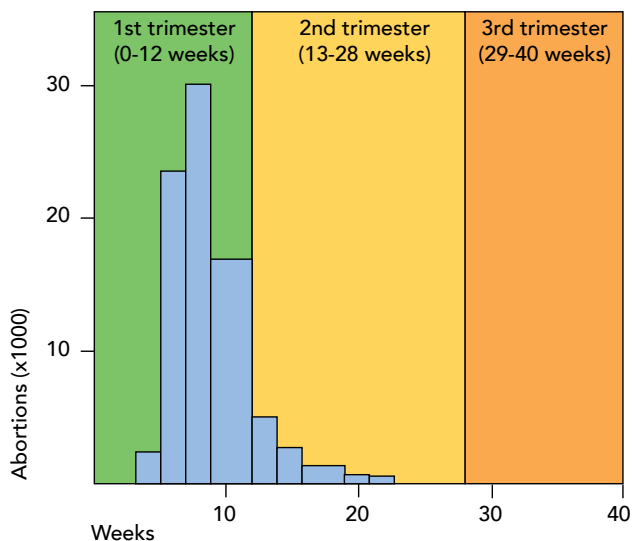
Choose the format that works best for your target audience. You may use more than one format for the same data for different groups, such as bar charts for managers and a simpler pictogram for a public meeting.

Whatever their format, formal data visuals should have a title, all bars/measures and lines should be labelled and easy to understand, and they should not appear overcrowded with too much detail.

You can analyse and present quantitative and qualitative findings by:

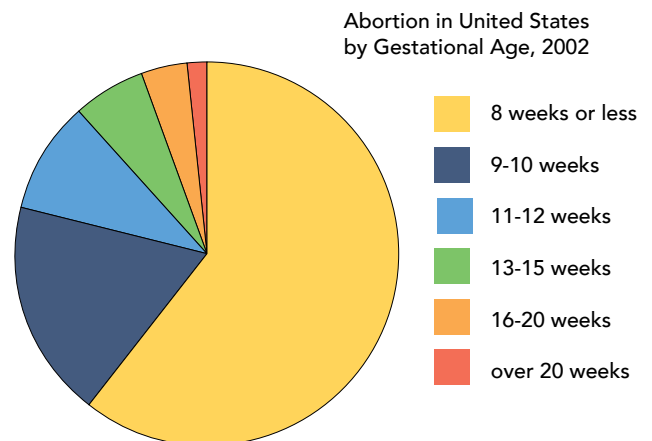
- Summarizing data so that findings can be clearly understood, with concise statements of the findings for each question you are addressing.
- Comparing primary data from surveys, interviews, focus groups, and observations with secondary data, noting any discrepancies, and, if necessary, gathering further information to explain the differences.
- Interpreting the findings to list the major issues. You may review the data with stakeholders, asking them:
 - Are there any emerging trends/clusters in the data? If so, why?
 - Are there any similarities in trends from different sets of data? If so, why?
 - Is the information showing us what we expected to see? If not, why not? Is there anything surprising and if so, why?

Figure 2e: A histogram or bar chart: UK abortion by gestational age, 2004



Wikimedia, 2007 under CC

Figure 2f: A pie chart: US abortion by gestational age, 2002



Severa et al., 2006 under CC

i A **Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis** organises information in the baseline and later steps in the evaluation to assess the conditions affecting the success of SPH efforts, to clarify directions and choices, determine where change is possible, and adjust and communicate plans during implementation (Peabody, undated). The CDC Better Evaluation Community Tool Box has guidance on SWOT analysis, as well as templates for analysis, such as the one [shown in the example](#). (CDC online) Graphic source: CDC, use of the graphic does not imply endorsement by CDC, ATSDR, HHS or the United States Government of the Implementers' Resource.

Communities for public health Share Collaborate Learn

SWOT Analysis Tool

A SWOT analysis will help you identify internal and external factors in the environment that can help with the development of your CoP's goals and objectives. Complete the SWOT analysis for your CoP's domain. Then use your results to help develop your SMART Objectives (via the [SMART Objectives Template](#)).

Evaluate: SWOT Analysis Tool
 State the idea/issue you are assessing: _____
 Identify **Strengths, Weaknesses, Opportunities, and Threats (SWOT)** for your CoP. The presence of weaknesses and threats are gaps to be addressed in planning, while the absence of strengths or opportunities clarifies the need for further planning or development before action is taken.

	Factors to Maintain	Factors to Address
Internal	Strengths What does your CoP do well? Potential criteria: <ul style="list-style-type: none"> Collective capabilities Morale, commitment, leadership Governance, participation norms, and defined roles Resources, funding, assets, people Experience, knowledge, data Innovative aspects Collaboration tools Accreditations, certification, requirements, mandates Processes, systems, IT, and communications Cultural, attitudinal, behavioural norms 	Weaknesses In what ways is your CoP lacking?
External	Opportunities What external factors help facilitate your CoP's activities? Potential criteria: <ul style="list-style-type: none"> Political, legislative, and financial environment Stakeholder involvement Technology development and innovation Quality of partnerships Development of knowledge Uptake in disseminated knowledge or best practices Competing or synergistic efforts outside the CoP Trends in public health that may affect the CoP's work 	Threats What external factors hinder your CoP's activities?

COP= Community of Practice

There are various ways of managing differing views on what evaluation findings mean.

One way that is participatory for many different kinds of people is to use a **problem tree**. Problems found in the baseline can be shown in the leaves and small branches of the tree. They are linked to their immediate causes that can be shown in the trunk, and to deeper causes that can be shown in the roots.

This method can be used to facilitate discussions and build consensus on the key action areas that are both feasible and relevant.

i The **Delphi method** provides another way of managing different views in interpreting findings. Stakeholders give their opinions, writing them on sticky notes or a white board, about what they see as most important in the data. They then respond to the aggregated results once all opinions are posted for all to see. Via group discussion, people explain their views and may change their opinions based on what they hear from other participants. In this process, recommendations are made on the basis of more complete information (Slocum, 2003).

Another way, which may be simpler and less time consuming, is to tabulate a timeline of positive, negative, and unexpected results and, for each result, ask *but why?* for respondents to answer why it happened, to deepen the analysis around the outcomes (Eggen and Chavez-Tafur, 2019).



More information on the Delphi method is available in [Participatory Methods Toolkit: A Practitioner's Manual](#) and the [Facilitating Experience Capitalisation Guidebook](#). You can read about problem trees and see an example of a problem tree in Chapter 3 of [DFID Tools for Development](#).



Producing city health profiles and action plans in Croatia

The Croatian Healthy Cities Network prepared baseline health profiles in three cities. The methods chosen were those that would be credible (scientifically based), sensitive (able to reflect local specificity), participatory (involving politicians, experts, and citizens), and that would engage interested parties in future collaboration. The exercise produced a mix of different types of evidence: a set of essays and a photo album on health in the city based on the stakeholder observations and existing data. In a workshop, stakeholders used this evidence to identify five priority themes and proposals for the city. The method increased the visibility of and the community's involvement in health. Limitations in quantifying the scale of the identified problems called for other methods to be used to obtain this data to later evaluate change (WHO Euro, 2002).

Present your data to both primary audiences (those directly involved in planning and implementing the SPH intervention) and secondary audiences (other stakeholders who may influence planning and implementation of the SPH intervention).

If you note that some key groups, whether policy makers, other officials, community leaders, or others, are not participating, think about the forums that they usually meet in and try to find time within their processes. Presenting data involves:

- Using accessible language and avoiding jargon, such as acronyms, and using clear charts and other graphics.
- Acknowledging stakeholder concerns in meaningful ways and showing evidence that has been reviewed by affected communities or those who work in affected services.
- Sharing the information in a timely manner.

Information may be shared with communities through online and traditional media, including newsletters and local newspapers, and through public meetings (See [graphic adjacent](#); NACCHO, 2012 used with permission).

Depending on the forum or media, you may present findings in a PowerPoint format. You may also choose to present findings via graphics, a short video, media briefings, posters, infograms, and/or policy briefs, depending on your audience.

Keep presentations brief (no more than 30 minutes for a verbal presentation), using visual aids and maps to highlight and locate important information for the audience. Summarise key points/messages at the beginning of your presentation and again in the last few minutes (NACCHO, 1994).



The National Association of City and County Health Organisation resource '[Mobilizing for Action through Planning and Partnerships](#)' provides examples in the resources it lists of [ways to organise and present findings](#).



Go to worksheet 2.4: With your team, discuss who needs to receive the baseline information and why, and thus who you will present the findings to and in what format.

Planning for challenges

Regardless of the measures and methods you use in your evaluation, you need to show that the data are reliable and valid and were rigorously gathered and analysed. For surveys, this depends on how objective the data collectors were and on how well the data was checked. For qualitative and participatory approaches, it depends on actively questioning and checking the findings. For both quantitative and qualitative evidence, triangulating the evidence on the same issue or measure from different sources or methods and finding a consistent picture between them can help to show validity.

As one key informant for this resource noted, *Evaluation can be challenging because it takes a lot of time to collect feedback, work with the community to analyse the data, and then share the results. Working with community organisations has been helpful in sharing these responsibilities of evaluation.* Their advice is to make sure to involve people who are affected by the work and to listen carefully to them. This takes time, but helps to shift the focus from evaluations as 'extractive' activities to shared processes where those involved and affected can see the value and purpose.

Euclid community meeting on grocery store role in improved diets



R Sikes, 2018



You can read more in a [Methods Reader on Health Policy and Systems Research](#) and in [Increasing the Rigour and Trustworthiness of Participatory Evaluations: Learnings from the Field](#)

Conflicts regarding the findings may arise among the stakeholders. These could be due to competition over resources, clashes of values, concerns about changes, distrust and unresolved disagreements, feelings of not being recognised or respected, or other causes. As one key informant for this work noted, *Just because there is tension, we shouldn't walk away from it. Tension is exactly what we need to make change.* However, if conflict becomes a barrier to input from any social group, it needs to be managed.

Managing conflict calls for understanding the sources of conflict and the interests and fears of those involved and identifying how to address them within a shared ethical framework, as discussed in [Part 1](#). For example, conflicts due to misperceptions and misinformation may be managed by sharing information among those affected to build greater shared understanding between groups regarding the experiences of each.

Keep in mind that evidence alone is not enough to produce change—you need relationships between different people who understand the work to generate or use opportunities to use it.



[Case \(1990\) in a Community Toolbox](#) suggests how to negotiate conflicts. You can also find useful videos on managing conflict at [Community Conflict: Finding Middle Ground- A Video Series](#).

Gathering and reviewing evidence can uncover power imbalances, bottlenecks, unanticipated issues or events, conflicts, and interests that may affect the SPH work and the plans and processes for evaluating it. A management style that enables collective discussion, feedback, and review is a critical asset in resolving such challenges.

We discuss additional challenges that you may face and how you can address them at the end of [Part 3](#) and [Part 4](#). If you face challenges not discussed here, please follow the links to these subsections. You may also find information in the resources listed in [Part 5](#). If you do not find the advice you need in this resource, please seek out someone who has experience or expertise on the issue. There is always a solution!



The White Oak Foundation, 2016, GSK under CC BY-NC 2.0

Part 3: Assessing Progress during Implementation

What you will find in Part 3

Assessing Progress in Implementing the SPH Intervention	3.1
Assessing whether SPH work is on the right path	3.2
The evidence to include in a performance evaluation	3.2
Methods for a performance evaluation	3.4
Organising, communicating, and using the findings	3.10
Planning for challenges	3.13



An evaluation story in Amish and Mennonite communities, continued...

Let's continue by looking at how the team assessed implementation. The performance evaluation included follow-up verbal surveys and key informant interviews conducted at regular intervals. *It was a great way to measure progress*, said a team member. Early on the team learned that community health workers (CHWs) would be critical to performing the work and providing feedback on how things were going. For example, while participating Amish and Mennonite women did not want to report negative experiences regarding services or local partners, they did share their issues with the CHWs. Discussing results of the performance assessment activities among team members, with the advisory group members, and with program participants made it possible to constantly review progress and adjust plans when needed. It led to learning along the way, particularly on issues raised by participants. The performance evaluation reviewed how community ownership of the program, power, relationships, and partnerships had changed over time, with the process moving at a pace and in a direction the community members wanted. As this was a guiding principle for the program, it was important to evaluate its implementation. The team also did its own self-assessment survey and held several retreats to talk about and deal swiftly with concerns.

PART 3: Assessing Progress in Implementing the SPH Intervention

Assessing whether SPH work is on the right path

Whether we are aware of it or not, we constantly monitor our actions to gauge how well they are working so that we may make adjustments along the way. A *process or performance evaluation*—also termed progress monitoring—helps you track the performance of your SPH intervention and how effectively inputs and resources are being used to achieve key outputs.



A **performance evaluation** assesses ongoing progress. It uses **process indicators**. These include measures of what **inputs** were applied, such as resources, capacities, and materials, and what **outputs** were produced, such as actions, events and publications. It assesses the level and timing of those outputs relative to what was planned or is needed to produce the intended changes. In sustained interventions, we may also track **intermediary outcomes** that we hope to achieve as the work progresses. .

Performance evaluation, conducted once or more often during program implementation, allows us to review, improve, and build confidence in practice. The people directly involved in implementation are the primary audience for the results, to discuss areas to adjust to improve program performance. Reporting your program's progress at key points to funders, managers, and community members also helps to fulfil contractual duties and/or ethical standards.



Implementing a process evaluation in Ecuador

In Quito, Ecuador, the 'healthy markets' strategy helps make safe, fresh, affordable food available to the city's residents. The strategy has two expected outputs: (1) the certification of markets that meet national standards, and (2) the community certification of markets that meet criteria set by citizens. In the latter, citizens propose criteria, such as better customer service, cleanliness or operating hours, that are used in *process evaluations* to make improvements (Obando and Loza 2017).



The frequency and timing of performance evaluations are decided when the SPH implementation plan is set, to link the assessments to the timing of activities and outputs in the plan. The assessment is often done more than once, with the frequency depending on the intervention and work plan. For example, a five-year project in Slovenia reported back on progress twice a year, using the findings to inform and adjust plans and to make the work less project-based and more program-based.

We suggest you prepare a calendar (or a table with time periods laid out in months or quarters) and in each time period, include rows labelled for:

- intervention plans,
- expected actions and outputs, and
- what will be evaluated and how.

The evidence to include in a performance evaluation

A performance evaluation explores the relationship between inputs, outputs, processes, and, in some cases, the intermediary outcomes. As discussed in [Part 2](#), specific indicators will vary from situation to situation, may be quantitative or qualitative and may come from primary or secondary sources. Many of the measures identified in the baseline will be repeated, as you may have noted when completing *Worksheet 2.3*. Measures must be relevant, valid, reliable, and generate information that will engage people.



Performance measures should be **SMART** and **SPICED**, as in the example from South Africa:

- **SMART**— **S**pecific; **M**easurable; **A**chievable; **R**elevant, and **T**ime-bound.
- **SPICED**— **S**ubjective; **P**articipatory; **I**nterpreted; **C**ommunicable, cross-checked, and compared; **E**mpowering, and **D**isaggregated.



Assessing performance of a violence and crime prevention project in South Africa

In South Africa, [Saferpaces](#) is working with teachers and young people in local schools to manage conflict in a non-violent way, using participatory monitoring and evaluation. SMART and SPICED indicators were established at the start of the program. The quantitative SMART indicators described easily measured *outputs*, while the more qualitative SPICED indicators were used for elements less able to be precisely measured, such as perceptions of safety. Progress indicators (also termed *milestones* or *progress markers*) described progress at three levels: what the implementers 'expected to see,' 'would like to see,' and 'would love to see.' For example, an 'expect to see' milestone was the provision of non-violent conflict management skills through sports and exercise classes. A 'like to see' milestone was a target number of young people participating, while a 'love to see' milestone was for participating youth to have confidential, conflict resolution exchanges during classes. The progress markers were used to assess whether or not all the inputs were provided and activities carried out as planned; how much they cost compared to the budgeted amounts; and whether the expected outputs were being achieved, such as number of people trained. The results were reviewed in meetings and deviations discussed, understanding that the changes would take time. The performance evaluation helped to keep people engaged in the work and to build confidence of success, as well as to adapt plans if needed (saferpaces, 2020, [online](#)).

Some add 'Inclusion' and 'Equity' to SMART goals to make SMARTIE goals. Inclusion covers whether excluded groups are involved in a way that shares power, and equity assesses if systemic injustices are addressed. For performance evaluations, you need to identify what measures to use to assess inputs, outputs, actions, and to process changes. Implementers, community leaders, and immediate managers, as primary audiences for the performance evaluation, should be involved in these decisions and in reviewing the evidence. Those directly implementing the program need to know how well things are progressing in order to make relevant adjustments and those with a direct interest need to be informed about how things are progressing, for purposes of accountability and to build confidence in the process. As discussed in [Part 2](#), the decision about what to collect is usually made at the time of the baseline assessment, so that is the time to

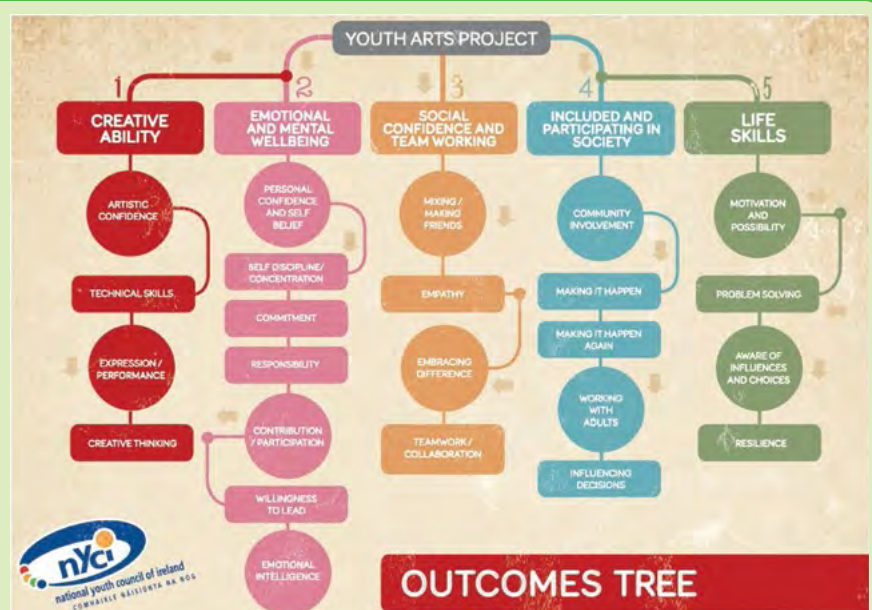
involve key stakeholders, and ensure that the necessary baseline evidence is collected for this later stage. While the specific measures will depend on your SPH intervention, they will fall within the six areas shown in the box, the methods for each of which are discussed next.

You may use a visual chart, such as the one shown in the example below from Ireland, or your [theory of change](#), as developed in Part 2, to identify the performance measures that are relevant for the different steps towards the change and the outputs needed along the way in your SPH intervention. Whatever information is collected, beyond total numbers, record the numbers relevant social features, such as gender, age, or area, to know how what was done reached the different groups that you identified in your baseline assessment.



Using visual tools to show the different outcomes and their links in Ireland

Capturing Magic in Ireland outlines an evaluation tool for work with youth. The various measures selected are shown in an outcomes tree, with the different areas of observable behaviours or conditions that show performance, as shown in the graphic. The *YARN model in Australia* has a similar visual representation showing the interaction between areas of performance, like intertwined balls of wool.



Source : [National Youth Council of Ireland, 2017: 5](#); [Chambers et al, 2018](#)



Information gathered during a performance evaluation includes:

- a. Changes in the **context**—in social tensions; any risks and assumptions, and any unexpected situations—all of which affect the work as it is implemented
- b. **Acceptance of the intervention**, including *different* participant group involvement in, organisation of, and time spent on activities; inclusion, attendance, and active participation in meetings and decisions; and perceptions of the process, benefits, and challenges.
- c. **Inputs and organisation of the intervention**, with measures of the knowledge and capacities of those playing key roles; the adequacy and quality of the inputs (data, time, funds, personnel, materials) applied; the way the resources are distributed to and accessed by different groups or areas; clarity of tasks, roles, and plans; and perceptions of and satisfaction with the program implementation among those involved. This may include changes in SPH, such as in community organising or other measures identified in [Table 2a](#) and [Part 2](#).
- d. **Resources**, including costs of and funds raised for interventions, by input and activity, and the timing and way resources are allocated and spent in relation to budgets and plans.
- e. **Organisational performance**, including institutional commitment, development, and capacity building for and resulting from intervention measures; communication and collaboration among those involved; level and growth of coalitions; stakeholders involved and the perceived benefits of their involvement; and the sustainability of the processes.
- f. The **outputs of the intervention**, including tangible products and outputs, such as public events and training sessions, as well as milestones or intermediate outcomes achieved, such as community uptake of a service—all of which are important for further implementation of the program (Brown, 2014; Abelson et al., 2010).



More information on performance evaluation measures is available in the International Federation of Red Cross and Red Crescent [Societies Project/Program Monitoring and Evaluation Guide](#) (IFRC, 2011).

How often you collect these measures, and the timing of periodic performance evaluations, depends on the duration and nature of the SPH intervention and the availability of resources. In a campaign lasting a month or two on a specific issue, the periodic assessments and reviews may be done weekly. For a more complex intervention that takes a year or more, assessments may be done quarterly.



Go to worksheet 3.1a: With your team and referring to a completed Worksheet 2.3, identify the measures you will use for your performance evaluation.

Methods for a performance evaluation

Performance evaluations can be conducted by gathering primary or secondary data. Primary data can be gathered in various ways, some of which were described in [Part 2](#) and others of which are described in this section (see the Methods and tools table on page 3.5).

Secondary information can come from the following.

- **Review of existing documents**, including minutes, attendance rosters, and reports to capture details on who participated and issues and incremental accomplishments raised
- **Information systems** that track service delivery and coverage
- **Financial accounts and records** used to assess resource use

This section outlines methods you can use to collect the evidence needed for each of the areas in the performance evaluation of your SPH intervention. As listed earlier, these areas are: context, acceptance, inputs, organisation of the intervention, the resources applied, organisational performance, and outputs of the intervention.

Methods and tools for the performance evaluation

PURPOSE	METHODS	PAGE
Gathering evidence on context	Surveys, interviews, and focus group discussions Participant observations, stories, and diaries Repeating social, empathy, and other mapping methods Media and other reports	2.11, 2.12 2.12 2.12
Gathering evidence on the program experience/ acceptance	Surveys, interviews, and focus group discussions Venn or chapati diagrams; power, relationship, and empathy maps Journals, diaries, storytelling Spider maps, speedos, Likert scales, and the CHANGE tool Wellbeing/pairwise/preference/matrix ranking and matrix scoring	2.11, 2.12 2.13, 2.14, 2.15 3.6 2.7, 3.5, 3.6 3.6
Gathering evidence on the inputs, organisation, performance, and outputs	Service use maps, circle maps, and venn diagrams Direct observation, activity logs, exit interviews, portfolio reviews Surveys, focus groups, participant observation Repeated forcefield analysis Likert scales, ranking methods Timelines, progress markers	2.13, 2.17 3.7 2.12 2.16 3.5, 3.6 3.7, 3.11
Gathering evidence on the resources	Assessing resources used, costs/value of inputs and outputs Cost-effectiveness analysis, valuing engagement	3.8 3.8

How do we assess changes in the context?

In your performance evaluation, you may use exactly the same methods described in [Part 2](#) to collect evidence and compare it against the baseline. These include gathering evidence on:

- Conditions, such as through maps, observations, and stories;
- Stakeholders, networks, and power relations, such as through stakeholder analysis, onion and venn diagrams, social network maps, relationship maps, and power maps;
- Service use, such as through service use maps and exit surveys; and
- SPH, such as through spider maps and Likert scales.

How do we assess experience or acceptance of the intervention?

Whether implementers or participants, the views of those involved regarding their experience and acceptance of the SPH intervention can be assessed through the following methods.

- In-depth and key informant interviews, participant surveys, and focus groups** with implementers, users of services, and community members. Repeating a survey at different points across the lifetime of a program can be used to assess changes in experience and perceptions of interventions, if the same tools and sample are included in each round.
- Likert and other rating scales** (described below), spider maps, and ‘speedos’ can be used in interviews, discussions, and participatory sessions to rate satisfaction levels and other perceptions. (Refer back to [measuring SPH in Part 2](#) for a refresher on spider maps and speedos). You can also use a ladder graphic, with the situation labelled on the ground, the intended change noted at the top, and the intermediary outputs on the steps. Rating scales are particularly useful to assess changes in perceptions in a range of qualitative measures where there is a continuum of levels, such as of service performance or social inclusion.

i Using rating scales to measure progress

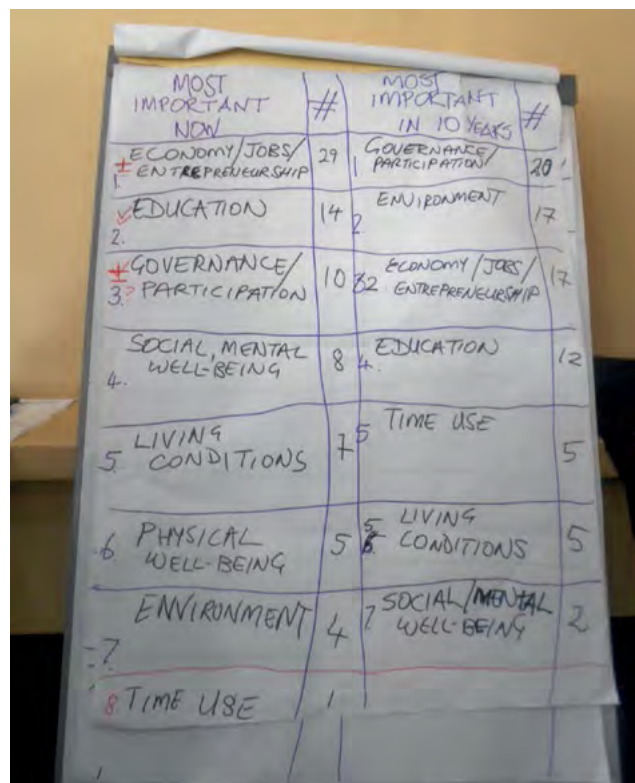
If you've ever answered a question that asked how much you agree or disagree with something, then you've answered a Likert scale question. The Likert rating scale is a type of survey scale. It asks a question and presents a series of answers to choose from, ranging from one extreme attitude to another, and normally with a moderate or neutral option in the middle. It uses an uneven number of options from which to choose (usually 5 or 7), such as very unlikely, unlikely, possible, likely, very likely. Or you might use a range from strongly agree to strongly disagree, or from very satisfied to very dissatisfied. The scale can also be used to rate specific characteristics, such as least to most powerful. Likert scales are considered to be one of the most reliable ways to measure opinions, perceptions, and behaviours. To analyse them, you add up all the scores and divide by the number of respondents to get an average score. You can see a Likert scale example in a [tool from the Tamarack Institute](#).

The [Community Health Assessment and Group Evaluation \(CHANGE\) Tool](#) enables community members to identify and prioritize what actions will improve their health. It can be used to assess progress in policies, systems, and change strategies, and to offer new priorities for future efforts. The data-collection tool tracks progress across a five-point scale, so that incremental changes can be noted.

- c. **Journals and diaries** can be used by implementers and participants to record experiences on how processes are working, including unexpected positive and negative events and outputs. An [empathy map](#), referred to in [mapping community conditions in Part 2](#), can help identify where people feel progress has been made or has not been made.
- d. **Ranking tools** are simple and inexpensive ways to obtain information about the preferences of a group of people as well as any differences in perceptions within and among groups of people. They are used to identify and monitor changes in needs and priorities for discussion and analysis. Ranking can be done by using a list of possibilities. Each person votes for their priorities by placing three or more beans, sticky dots, or other counting object next to those options that they consider priorities. This yields a chart on the priorities that can be used for review and discussion.

In the graphic below, urban youth in Lusaka ranked their current and future health priorities. Ranking can also be used to show what aspects of interventions are most or least appreciated and other perceptions

Ranking chart after voting in a youth meeting



Lusaka, TARSC, 2018

i Wellbeing ranking, preference ranking, matrix ranking and matrix scoring are

participatory tools that can be used to prioritise or provide the relative weighting of different dimensions of performance. 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 according to whatever categories of features (eg. participation in or support for an intervention) or wellbeing (eg. trust/ self-confidence) they decide upon.

Pairwise ranking provides a systematic method for comparing each item on a list with the other items on the list. Each choice is compared with all others, one by one. It can be used to prioritise areas that are performing well or badly, that may need adjustment. These ranking methods and the information shared can be compared over time to identify changes. Discussions on the findings contribute to the performance evaluation (Loewenson et al., 2014).



A guide on how to do ranking and scoring appears in the [Organising Peoples Power for Health toolkit](#) (see activity 12). You can read further on how to do ranking methods at [Pairwise Ranking Made Easy](#) by Russell (2001).

Across these different methods, engaging with the experiences and views of those directly involved can improve the quality and credibility of the findings. Preskill and Jones (2009) provide a [step-by-step guide](#) on how to solicit input from stakeholders in an evaluation, including methods such as storytelling. Involving those who are implementing and/or directly affected by an SPH intervention reflects SPH principles and can help build teamwork. Where possible it is useful to choose methods that can be integrated within the regular tasks and capacities of the team.

How do we assess the inputs, outputs, organisation, and performance?

Secondary data on the performance of interventions, in terms of inputs, outputs, and practices, can be collected through records of the resources used and the activities implemented. Primary data can also be gathered using the following:

- a. **Direct observation** of services, systems, programs, and meetings for what they do and how they are functioning. **Photographs and maps** can show changes or activities for different areas and social groups. You may include the numbers of different people or areas involved in meetings or actions and repeat observations to show changes over time.
- b. **Measuring outputs directly**, such as water quality or materials produced.
- c. **Exit interviews** of clients after they use services, with questions regarding their interaction with and experience of the program (discussed with links to resources in [Part 2](#)).
- d. **Portfolio reviews** showing work produced and **event or activity logs and record books** documenting accomplishments, meetings, or activities related to the milestones and goals. **Life histories, narratives, and structured storytelling** represent experiences of and changes in practices. **Role model stories** or narratives can show how particular social features link to the performance of interventions.
- e. **Spider diagrams**, presented in [Part 2](#), can be used to identify and analyse relationships between actors in and elements of processes, with the spider's body representing the issue of focus and each of the spider's legs the factors affecting it. The factors can be discussed, ranked, and analysed.



Using storytelling as a method for evaluating practice in California

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

- f. **Timelines** help to link evidence to key in a process and can be used to focus discussions on implementation issues at key stages of the process



A timeline helps to understand and demonstrate the evolution of an intervention.

It tracks important events, including changes, over time from the perspective of those involved. It is done in a workshop setting. Working collectively or in small groups, representatives of different stakeholder groups involved in the intervention draw a timeline and record important events and milestones along it, noting dates and using words, symbols, pictures, or all three. The timelines are presented and the presentations are captured in notes. The interactive process stimulates reflection, ideas, and discussion (see the example from Chile). A timeline can also be implemented in the form of a [seasonal calendar](#).



Using a timeline to evaluate performance of the Mesa de Trabajo, Chile

The Santa Teresa camp in southern Santiago is densely populated with over 300,000 inhabitants and high



levels of poverty and unemployment. From 2017, Techo Internacional supported the community with training and with social and neighbourhood improvement activities. An evaluation was implemented of the housing project and tenure negotiations. As part of the evaluation, participants created a chronological timeline of program events and milestones with start and end dates, drawing on participants' collective memory ([Techo Internacional, 2019](#)).

How do we assess whether funds and other resources are being used effectively?

An important aspect of the performance evaluation is assessing how resources (money, time, materials) are being used relative to the *outputs* being achieved. This is the intervention's cost effectiveness, or the effectiveness and efficiency of resource use. (This is different to cost benefit, which refers to the costs of producing *impacts* or *outcomes* and is discussed in [Part 4](#)).



Cost effectiveness refers to the relative cost of processes for producing different outputs.

Cost benefit refers to the cost of an undertaking relative to the value of its benefits.

There are different ways of collecting and using evidence on costs, noting that not all costs or outputs can be expressed in monetary terms.

- Information on expenditures for different inputs can be obtained from **official accounts**.
- **Interviews** can be used to collect evidence on and value the time, resource, and material contributions from community members and others not included in the accounts.
- Work **diaries or timesheets** can provide evidence on unpaid time and inputs.
- **Interviews and focus groups** can be used to identify areas of savings. Examples of this are reductions in harms that cost households, or legal costs related to conflict or crime.

The major challenge in assessing performance on **costs** is getting valid cost data that can be extrapolated from one situation to another. Direct costs are easier to measure because they are often tracked as program budget line items. Less easy to measure are the costs of inputs that were not programmed, like those that the community or other sectors or actors contribute to the program, including for any digital or in person participation. There are also background costs that would have been spent anyway, but that also helped in the program performance, such as health system costs. A judgment may need to be made on what elements or portions of these elements need to be included if they are critical for the SPH intervention. Where you cannot find the specific cost, you may be able to use a proxy indicator to approximate costs.

Assessing **effectiveness** depends on having clear measures of the performance targets. Recall from [Part 2](#) that different audiences will have different ideas regarding which measures of progress are important.

You should have identified these when you reviewed the evidence for the baseline and theory of change; and you can identify what can be costed to address these different interests. Not all measures of SPH can be measured quantitatively, as discussed earlier, making comparisons with costs more difficult. Collecting good information about the numbers of people who have been reached by or included is one important measure of effectiveness, but this also needs to be disaggregated by the social features you identified in the baseline to assess equity. You may otherwise find that the program was cost effective only for the wealthier, more accessible, or higher status groups in the community.

You could also do a qualitative analysis. You can categorise both the input costs and outputs achieved by their scale (e.g., huge, big, middling, small, negligible). This judgment can be made by the team and, if useful, with input from other stakeholders. If the qualitative evidence is organised in a matrix, some input and output costs will be found in the extremes of the quadrants (e.g., the huge/big costs with small/negligible outputs, or vice versa). These extreme quadrants provide useful evidence about the cost effectiveness of the intervention.

You may also ask key informants or focus group participants a simple question: is the SPH intervention leading (or has it led) to any reduction in costs for the services or communities involved? This answer should be backed with budget figures when possible.



You can find more information on how to gather and organise evidence to assess costs in relation to outputs and benefits in [Involve \(UK\) Valuing Engagement tool](#). Further guidance and an example of cost effectiveness analysis can be found in the [CDC resource on cost-effectiveness analysis](#).

Where you are not sure about an indicator or tool, you could, as a trial, collect the same measure in two different ways and compare the findings. If the results vary, identify what is causing the difference and what works best for your assessment.

Can we do these methods online?

While many of the methods discussed in Parts 2, 3, and 4 of this resource work best when those involved are able to meet in person, when the situation demands, digital tools can be used for some of the methods. As outlined in the box, there are a number of online methods and tools, including surveys, focus groups, ranking and rating scales, and mapping. This is a rapidly developing field; you may want to search online or connect to networks listed in [Part 5](#) for new online tools.

i Public Agenda: Online methods for surveying, ranking, and rating in social engagement

Public Agenda, a national, nonpartisan, nonprofit research and public engagement organisation headquartered in New York City has developed or compiled a range of [online tools for public engagement](#) on different matters, including health. One example is the [Civic Engagement Scorecard](#). The scorecard is an online measurement tool that allows people to rate their experiences as input into decision making in different processes and forums. It raises a series of questions, which can be tailored to different purposes and situations, for people to rate experiences and interventions by selecting options on a list or moving a sliding scale. The tool compiles the results of the collective input of a group of people to be used to understand and or support their engagement (Leighninger, 2020).



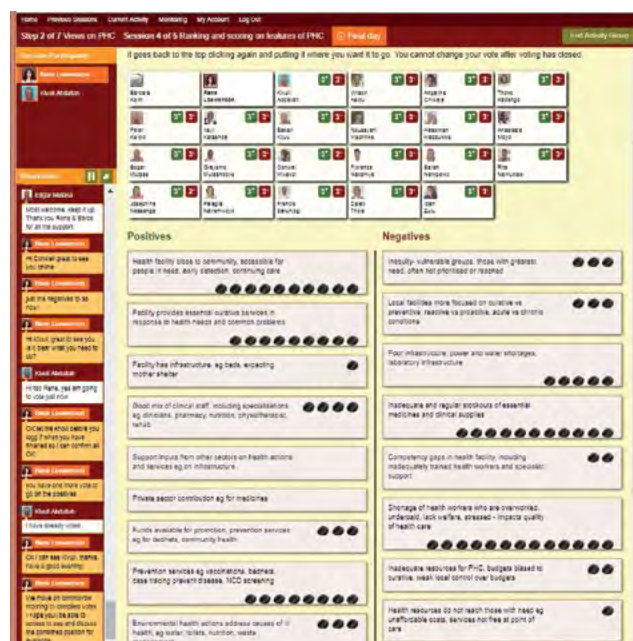
Digital tools are being more widely used in SPH generally, including in planning and participatory budgeting, but less so in evaluations of interventions. We discuss them here, but you can make your own decision regarding their relevance for any of the three stages of evaluation. The most important consideration is that you use them consistently across the stages. One example of an entire assessment process implemented online is the [EQUINET PRAonline website](#) that used participatory action research methods online with health workers and community members from five countries in Africa to assess their experience of performance based financing (Loewenson et al., 2019).

[Mindmixer](#), an online tool for SPH in urban planning, provides a platform for submission of ideas, polling preferred choices, identifying actions, implementing surveys, and sharing visual tools. Other tools similar to Mindmixer are: [citieshealth](#), [Bangthetable.com](#), [citizenlab.co](#), and [Metroquest](#).

The evaluation guidelines and principles presented in this resource also apply when working online. However, there are other issues to consider as well,

EQUINET PRA online discussion of ranking scores

Visual impression of ranking dots and an online chat on findings. The specific words have been deliberately blurred.



Loewenson et al., 2019

such as whether all potential participants have access to necessary technology—including internet coverage, bandwidth, and financial resources—and are comfortable using digital tools. Other issues include how online tools maintain trust in shared confidentiality and enable collective discussion and validation.

A well-constructed online evaluation process can generate excitement as people with common features or interests share experience and analysis, sometimes across countries. However, as [EQUINET PRAonline participants observed](#), moving beyond a single digital tool to an entire online process requires accessible tools; very good facilitation and guidance, especially to encourage input in discussions; and rapid response when challenges arise.



You can read more on principles and tools for digital engagement in [Digital Engagement, Social Media and Public Participation](#) and see useful compilations of digital tools for public engagement, some of which related to evaluation on the [Public Agenda website](#).

As noted in [Part 2](#), decisions around which methods to use depend on what works for your context, time, and resources; you are likely to use a mix of tools. For example, focus group discussions can help discover—in less time than surveys—what people think and feel about how interventions are being implemented and whether SPH efforts are meeting expectations. They can help to generate ideas from those directly involved on how to make improvements.



Using diverse methods for performance evaluation in South Africa

Performance evaluation processes often use a mix of methods for gathering evidence. For example, the saferspaces program described earlier, used a mix of the following tools to measure progress:

- Tool 1 - [Behaviour Changes – New Ways of Doing Things, New Ways of Thinking](#) to generate information from self-assessment of the behaviour changes in key people who have influence on performance and to explore participants' ideas on necessary next steps or adaptation of planning.
- Tool 2 - [The M&E Web](#) to support the assessment of the progress in interventions for training, exchange of experiences, or other forms of support.
- Tool 3 - [SWOT Analysis](#) to generate information from participants and to enable stakeholders to reflect on the ongoing process to define next steps and possibly adaptations in planning.
- Tool 4 - [A Look at our Quality of Life](#) to enable the different stakeholders in the community to identify changes, discuss trends, and compare progress against plans—and to be aware of different existing perspectives to strengthen the positive changes and counteract negative ones.
- Tool 5 - [Rich Picture – Mind Map](#) to enable participating stakeholders to describe and analyse changes in indicators formulated in the planning phase ([safterspaces, 2020](#)).



You can find more information on many of the methods presented here in [The Community Toolbox](#).

You need to be aware of the limitations of any chosen method and discuss the implications of those limitations when you review and present the findings. For example, power dynamics in focus groups may cause seldom heard voices to be less vocal. In this case, you may use visual or participatory tools that are more accessible across all participant groups. You may also work separately with different groups, enabling participants to feel more confident and you to identify differences between groups in the results.

Whatever the methods, preparation and paying attention to any challenges or deficits in their implementation are essential to ensuring the quality of gathered evidence.



Go to worksheet 3.1b: Building on Worksheet 3.1a, identify the sources/methods to use in your performance evaluation and who will implement them.

Organising, communicating, and using the findings

How do we organise the information?

Performance evaluations require active processes to organise and review the evidence. These processes:

- **Monitor progress against plans** to review the differences between planned targets and what has been achieved, and to discuss how practices or plans can be adjusted.
- **Check if any changes need to be made** to the assumptions/risks identified for the program and monitor how they need to be adapted.
- **Identify whether all participant groups are achieving the same progress** or whether the experience differs between groups, and if so, to understand why.
- **Identify any additional information needed** to help clarify issues and plan the outcome evaluation (IFRCRC, 2011).



The ways of analysing, organising, and communicating baselines evidence for different audiences, as described in [Part 2](#), can also be used for the performance evaluation. In a performance evaluation, you will want to use the analysis (from one or several rounds, if you are repeating the evaluation) to celebrate progress made and identify trouble spots or sticking points when progress is faltering (Burns et al., 2004).

The evidence gathered during a performance evaluation can be combined in an accessible form to help identify progress made against planned outputs, processes, or interim outcomes.

i One way to do this is to use progress markers for the different measures. **Progress markers** are selected when action plans are prepared. They identify what participants would:

- *Expect to see* (usual situation),
- *Like to see* (improved situation), and
- *Love to see* (more ideal situation).

They are then used to monitor progress towards the desired actions and outputs. Achievement of these milestones is tracked via a table like the one on the right. For different time periods the cells are empty, half filled, or fully filled, depending on progress. Regular meetings are held to assess, review, and discuss the progress shown in the table, as well as obstacles to overcome and opportunities to tap. The adjacent example from Lusaka, Zambia, shows, for example, progress related to health centre committee roles. The markers were jointly set by community and service personnel and were used to track achievements (Mbwiki Muleya et al., 2017:6).

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						
2	HC staff & CMs disseminating or sharing information on planning and any other current issues						
3	HC giving CMs feedback on planning activities and any other current issues as soon as it is received						
4	HCs & CMs respecting each others views during meetings & discussions						
5	Participants who attended the 2007 PRA orientation workshop sensitizing or sharing the information with their immediate workmates and colleagues.						
LIKE To See Progress Markers							
1	HC providing necessary materials & simplified guidelines to CMs on planning process						
2	HCs & CMs beginning the planning cycle activities without being prompted by higher level						
3	HC providing & sharing information to CMs on budget allocation & expenditure for HC						
LOVE To See Progress Markers							
1	75% of HWs conversant with planning process						

Key: Done Started/Ongoing Not Started/not done

>> You can read more on monitoring progress markers for performance evaluation in the [Outcome Mapping approach](#) (Earl et al., 2001).

You may also use progress markers to track negative, positive, and/or unintended results in relation to performance. To better understand how equitable SPH program performance is, you may choose to track progress markers such as inclusiveness, gender sensitivity, social inequalities, or changes in other key features that you have identified as important. Interrogate the findings to explore their limitations, the reasons behind them, and what lessons they offer. Reassure audiences that, for learning purposes, negative findings are as useful as positive findings; they do not mean the intervention is failing, but rather point to opportunities for strategic adjustments.

It is useful to gather implementers, community representatives, and others to review the findings and generate shared analysis and learning. A [world café method](#) is a simple, flexible format to help structure conversations on specific evidence or questions for analysis and learning. **Rating and ranking**, discussed earlier, can be used to identify prioritised issues, and the [knowledge tree](#) method, similar to the problem

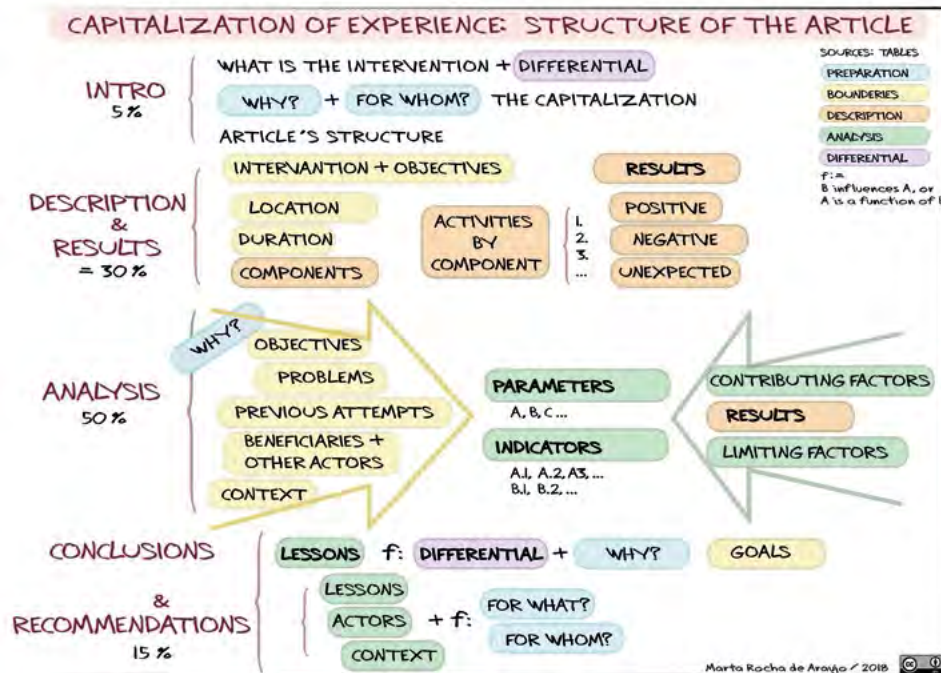
tree method discussed in [Part 2](#), engages people in identifying causes of progress, or lack of it, and what this implies for plans.

>> You can read more on these methods in the [Facilitation Guide for Learning Review](#) and [Guide to Knowledge Trees](#) by the Action Evaluation Collaborative

How do we report on the progress?

Many people find writing results reports challenging and are happy to leave it to others. This may mean that those directly involved in an intervention may not be directly involved in communicating the findings, which is not ideal. As an evaluation team, you can manage this by agreeing collectively on a structure for the report, such as shown in [Figure 3a](#). That may make the report less intimidating to produce. Set aside time for people to make and discuss inputs. Give enough time for those who are less familiar with research and data to discuss the findings, allocate writing tasks to those more comfortable with this role, and use the more accessible ways of reporting evidence visually, discussed in [Part 2](#). You may also seek help with copyediting the report if you want to share it widely.

Figure 3a: Organising the structure of a report



Source: [Eggen & Chavez-Tafur, 2019:57](#).

➔ You can find further ideas on organizing and writing reports in [Facilitating Experience Capitalization](#) (Eggen and Chavez-Tafur, 2019).

While significant effort usually goes into producing written reports, there are many other ways of reporting on progress, including visual summaries presented via posters, videos, or in live drama. Some of the [methods shown earlier](#), such as timelines and progress markers, use visual evidence that can be integrated into reports and may make community voice more visible.

Figure 3b: A traffic light approach to present data on performance

Examples indicators	Target	Actual	% of target	Explanation of variance discussed in project/ programme management report.
Number of project/ programme beneficiaries	2000	2100	5%	
Number of bed nets distributed	100	0	-100%	Delivery of bed nets hindered due to road access in rainy season. Lesson learned - distribute before rainy season.
Number of people trained to maintain bed nets	500	400	-20%	Absence of some trainees due harvesting season. Lesson learned - undertake training earlier in year.

IFRCRC, 2011:55

The evidence can also be organised using a **dashboard** format. This uses traffic light colours (red = poor, yellow = medium, and green = high) to show the level of performance against goals (see *Figure 3b* above). The assignment of colours is based on the achievement of a certain percentage of the output measure, or on the

difference between the target and the level achieved. The assignment of colours can also be a judgment call made by of the group reviewing the findings. As *Figure 3b* shows, the reasons for variances and the proposed actions can also be shown.

How you and your team decide to present the findings depends on the target audience(s) and forum. To facilitate collective discussion among diverse stakeholders, the evidence may be more meaningful if communicated visually, in dramas, or via written or verbal storytelling.

i Stop drama is a way of role playing the challenges faced during an intervention. The audience of stakeholders can stop the drama at any point and propose ways to address a barrier, overcome an obstacle, or take ignored factors into account. The proposed options may be discussed and tested within the role play drama. The proposals and discussions reveal factors affecting performance. Further, those options seen to be more feasible, acceptable, or effective may be integrated into the intervention to improve performance.

For managers and funders, you may use graphics, tables, and dashboards that present data within a written report and with key messages. For those less familiar with quantitative data, the visual formats described earlier may be more accessible.

It usually is a powerful experience for audiences to hear direct testimonials from those involved and affected, and to see visual representation of progress. As one key informant noted, before such report-back forums, it is useful to discuss and practice presentations to build confidence. It is also important to debrief all team members regarding presentations of findings.

Youth presentation on climate effects on pathogens on fresh vegetables



[NASA HQ PHOTO](#), My community my earth, Nigeria, 2014 under CC

Whatever reporting method you choose, it is useful to solicit feedback on the final product before it is widely disseminated. Ideally, feedback would be provided by representatives from each of your target audiences. If you have an advisory group, it can play this role.



Documenting evaluation of urban engagement for health in India

For 10 months, India's Dekha Andekha engaged residents of an urban slum in exploring their lives and health through art (including photography, clay, and textiles) and then exhibited this work. The evaluation was iterative throughout the project and generated both qualitative and quantitative evidence. To quantify outputs, researchers counted the number of people involved in meetings held, the number of meetings that took place, and the number of people visiting the exhibition of the final products. At the same time, a photojournalist followed the process, taking photos to illustrate stories of change in the evaluation. The photo stories supported reflection on the process and communicated the findings more widely (Aggett et al., 2012).



Go to worksheet 3.2: With your team, list the different audiences for the findings of the performance evaluation as well as how and when you will report your results

Planning for challenges

There are many challenges in implementing performance evaluations, including language gaps, sensitivities around particular issues, power imbalances, timelines being affected by contexts that are difficult to control, and resource constraints.

You may also encounter conflict around the findings. If so, return to the [discussion on conflict in Part 2](#) and review the ways of dealing with this.

Many outputs may take time to emerge and some may be intangible and hard to measure. Measures that appeared to be relevant and feasible during planning may be found in time to be difficult to collect and need to be adjusted. You can plan for these and test your tools and measures through a small pilot.

The situation demands vigilant oversight to supplement initial indicators or make adjustments as needed. Be careful, however, to avoid changing indicators completely, as they need to be compared over time. As noted earlier, try not to collect too many indicators too often, as this can overburden the team and stakeholders.

As explained in [Part 1](#), evaluation generally progresses in phases over the life of a program or intervention, from baseline assessment to performance evaluation to outcomes evaluation. However, the uncertainty and complexity of many SPH interventions may result in a less linear path. Course corrections may call for more backward and forward movements to review both outputs and goals.



A community health worker conducting a survey in the Korail, Bangladesh, UK DFID under CC

Part 4: Assessing Outcomes and Impacts after an Intervention

What you will find in Part 4

Assessing Outcomes and Impacts of an SPH Intervention	4.1
Assessing the changes from SPH interventions	4.2
The evidence to include in an outcome or impact evaluation	4.3
Methods for an outcome or impact evaluation	4.6
Organising, communicating, and using the findings	4.13
Planning for challenges	4.17



An evaluation story in Amish and Mennonite communities, continued...

In the final stage of the Ohio evaluation, the team assessed the outcomes from their intervention. The outcome evaluation compared evidence from the baseline assessment with that collected after the completion of the intervention. The team explored whether there were changes in knowledge and behaviour regarding breast cancer screening, in uptake of screening and mammography, and in information sharing and power relations between those involved. The evaluation involved anonymous community member surveys, key informant interviews, and CHW follow-up with community clients. There were differences among the women in terms of their confidence levels and beliefs, but most were now sharing information and encouraging other women to get mammograms. Several hospitals reduced mammogram costs and some hired Amish liaison personnel. The outcome evaluation found improvements in relationships between health department personnel and community members that were attributed to the project. The team prepared a report with input from all stakeholders and is preparing to do an epidemiological study to see if the improved uptake of screening reduced breast cancer rates and deaths compared to a decade ago. In [Part 5](#), we share some of their concluding reflections.

Part 4: Assessing Outcomes and Impacts of an SPH Intervention

Assessing the changes from SPH interventions

In Part 1, we defined an *outcome* as the change achieved after an intervention, while an *impact* is a positive or negative outcome that can be directly attributed to the intervention. The results of interventions are assessed in outcome and impact evaluations.



An outcome evaluation focuses on the observable conditions or outcomes that a program is expected to have changed. **An impact evaluation** examines how the program led to the changes produced and what else could have caused these changes.

When do we do an outcome or impact evaluation?

The timing of an evaluation depends on when the different outcomes will be achieved, according to your theory of change and the workplan discussed in [Part 2](#).

Your performance evaluation, discussed in [Part 3](#), will help you to check your various assumptions and confirm the timing of the outcome/impact evaluation. This timing is important. If your evaluation is done too early, you may not have allowed enough time for the expected changes to take place. If done too late, you may find that the momentum built in support of the work has waned or been lost. You may also need to take into account timelines required by formal authorities, such as funders and government agencies. It is important to make very clear what expected outputs and outcomes can be achieved in these required time frames.

The expected outcomes and impacts are informed by the baseline assessment and identified at the start of the intervention with community representatives, implementers, managers, and funders. As raised in [Part 1](#), there are also official requirements.

With SPH, many factors can affect the changes achieved. It is not always possible to attribute outcomes to SPH efforts alone. Other contributing factors may need to be investigated. The evaluation should explore both the positive and negative changes that resulted from the intervention. Some of the causes of change may be those we planned for, while others may be unplanned factors or confounders that interfered in the process. There may be spill-over effects, where the SPH intervention led to changes in areas or groups beyond the intended beneficiaries. It is important to track all effects and to assess what led to them.

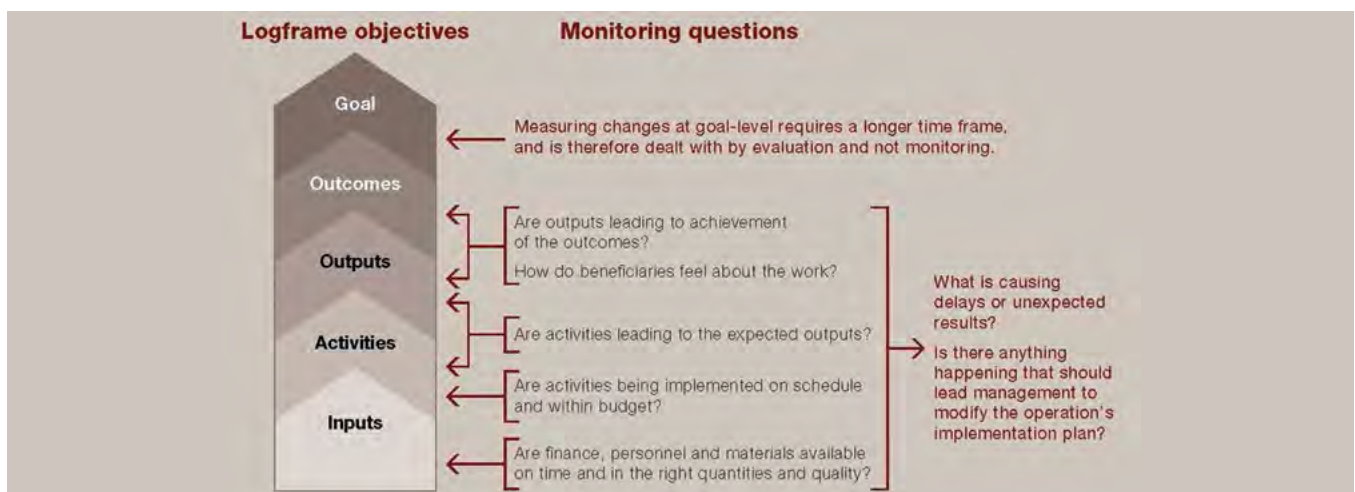
If a logic model was used to frame the SPH intervention, as discussed in [Part 2](#), an outcome evaluation provides a means to address the chain of relationships between inputs, activities, outputs, outcomes, and objectives/ goals, as captured in [Figure 4a](#).



The [LEAP framework](#) is an example of an evaluation that follows a logic model, with further information at the [Scottish Community Development Centre](#).

If you are using a theory of change that provides for a less linear and more complex set of relationships, there are a range of evaluation models that can be used to frame the sort of questions posed in [Figure 9](#). [Better Evaluation](#) (2014) provides examples of these including: a results chain, the 'five whys', impact pathways, outcome mapping, and realist evaluation. The next section further discusses the questions posed in an outcome evaluation and the methods to answer them.

Figure 4a: Evaluation questions for a logic model



The evidence to include in an outcome or impact evaluation

The box below outlines the broad questions that an outcome or impact evaluation seeks to address. The specific indicators or measures for each of these questions depend on the broad context, the local situation, and the intervention.



Information gathered in an outcome and impact evaluation

Regardless of specific questions related to the details of an SPH intervention, there are some general questions that we seek to answer as part of our final evaluation.

- Was our baseline analysis of the **context and situation, issue, or need** correct? Has it changed? What are the external factors that influence this that are relevant to our work?
- Were the **inputs**, resources, and capacities available and being used as planned? What were the strengths and weaknesses of the process?
- Were all of the right **participants** appropriately involved? Who did the program serve (disaggregating the different groups)? Are we reaching the right **wider beneficiaries**, beyond the immediate participants in the SPH intervention? What factors are affecting people's involvement or uptake?
- Did we take the **actions** and implement the **processes** we said we would? What was actually implemented? What were the gaps between the plan and the reality? What worked well? What could be improved? What have we learned about these actions? What assumptions were not correct or should be reviewed? What does this imply for future actions?
- What **outputs** were achieved? What were the gaps between the plan and the reality? What worked well?
- What **outcomes** were achieved? What differences did the intervention make in the short, medium, and long term? How do people perceive the outcomes? How sustainable are these changes? What **unintended/unexpected** positive and negative changes took place?
- What **factors** led to these outcomes? What outcomes resulted directly from the participation activity or program? What other factors or **confounders** have helped or limited this activity? To what extent were these potentially under the control of the program?
- What **value and benefits** were obtained for the resources applied?



(Perrin 2012; Healthcare Improvement Scotland, 2013).

We may use various measures to help answer the general questions posed above. Some measures will be the same as those [defined for the baseline \(Part 2\)](#) or those [used to assess performance \(Part 3\)](#); they will be repeated in the final evaluation to enable you to compare how things changes. Other measures will be focused on particular outcomes and impacts that relate to the goals you set. The broad outcome measures are outlined in [Table 4a](#).

Table 4a: Outcome and impact measures

Outcome/impact area	Measure
SITUATION/CONTEXT	
Changes in the political and social context, and unexpected events	<ul style="list-style-type: none"> Political and social events and reforms not related to the intervention and situational changes during the same time frame. Refer also to changes in context measures in the baseline assessment.
Changes in health, health care, and other services not related to the intervention	<ul style="list-style-type: none"> Other health status and disease indicators. Changes in health service outreach and coverage. Changes in social determinants of health (such as access to education).
INPUTS, ACTIONS, PROCESSES (INCLUDING SPH) AND OUTPUTS	
Inputs, actions, performance, and outputs, including on SPH	<ul style="list-style-type: none"> Refer to Part 2 and Part 3 for measures.
PARTICIPANTS AND WIDER BENEFICIARIES	
Changes in the social features and power of different groups of participants and wider beneficiaries	<ul style="list-style-type: none"> Changes in social inclusion, social cohesion, voice, agency, representation, networking, and alliances, and in the enablers and barriers to SPH for different groups. Refer to Part 2 and Part 3 for related measures.
Equity and distribution in change/benefit/satisfaction	<ul style="list-style-type: none"> Differences in outcomes between areas with different social features and different levels of vulnerability. Social (race, gender, etc.) differentials in and social barriers to all outcomes. Perceived benefit/satisfaction in different groups (see also perceived performance measures in Part 3).
OUTCOMES (INCLUDING IN SPH)	
Scale and level of the change/ impact on health, health determinants, and in health and other sector services (disaggregating for different social groups)	<ul style="list-style-type: none"> Changes (intended and unintended) in various health and disease indicators and in social determinants of health, relevant to the SPH intervention. Changes in health service outreach, uptake, and coverage. Changes in community and implementer satisfaction with service relevance, quality, and accessibility. Changes in access to and resources allocated for prioritised services.
Changes in power and participation and in whom (disaggregating for different social groups)	<ul style="list-style-type: none"> Changes in knowledge, inclusion, deliberation, information flow, mind-sets, confidence, consciousness. Changes in the collective influence of community members over processes and situations that have a bearing on their lives; in self-help capacities of various groups within a community and in bargaining power of these groups. Changes in the agendas, voting behaviours and practices of institutions, and in distribution of and access to opportunities and resources.
Changes within and across different groups and personnel involved; in institutions and in their relationships with people	<ul style="list-style-type: none"> Changes in knowledge, information flow between communities, and services. Changes in health practices, behaviours, health-seeking behaviours. Changes in individual vs. social/collective dialogue and action. Increased coalition formation across community groups. Changes in public dialogue and input to forums and in communities voicing demands to authorities. Trust between community members and health care personnel. Community/implementer satisfaction with institutional processes.
Longer-term issues (disaggregating for different social groups)	<ul style="list-style-type: none"> Structural or deeper social, institutional, service, health changes that take time to produce, including closing inequalities, and shifts in social discourse/ how issues are perceived. Changes in institutional policies, funding priorities, and investment in people.

Table 4a: Outcome and impact measures (continued)

Outcome/impact area	Measure
VALUE FOR RESOURCES	
Value for resources used	<ul style="list-style-type: none"> • Distribution of costs and benefits across program areas, beneficiaries. • Monetary and non-monetary (in kind, time, unpaid labour; commitments to monitoring) costs relative to the value of different benefits achieved. • Social return on investment.
CONFOUNDERS AND UNEXPECTED OUTCOMES	
Unintended positive and negative outcomes	<ul style="list-style-type: none"> • May cover any of the above outcomes if not intended. • Negative outcomes may include those that undermined authentic SPH.

Sources: Fiorati et al., 2018; Haldane et al., 2019; Falleti and Cunial, 2019; Banerjee and Bharadwaj, 2011

These outcomes can be seen as a hierarchy. Some outcomes lead to or are necessary for others, as shown in *Figure 4b* below. For example health outcomes, such as reduced breast cancer rates, may arise from strengthened community information as a community outcome, which itself depends on processes such as health literacy activities, which themselves arise from inclusion of community members in planning changes in organisational structures, all of which may be included in an SPH intervention.

The decision on which specific indicators to choose for these different areas relates to the program’s purpose, and what measures may be reliably and feasibly collected and expected to yield valid information.

Other issues to consider include:

- Outcomes are time sensitive.
- The more immediate the link between the program action and outcome, the more likely the program contribution to its achievement.
- Positive outcomes may also occur when something negative is removed.
- Some outcomes may need more than one indicator. What constitutes a sufficient positive change should be agreed to with stakeholders at the outset of an intervention.
- Avoid over- or under-ambitious numerical targets (Baker and Bruner, 2010).

What measures do we use to assess cost benefit?

One aspect of outcome/impact evaluation is assessing how resources (money, time, materials) were used, analysing the distribution of costs against the outcomes achieved. We discussed measures to assess [cost effectiveness in Part 3](#). This tells us how effectively and efficiently resources were used for program outputs. In this section, we discuss evaluating cost benefit, or how the costs of the intervention are related to the outcomes or benefits achieved.

Evaluations generally look at four main domains in relation to cost: resource allocation, contracts, spending, and performance verification. Data collection on financial costs has focused on how expenditures were planned or budgeted compared to what was actually spent (IOM, 2014). As raised earlier, it is difficult to compare financial data with qualitative evidence on the benefits of participation and changes in social power. While linking funding to specific quantifiable *outputs* can help to judge *cost-effectiveness*, it is more difficult to assign a monetary value to many of these qualitative SPH *outcomes* (Involve, 2005).

For accountability, however, we still need to provide evidence on whether or not funds were used for their intended purposes; how well expenditures matched the original budgets; and how much the funding amounts and disbursement mechanisms influenced achievement of the goals.

The Oklahoma example provides useful information on measures or indicators used to link input costs to outcomes. The detailed example in [Part 1](#), featuring the cost benefit of CHW programs in the USA, illustrates how measuring the savings CHWs made by shifting from high-cost hospitalisations to lower-cost primary care visits for high-risk chronic patients helped to get funding from insurers for the CHWs.

Figure 4b: Hierarchy of outcomes



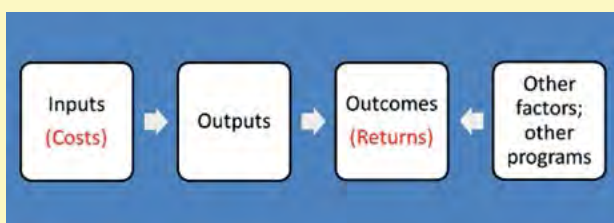
Haldane et al., 2019:online

i Assessing cost benefit of an intervention

In 2017, the Disaster Resilience Network in Tulsa, Oklahoma, in the USA, evaluated the cost benefit of community activities implemented at the local level. The team started by establishing the scope of work and identifying stakeholders. The team mapped project inputs to outcomes and collected data to isolate causes and link inputs and outcomes to the extent possible.

To collect the evidence for this, the team used literature reviews, extensive document analyses, and interviews with more than three dozen key informants in the city.

- The costed **inputs** included paid staff time; volunteer hours; hiring trainers, facilitators, and interpreters; renting meeting spaces and purchasing refreshments; production and distribution of materials, videos; fees for training and certification; and travel expenses.
- The **outputs** included education and outreach and numbers participating, preparedness plans, and coalitions built for identifying vulnerabilities and resources in neighbourhoods. Community informants also described spin-off activities attributed to prior efforts.
- As **outcomes**, team members intended to determine the extent to which activities increased preparedness; led to actions that could reduce disaster losses; or produced other benefits, such as increased peace of mind and feelings of safety among Tulsa residents. However, they found it difficult to track and quantify these factors and assign costs to them. Interviewees did identify increased social networking and higher levels of trust as important outcomes, which, while difficult to assign a monetary figure to were valued by participants.



(Ritchie et al., 2019).

In your SPH intervention you will need to examine your own planned final outputs and outcomes that are important for different stakeholders and see what you can quantify for any cost-benefit analysis. As for the analysis of cost-effectiveness discussed earlier, it is also important to have clearly defined measures for outcomes/benefits in [setting the theory of change](#), planning the intervention and [baseline assessment](#), and having disaggregated information on the social groups involved, to know how the outcomes or benefit are distributed. The decision on what is a benefit needs to be made at that stage, in dialogue with key stakeholders, whether it relates to SPH itself, the conditions affecting health, health care, or other outcomes.

As discussed in [Part 3](#), not all benefits can be easily costed. For example, changes in participant experiences of services, perceptions of quality of care, and level of inclusion in decision-making may be difficult to quantify. Discussing these challenges with stakeholders when setting the theory of change helps to ensure credibility of what is reported in the outcomes evaluation. The next section discusses a Social Return on Investment (SROI) approach that may help to address this.

The next section also provides further information on methods that may be used for cost-benefit analysis, and for other areas of outcome/impact shown in [Table 4a](#).



The [Involve Toolkit on Costs and Benefit Analysis](#) and Annex 2 of [A Guide to Evaluating Public Participation in Central Government](#) outline cost areas to use in an economic analysis. An [Australian Government Evaluation and Value for Money](#) resource provides more information.



Go to worksheet 4.1a: Use the worksheet to identify the questions for the outcome/impact evaluation and the measures to use for them.

Methods for an outcome or impact evaluation

As discussed earlier, choosing a specific evaluation method depends on context, resources, and time. Some of the evidence will come from secondary data gathered from **existing documents**, including meeting minutes, attendance rosters, and reports, and from **service information systems** on service coverage and **financial accounts and records**.

Methods and tools for the outcome/impact evaluation

PURPOSE	METHODS	PAGE
Gathering evidence on context and situation	Surveys, individual and group interviews, and focus group discussions Participant observation and diaries Repeating social, empathy, and other mapping methods Media and other reports	2.11, 2.12 2.12 2.12
Gathering evidence on the inputs, actions and outputs	Surveys, interviews, and focus group discussions Venn or chapati diagrams and power, relationship, and empathy maps Journals, diaries, and storytelling Spider maps, speedos, Likert scales, and the CHANGE tool Well-being/pairwise/preference/matrix ranking and matrix scoring	2.12 2.13-15, 3.6 3.6 2.7, 3.5, 3.6 3.6
Gathering evidence on the beneficiaries and equity in benefit	Service use maps, circle maps, venn diagrams, and forcefield analysis Direct observation, activity logs, exit interviews, and portfolio reviews Surveys, focus groups, and participant observation Likert scales and ranking methods Timelines and progress markers Storybanking and cellphilmimg	2.13, 2.16, 2.17 3.7 2.12 3.5, 3.6 3.7, 3.11 4.8
Gathering evidence on outcomes—intended and unintended	Surveys, focus groups, and participant/direct observation Repeat mapping of different kinds and venn diagrams Activity logs, exit interviews, and portfolio reviews Repeat Likert scales and ranking methods Timelines and progress markers Citizen report cards, outcome star, and wheel chart	2.12 2.13, 2.14 3.7 3.5, 3.6 3.7, 3.11 4.8, 4.9
Linking to causes to determine impacts	Mapping, diaries, calendars, activity logs, and timelines Contribution analysis Causal flow diagrams and most significant change technique Spider diagrams and matrix ranking	2.17, 3.6, 3.7 4.10 4.10, 4.11 3.5, 3.6
Gathering evidence on cost benefit	Financial monitoring and analysis of performance that can be linked to outcomes (See Part 3) Cost-benefit analysis and social return on investment	3.8 3.8, 4.6, 4.12

Some of the evidence gathered from an outcome/impact evaluation comes from repeating questions asked during earlier baseline and/or performance evaluations. This usually means using the same methods described in [Part 2](#) and in [Part 3](#), but adding some new questions to the existing ones, as shown in the example.

i The Washington State Department of Health [Community Engagement Guide](#) provides a list of questions used to assess the outcomes of community engagement efforts, some asked before, during, and after the intervention, as shown adjacent (WSDH, undated: 13).

The questions asked helped to identify whether the SPH strategy was the right one to use, what affected the ability to implement principles and strategies agreed on at the beginning, and what role this played in the achievement of the outcomes. Such questions should also assess the distribution of these outcomes, who benefited from the process and changes, and whether everyone had an equal opportunity to participate and obtain benefit. Assessing the distribution of the outcomes or impacts is important to see how far the intervention addressed or amplified inequalities that were present in the area or community (Everyday Democracy, 2018).

Example Questions	Before	During	After
How was the need for this project identified?			
Are the right community members involved?			
Does the structure and process allow for all voices to be heard, especially those impacted by historically and contemporary injustices?			
How do you plan to support your partners or community members?			
What training, information or resources will they need?			
How do you plan to intentionally provide space for those impacted by injustices for their issues to be heard and addressed?			
How does the community measure/define success?			
How well does the group work together?			
Who has a voice and who doesn't?			
How does the group make decisions?			
How are conflicts or disagreements handled?			
Who leads the engagement efforts, meetings, or events?			
How are community members involved in developing the project?			
If you did a stakeholder analysis, did your results have the desired effect? Were they helpful?			
How did you ensure your community engagement effort was <u>culturally and linguistically appropriate</u> ?			
Did stakeholder involvement improve the work, effectiveness, or political and community support of the effort?			
Who came up with the project goals and plan?			
What could you have done better to identify and involve community partners and representatives?			
What strategies did you use to ensure all voices were heard?			
When partners who have been impacted by injustices or represent groups who are under-represented or historically marginalized brought forward issues, how were those addressed?			
Did your partners feel supported? What could be improved?			

How do we assess changes in context, inputs, actions, and outputs?

Methods described in [Part 2 to assess context](#) and in [Part 3 to assess changes in terms of inputs, actions, processes, and outputs](#) can also be used in your outcome/impact evaluation. Repeating the same methods and measures used previously allows you to compare findings across time.

You may also use information from the baseline and performance assessments to interpret your evidence on outcomes. This will help to identify why some activities or approaches worked or did not, and why unexpected outcomes or spill-over effects took place.

How do we assess changes in the participants and beneficiaries?

Changes experienced by program participants and wider beneficiaries, including in their power and agency and in the distribution of benefits, can be assessed using tools described earlier and those discussed below.

- Surveys, focus groups, and participant observations can be used to determine who benefited and how, and what barriers were experienced.
- Various forms of stakeholder, relationship, and power mapping described in [Part 2](#) and [Part 3](#) can be used to observe changes in social networking, relationships, and power dynamics between different actors within communities.

i [Storybanking](#) uses both active and passive story collection strategies. Active story collection involves person-to-person interaction, while people can also share their stories indirectly in passive approaches, such as through a telephone hotline, response postcard or web form. Stories can be shared digitally, using photographs, videos, and other methods that make sharing and telling stories easier. It calls for time, patience, guidance, and consent procedures in the primary language of those involved. (Community Catalyst, nd).

[Cellphilmimg is a participatory video technique](#) for collecting and sharing stories of challenges and/or successes related to the intervention—as an input into the impact evaluation process (Tamarack Institute, 2020).

- Timelines, progress markers, Likert scales, and ranking methods outlined in [Part 2](#) and [Part 3](#) can be used to assess participants' and beneficiaries' perceptions of changes, including which changes they prioritise and when the changes reached certain groups or areas.
- Communities and implementers can bring their own stories of how they or their situations have changed. They can use storybanking and cellphilmimg for this (See box).

The methods described next for gathering evidence on outcomes can also be used to assess changes in participants/beneficiaries and equity in benefits, where these are key goals of the intervention.

How do we assess outcomes?

Outcomes are defined as changes in measures related to key goals, and assessing them requires comparing baseline measurements with final measurements that have been gathered in the same ways, from the same sources.

We don't repeat here all of the quantitative, qualitative, and participatory methods used in the baseline ([Part 2](#)), the performance evaluation ([Part 3](#)), or the various [digital methods noted in Part 3](#) that may be used again in this final evaluation.

It is important that whatever method was used for the earlier assessments, it needs to be repeated for the outcome evaluation if the sets of evidence are to be reliably compared.

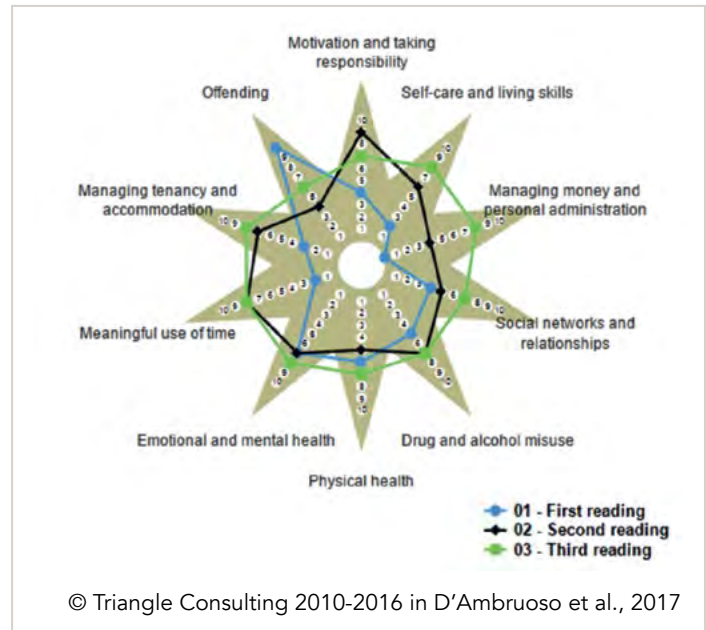
There are, however, some methods that more directly enable reporting and community dialogue on change.

Citizen report cards enable service users to report on changes in service quality, adequacy, and efficiency, as exemplified in the Bogota experience described in [Part 1](#). They act as an evaluation tool that also strengthens participation. They work best when the findings are discussed directly with service providers to address issues identified (ELLA, 2012).

An [outcomes star](#) can be used to assess progress against goals, across as many as 10 dimensions (see *Figure 4c*). The star provides a visual representation of outcomes for reporting, review, and discussion. Coloured lines represent participant views on the measures at different points in time, with the final line being the outcome measure.

The star can be complemented by qualitative methods, such as storytelling, to help understand the reasons for the differences.

Figure 4c: Outcomes star

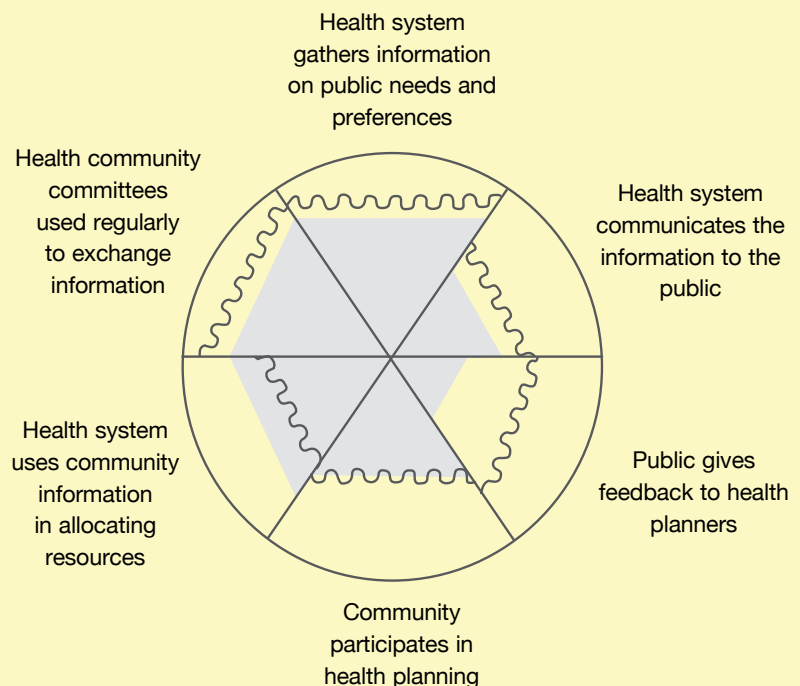


i A **wheel chart** is another tool that can be used for collective review of a range of outcomes over time.

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 an intended outcome. Participants collectively assess the level of the outcome from program onset to final evaluation. 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 accordingly.

The wheel chart can also be used to reflect the intended level of 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 is now (shaded area) and what the situation should be (squiggly line). The levels may also be quantified to give a measure of the difference. After the chart is completed, it is "interviewed," meaning that stakeholders discuss the findings to review what has led to the findings (Loewenson et al., 2006).

Example of a wheel chart:



KEY	
	should be
	is now

Loewenson et al., 2006:55

Before and after photographs can be used to review and discuss the changes achieved, including what the driving factors were for the changes (UNESCO, 2009).

The saferspaces organisation used ranking and scoring (described in [Part 3](#)) in its [How did our strategies work? \(Influence Matrix\)](#) for communities to identify outcomes and rank those they prioritised.

How do we assess impacts?

So far, we have discussed methods to describe outcomes after an SPH intervention. To understand the intervention's role in creating those outcomes, or its impact, we need to dig deeper to understand what led to these outcomes to know what role the intervention played.

Methods that link outcomes to the factors that lead to them are critical to understanding whether or not the outcomes are indeed *impacts* that can be attributed to your SPH intervention. If you are not sure, then it is better to refer to the changes as *outcomes* and not impacts.

Performance evaluation results provide valuable evidence on how the organisation of inputs, processes, and outputs may have contributed to positive or negative outcomes, and should be used in any dialogue on contributing factors, but there are additional methods that you may use.

i **Contribution analysis**, as described below, can help confirm or revise a theory of change.

- 1: Set out the attribution problem to be addressed.
- 2: Referring to the theory of change (identified in [Part 2](#)), test whether or not it explains the change or if there are other explanations.
- 3: Use the evidence gathered to test various explanations.
- 4: Assemble and assess your contribution story—essentially, the reasons why your team thinks the intervention contributed to the changes—and the challenges to it. Bring stakeholders together to discuss: how credible is the story? Do the results validate your theory of change?
- 5: Where needed, seek additional information.
- 6: Revise and strengthen your contribution story.

Guidance for these steps is provided in [Contribution Analysis \(Mayne, 2008\)](#).

Various forms of mapping can show the distribution of changes compared to the distribution of features of areas, social groups, institutions, and services, allowing us to explore the relationship between them. **Diaries, calendars, activity logs, and timelines** can be used to relate changes in outcomes to the introduction or production of particular inputs, processes, and outputs.

i The **most significant change (MSC)** technique involves participatory monitoring by project stakeholders across a project cycle to assess impact. The domains of change to be monitored are broadly defined with stakeholders, together with how often to monitor them. Significant change stories are then collected in the field from those directly involved in an intervention by responding to a simple question, such as: *During the last month, in your opinion, what was the most significant change that took place for participants in the program?*

Respondents also indicate why they consider a change to be significant. The stories are reviewed and a story is selected for each domain of change that shows the most significant change for that domain. This may be done sequentially over time at different levels of a program's hierarchy, choosing from stories selected by panels at the level below.

Once completed, the selected set of stories, the changes found, and the criteria for the choices are discussed by those involved. They sit together in multiple sessions to read and validate the selected stories and discuss the value of the reported changes in each domain to collectively identify the impact(s) of projects or interventions. Unequal voices can be balanced by making the information public and inviting feedback, and by having an 'any other changes' domain to open up the breadth of change options. The method is detailed at [The Most Significant Change Technique: A Guide to its Use](#) (Davies and Dart, 2005).



All of these methods require a structured discussion to validate changes and explore what contributed to them. When participant groups are diverse, this may be done first with key groups or areas separately for the initial discussions, and then across groups to explore where agreement exists on factors affecting change. As noted earlier, this will be important where there are differences in power, literacy, social status, or other factors that may disadvantage particular groups or make them less confident when asked to articulate their perceptions or experiences. Where views differ, you should explore why. Referring back to your theory of change helps to see whether the evidence validates the assumptions and pathways developed.

A range of tools can be used to identify relationships and which factors contributed to outcomes.

Causal flow diagrams show how stakeholders understand what factors contributed to the impacts. People draw a change that they believe resulted from the intervention and each participant presents their drawing in 1-2 minutes as a testimonial that is documented as part of the evidence of change. When all the drawings are presented and available to view, the common and different impacts and perceptions are

discussed, resulting in a form of collective validation (UNICEF CEE, 2005). The factors seen as most important can be ranked using the **matrix ranking** method (discussed in [Part 3](#)) and linked to outcomes using **spider' diagrams** (also discussed in [Part 3](#)).

Feedback loops help to draw in the perceptions of community members and other groups. The constituent voice operation cycle, for example, communicates findings to and collects feedback from the wider groups and includes this in the analysis (Keystone, 2016).

Some methods identify factors leading to outcomes by exploring the counterfactual. This includes exploring what would have happened in the absence of the intervention, comparing differences between groups/areas with the intervention to those without, or in a **general elimination** method, identifying and using evidence to rule out alternative explanations (Roger 2012).



UNICEF has a toolkit of [Useful Tools for Engaging Young People in Evaluation](#), such as card visualization and smiley-face Likert scales



Reviewing change with communities in Australia

[The Opening Doors Community Leadership Program for Social Inclusion in Australia](#)

implemented a theory-of-change-driven evaluation. Opening Doors builds local community leadership with the knowledge, skills, resources, and networks to create more socially inclusive communities. A 2016 evaluation sought to identify whether and how the program had affected social isolation in the community. It used [ripple effect mapping](#), a participatory approach that combines appreciative inquiry, mind mapping, and qualitative open-ended group interviews with stakeholders on the intended and unintended changes. In a workshop, participants brainstorm and map the effects of a program, identifying the 'ripple effects' of changes achieved, as well as their drivers and barriers. The workshop helps to identify contributors to change and is also a celebration of what has been achieved. After the workshop, follow-up interviews are conducted to clarify the evidence and identify the key ingredients for achieving the changes (Naccarella, 2016; Sero et al., undated; graphic [Wikipedia Commons, 2005](#)).

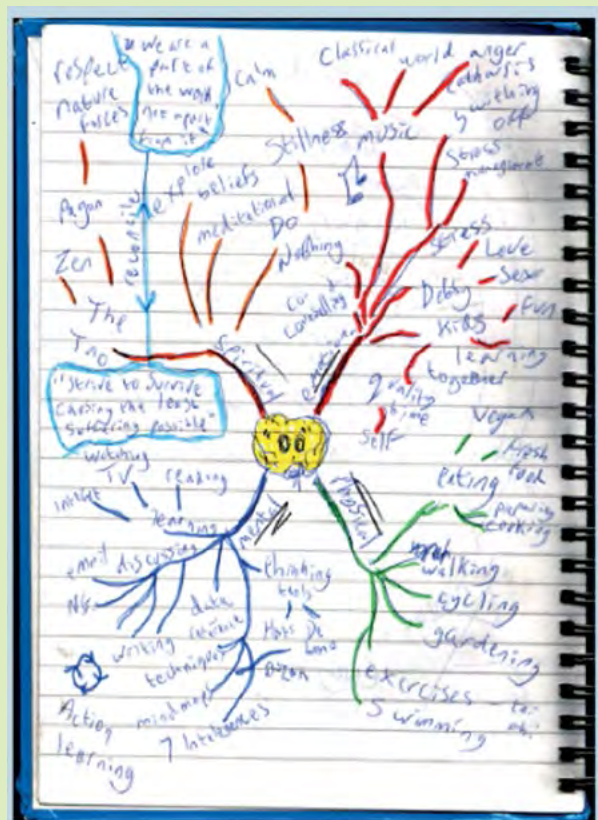


Image: Mindmap, Graham Burnett, <http://en.wikipedia.org/wiki/File:Mindmap.gi>

How do we measure the cost benefit of the intervention?

[Part 3](#) shows the various cost-related indicators gathered in a performance evaluation to assess cost effectiveness. Similarly, the costs for cost-benefit analysis include the following.

- **Monetary costs**, including staff time (paid and unpaid), staff expenses, external staff/consultants, fees to participants, participants' expenses, training for staff and participants, administration, venue hire, other event costs (e.g., refreshments, equipment), production and distribution costs for materials, and monitoring and evaluation fees.
- **Non-monetary costs**, including time contributed by participants; development of skills for the new approach (taking time from other work); and risks, including risks to reputation, distrust (from bad participatory practice), as well as stress, uncertainty, and conflict.

Cost-benefit analysis compares the cost of the intervention to the level of impact or outcome achieved. As shown in the example in [Part 1](#), the benefit may be due to CHW roles in an SPH intervention bringing savings to health systems and benefits to patients and services. Cost-benefit analysis requires a single unit of value to be used for all outcomes so that a comparison can be made with the input costs of the intervention. The financial costs can then be related to the value of the positive outcomes as benefits. You may use such an analysis to compare different SPH intervention approaches, such as comparing digital with in person approaches, remembering always to disaggregate the findings for different social groups.

To identify the costs (see the [cost measures in Part 3](#) for what these may be):

- Collect cost information from financial statements, budgets, accounts, insurer records;
- Identify the direct monetary costs of the SPH intervention, including a portion of the shared and overhead costs (eg., salaries); and
- Identify the indirect costs, including non-monetary costs of all partners.

To identify the benefits:

- Identify and cost all the benefits of the SPH intervention and allocate a common unit value to each (it can be a monetary value or a number of beneficiaries); and
- Identify benefits that you cannot cost because they can't be measured or are spill-overs. Use this information in additional explanatory text.

The cost benefit ratio equals the total of the benefits divided by the total of the costs. It can be expressed as a ratio of the dollars of benefit or people benefitting per dollar (or other currency) of cost (Giffin and Giffin, undated). If you need help, you may find it online or by consulting with local financial management experts, economists and others.



You can find cost-benefit analysis worksheets in the [Involve Valuing Engagement Toolkit](#). A step-by-step guide to cost-benefit analysis is also provided in [Cost-Benefit Analysis: A Primer for Community Health Workers](#). WHO Regional office for Europe provides information on a [social return on investment model](#).



A **social return on investment (SROI) model**

is a participatory, multi-stakeholder approach that balances the sum of the benefits of a project with the investment that was required to achieve those benefits. SROI accounts for social value beyond traditional economic evaluation tools, by considering value produced for multiple stakeholders in economic, social, and environmental dimensions. It calculates the ratio of the value of benefits to the value of the investment. For example, community housing developments have a positive impact on social connections and networks, which have a positive impact on the health of older people, which reduces the need for support and, as a consequence, the total cost of care in old age. The SROI approach helps to understand such relationships. It identifies benefits from investments in health and wellbeing beyond the economic sphere, accounting for those aspects of social value that cannot always be expressed in monetary forms (Hamelmann et al., 2017).

It may be difficult to meet funder expectations that all the costs and benefits of participation be quantified. Short funding and program cycles may not provide enough time for longer-term outcomes to be achieved, as discussed in [setting the theory of change](#).

You may complement any cost-benefit analysis with persuasive qualitative information on the changes achieved and the way they are perceived by different stakeholders, compared with the total budget of the intervention (as seen in the following example from Ireland). Involving a credible, trusted, independent organisation in cost-benefit analysis may also help to overcome such challenges.



Assessing the economic benefit of SPH in Ireland

As part of Ireland's Community Participation in Primary Care Initiative, work was commissioned in County Donegal in 2009 to examine the economic benefits of community engagement in health. The question was: *If the community and voluntary sectors did not exist, how much more would the health budget need to be?* Rather than trying to measure the cost benefit of individual health improvements attributable to the SPH interventions, the work sought to identify the collective resources that the community and voluntary sectors were contributing to creating a healthier population (Garratt, 2009).



Participatory mapping in India

In March 2008, social and land rights activists in the Uttar Pradesh Land Alliance conducted a participatory evaluation of community empowerment projects in the Chitrakoot and Jaunpur districts. They used village mapping to help community members visualize their experiences resulting from changes in the land tenure situation after the empowerment projects. The mapping showed that the two projects supported vulnerable groups in gaining recognition of their land rights and access land, and promoted discussion on the way forward. The village mapping was perceived to be an accessible tool and is now used more regularly to take up land issues. It became the starting point in a 'know your village' exercise to support local awareness and evidence-based lobbying and advocacy with local authorities in land rights (Banerjee and Bharadwaj, 2011).



Participatory evaluation of a community empowerment project for access to land, Uttar Pradesh, India
© L. Collins, Gulliver

In any analysis of costs and benefit, you will also need to take into account any positive (or negative) spillover effects that were not a part of the original plan (as seen in the example from India, where recognition of land rights may act as security for a much wider range of unplanned benefits planned). As noted above, the time frames within which outcomes occur mean that they may or may not be detected within the time frame of a program evaluation, an issue to be made clear in planning the outcomes and timings for the evaluation, or to be reflected as a limitation when reporting the findings.



Go to worksheet 4.1b: Continuing with the outcome evaluation measures from Worksheet 4.1a, identify the methods for gathering each and who will implement them.

Organising, communicating, and using the findings

Once you have collected the information you need, the next step is to put aside enough time to make sense of it. What do the numbers mean? What do people's opinions tell you about the program's outcomes and impacts?

Analysis of an outcome evaluation generates useful information that can help improve practices and make the case for continued funding and community support. The questions asked and the hypotheses stated in your theory of change regarding how SPH would lead to improvements provide a useful structure for organising and presenting your evaluation findings.



You may also organise and report findings according to each of the questions asked in the evaluation or the goals of the work. The interests and concerns of key stakeholders, identified during earlier evaluation phases, also point to questions that the analysis needs to answer, with the information presented in an accessible and credible form for that audience. Once you have organised the findings, review them with different stakeholders, both to validate and to interpret them and to discuss the valuable learning from what worked well and what did not work.

How do we show the outcomes and impacts of the intervention?

The processes for [organising evidence in Part 2](#) and in [Part 3](#) may also be used here. Quantitative data can be shown in cross tabulations and frequency tables, with averages, medians, and measures of variation. Qualitative data can be categorised according to themes and represented with quotes or presented visually, such as in wheel charts or maps. There are many different options for visual presentation of findings, from bar charts, pictograms and other graphical methods to photographs, such as the before and after images below.



Before (2009) and after (2012) images of a community intervention to clear waste and use the land for an income generating car park project, Zimbabwe. Photo: A Kadungure TARSC

There are visual ways of explaining the relationships between different data sets, such as:

- Showing relationships among data points with scatterplots, matrix charts, and network diagrams;
- Comparing values using bar charts, histograms, and bubble charts;
- Showing changes over time using line and stacked graphs; and
- Showing differences across geographic areas using maps (Better Evaluation, 2014).

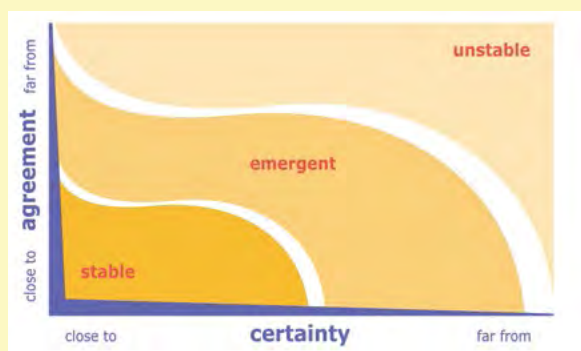
Attributing outcomes to certain factors requires particular forms of analysis as explained below.

- Evaluation findings can be categorised into those that are and are not directly related to the SPH intervention. Give prominence to findings that had most influence. Identify factors that are raised with greatest frequency and explore how they relate to the logic of the program.
- Statistical procedures, such as correlations, time series of trends, and significance tests, can be used to explain whether the changes or relationships between features of the intervention and outcomes are significant.
- Participatory methods, such as matrix ranking, venn and spider diagrams, contribution analysis, and similar tools, can help you judge the contributions of different program or service inputs to the identified outcomes.
- Stakeholders can discuss findings from initial tabulations in an evaluation workshop, exploring the patterns they see and explaining their views on what led to the outcomes.
- An option that is less likely to be available to you involves comparing how the outcomes in your community, where the SPH intervention was implemented, differ from what is happening in a similar community without the intervention. Since similar settings are never identical, you would need to know what other factors may have affected the differences between the two areas (Catley et al., 2014).



You can read more on participatory methods for analysis linking factors to impacts in the [Participatory Learning and Action: A Trainer's Guide](#).

i One way to bring qualitative and quantitative findings together is through a **Landscape Diagram**, a tool to help stakeholders see, understand, and map current conditions and factors that might be enabling or preventing an outcome. On the diagram's horizontal axis (see graphic) is the degree of certainty or stability of the factors that people think influenced a particular outcome of the SPH intervention (for example, leadership support). The vertical axis indicates the degree of agreement there is amongst various partners on features of the program that may have contributed to the particular outcome (for example, leadership training). The closer to the point where the axes intersect, the greater certainty and agreement there is between program features and outcome factors (Tamarack Institute, 2020; Graphic: Human Systems Dynamics Institute, adapted by [Tamarack Institute, 2020](#)).




You can also triangulate different types of evidence to check or confirm interpretations of cause. For example, you can compare qualitative and quantitative evidence to show their similarities and/or differences in outcomes, as in the landscape analysis example.

While an analysis may focus on positive outcomes, it also needs to identify what did not work and why. Negative findings also have implications for the intervention. Combined, the two types of findings provide learning for local practice and insights for wider exchange.

Example table of formats for different audiences

	<u>Full Evaluation Report</u>	<u>Evaluation Snapshot</u> (short summary)	<u>Slide presentation</u>	<u>Online and media coverage</u>
Project team	●			
Funding agency	●			
Councillors		●	●	
Target audience				●
External stakeholders		●		

 **Go to worksheet 4.2:** With your team, use this worksheet to identify the structure for your analysis against your program goals.

How do we present and communicate evidence?

The suggestions made in [Part 3 regarding reporting evidence](#) apply to your final reporting from the outcome/impact evaluation. The credibility and clarity of your reporting is an important contributor to uptake of the findings. Many other factors also affect uptake, including interest in the findings, the political context, the quality of the evaluation, and the working relationship between the evaluation team and those to whom they are reporting. You can have an influence on these factors at all stages of the SPH intervention and evaluation, such as by including stakeholders in the discussion of the goals and measures, discussed earlier.

Given the diversity of interests and stakeholders, there may be multiple forms of internal and external reporting on the findings depending on how they will be used.

Findings may be reported for the following purposes.

- **Celebration and advocacy** to highlight accomplishments, build morale for all involved, and contribute to resource mobilization;
- **Project/program management** to inform decisions on programs;
- **Learning and knowledge sharing** to inform future programming; and
- **Accountability and compliance reporting** (IFRCRC, 2011).

The [Community Sustainability Engagement's Evaluation Toolbox](#) recommends preparing a table, like the example below, that lists your audiences and the most appropriate format(s) in which to present the results to each. The stakeholders and formats in the table would differ in different contexts.

Reporting and soliciting feedback has been a consistent part of every stage of the evaluation and should not just start with this stage. You will have built relationships around this work. Regardless of format type used, the content needs to be:

- Relevant and useful for the specific purpose and audience, avoiding excessive, unnecessary reporting and information overload;
- Timely for its intended use;
- Complete, with sufficient information for its intended use;
- Reliable, with accurate representation of the facts, showing the source of conclusions, and avoiding biased opinions; and
- Simple, user-friendly, and in a language and format appropriate for its intended audience.



When sharing personal stories and testimonials, refer to the [ethics discussion in Part 1](#) on confidentiality and your responsibility to obtain consent and protect privacy.



Standards for protecting patient health information

The Health Insurance Portability and Accountability Act (HIPAA) sets a national standard in the USA for protecting sensitive patient health information from being disclosed without the patient's consent or knowledge. The main goal is to ensure that every individual's health information is properly protected while allowing the flow of health information needed to provide and promote high-quality health care and to protect the public's health and wellbeing. You can read further about protected health information in a [CDC information graphic](#).

You can use different strategies to test the best dissemination format. For example, you can:

- Prepare different draft versions of the study findings for different readers, allowing you to compare which version has most appeal and leads to best recall of the key messages.
- Role-play presentation of the findings to different audiences or with different tools and see which is most accessible to use to share results.
- Check how information is already being presented to key stakeholders, such as in existing online public information websites, and be guided by which features people like most.
- Involve someone who has communications expertise and knows how to reach your audiences.

i Generally a **written report** contains the full story regarding the intervention, including technical information and findings. The full report usually contains:

- a. A summary of key findings.
- b. The methods used for the evaluation(s), the opportunities for those directly involved to interrogate and validate the evidence, the peer reviewers, and limitations.
- c. The purpose and aims of the intervention and the situation in which it was introduced (using information from the baseline assessment).
- d. The theory of change, and the story of the intervention and its implementation, using relevant information from the performance evaluation.
- e. The evidence on the intended and unintended outcomes and impacts, and the factors that have contributed to them, using information from the outcome/ impact evaluation.
- f. Learning, insights, and recommendations for follow-up action.

Some reports follow the one-three-twenty-five (1:3:25) principle, which suggests one page of key messages, a three-page summary, and 25-page report.

Devote time and careful attention to your 'Summary of Key Findings' because many people may not read the full report. The summary appears at the beginning of the report, but should be written last. It should give readers an overview of the evaluation's purpose, its key findings, and the lessons learned. You may ask different people on your team to read it using the lenses of different members of your target audience, to check for issues in how they may understand or use the evidence.

Make clear the limitations of your methods and ensure that the recommendations are realistic and align with the reasons for the evaluation. Write them as 'action items' and make sure that they are supported by the evidence presented. Don't bias your reporting by eliminating negative results. Report the positive and the negative findings because both inform the recommendations.

From the full report, other materials, including some using other media, may be produced and disseminated. Some examples include:

- Briefs, memos, leaflets, websites, slides, exhibits, short videos, and video testimonials for policy, professional, and official audiences;
- Displays, posters, leaflets, videos, cartoon stories, plays, photographs and other visual forms for communities; and
- News briefings and news releases/video clips for news reporters.



Annual health forum in Seixal, Portugal

For the past three years, Seixal in Portugal has held a two-day annual health forum that is attended by several hundred representatives from partner and voluntary organisations. Half the forum is set aside for a survey and debate about health priorities in the city and the future work of the Healthy Seixal Project. The findings from the questionnaire and from the debates are carefully noted and are the focus of follow-up coordination meetings. The community consultation during the health forum drives the agenda for the Healthy Seixal Project for the coming year (Heritage and Dooris, 2009).

These materials may be used in feedback workshops, briefings, video conferences, webinars, and other forums, as described in the example from Portugal. You can maximize the impact of your report by co-ordinating its release with a suitable event.

More accessible, simpler, and visual formats can be used for presenting detailed information to the public.

For example, The [Castlemaine 500](#) project developed a storybook to present its findings (see screenshot and [the Central Virginal Greenhouse Alliance website](#)). Storybooks provide evaluation information in a visually appealing way that is less dry than standard evaluation reports (Third Ecology et al., undated).



You can widen dissemination of your findings by having some of those involved present them directly online. This allows for many different voices to be heard, including those from the community. Online videos, such as the examples from the [Vitorias Meurio network](#) in Brazil (shown in the screenshot below) help to bring evidence to life.



[Better Evaluation \(2014\)](#) provides guidance for accessible reporting and the [Cottage Health Evaluation toolkit](#) provides guidance on setting up a communication plan.



Go to worksheet 4.3: With your team, use this worksheet to identify the targets for reporting and the format and key content for each.

Planning for challenges

While many of the challenges and ways of addressing them discussed in [Part 2](#) and in [Part 3](#) are also relevant to this stage, this can be the most challenging stage of evaluations. As noted in the Building Movement Project (undated): *Community residents live in a web and, as individuals become more civically engaged, the outcome and impact of their behavior is difficult to track. To fully assess the impact, we would need to have detailed knowledge of the web and the web is constantly evolving. The challenge is to be able to track changes in the web that can be attributed to a specific set of actions.*

To do this work, you need to be flexible and comfortable with ambiguity, and you need to be able to manage tensions and issues and help others navigate changing environments. Keep in mind the bias you can introduce by looking for issues you are interested in, like improvements from SPH, and ignoring other effects.

The massive amount of information generated for the baseline, on performance and in assessing outcomes can be overwhelming. It is easier to manage this if you synthesise, analyse, and review the evidence at each stage in a timely and digestible way. This means planning for and embedding evidence and analysis within the SPH intervention from the beginning and being open to feedback from key stakeholders throughout the process.

The challenges in SPH processes cannot be met by tools alone, as these processes involve identity, values, rights, and politics. How you address these challenges determines whose story gets told and how.

The key issue is to find ways of discussing them with people who can provide advice. Over time, you build experience and learn from practice, including from mistakes, so having a safe space in which to reflect on practice is important. It calls for relationships built on trust, shared interests, and often diverse capacities and disciplines.

Involving community members, service providers, authorities, and other stakeholders (as recommended in [Part 1](#)), such as through an advisory group (as recommended in [Part 2](#)) is one source of valuable support for dealing with challenges. You can consult on how to solve problems, resolve tensions, and overcome bureaucratic obstacles as soon as they arise.



Keeping indigenous communities in Australia involved at all stages

'Smart and Deadly' was a community-led sexual health promotion initiative involving young Aboriginal people in north-eastern Victoria, Australia. A local working group, with majority Aboriginal membership, was formed and followed by extensive consultation with Elders and Aboriginal workers. The project management team facilitated active involvement of the health sector, schools, education departments, local councils, tertiary institutions, and the broader Aboriginal community. The team held regular presentations with the local Aboriginal community to seek input, feedback, and endorsement for each stage of the initiative, including when reviewing and reporting results ([Chambers et al., 2018](#)).

Meeting these challenges and showing the learning in ways that meet the diverse needs of different groups requires capable and strategic leadership. Fortunately, these are the same capacities and relationships found in SPH efforts.

Reflecting with the team

At the end of your evaluation efforts, it is important to discuss, debrief, and reflect on the experience with your team members. Considerations include:

- What was new, interesting, and exciting, and what was challenging and demanding?
- What aspects of the assessment process should we include or drop in future evaluations?
- How do we better reflect our aspirations and principles for SPH in our evaluation processes? What should the role be for communities? What capacities, processes, and methods do we need to build for this and how will this help to build critical review within our SPH processes?
- How do we integrate monitoring and evaluation in our ongoing work?

You can also use some of the tools in this resource in your team review. Don't worry about making errors if this is your first time. Experience is a great teacher! Your experience makes you better prepared for the next time and an evaluation resource for your colleagues.



Colors of Cancer Walk & Health Resource Fair, City of Miami Gardens, under CC BY-NC-ND 2.0

Part 5: Worksheets, Resources, and Next Steps

What you will find in Part 5

Worksheets, Resources, and Next Steps	5.1
Next steps	5.2
Overview of methods, tools, and their uses	5.3
Glossary	5.7
References	5.9
Resources for more information and support	5.12
Worksheets:	5.13



An evaluation story in Amish and Mennonite communities, continued...

At the start of Parts 1-4, we told part of an evaluation story related to a participatory intervention conducted by Project Hoffnung with Amish and Mennonite women and health services in Ohio. The SPH project aimed to prevent breast cancer deaths within the target communities. The evaluation was embedded in the intervention and was guided by community and other stakeholders. It progressed through a baseline assessment to inform plans, a performance evaluation to review progress and adjust plans, and an outcome evaluation to show the changes achieved. A key informant noted, *the most successful measure with the community was when they didn't need me anymore*, when sharing her experience of how the community coalitions she worked with had become nonprofit organisations. A photo story book produced with the community, '[Life Through Their Lens](#),' provides a history of the project and gave the community a voice to share what they wanted about their lives. Reflecting on the evaluation, a key informant observed that ground rules help to make roles and processes clear for all, including community members. She recommended involving advisory groups, but said not to assume that they speak for all participants. Each evaluation was seen to be a foundation for and a way to stimulate wider interest in the next community-led project.

Part 5: Next Steps and Resources

Next steps

The next step is action!

Now that you have read the Implementers' Resource, we hope you feel ready to begin planning an evaluation. If so, take a deep breath, go back to [Part 1](#), and begin working through the resource with your colleagues. We hope the worksheets we have included will help.

You may want to use the resource to help your team build skills as you collectively work through the evaluation so that they may lead and facilitate the process next time. They will learn by doing, but we have produced a separate Facilitator's Guide that explains how to use the Implementers' Resource.

The separate '[Making Change Visible: Facilitator's Guide](#)' is available on the Shaping Health website. It shows how the MCV Resource can be used in three different types of training workshops/skills sessions. It provides facilitators with:

- Tips for preparing for and facilitating evaluation training workshops/skills sessions
- Suggestions, outlines, tips for using the MCV resource and worksheets and sample schedules for the three different types of training workshops/ skills sessions above
- Suggestions for how participants can evaluate sessions and an evaluation form for facilitators to complete to provide feedback on their use of the MCV resource.

Finally, we welcome feedback on the resource. While developing and producing it, we have solicited extensive peer review and received valuable feedback on it, but it is still a first edition. There is a feedback form in the [Facilitator Guide](#) for you to fill and email to us at admin@tarasc.org.

Once we have tested and assessed its use in practice, we hope to revise it and produce a more interactive online version. If anything is not clear or raises questions, please let us know. Your feedback is valuable and sincerely appreciated.

Please email us at admin@tarasc.org with your comments and questions. Be sure to tell us about your organisation and your SPH work. We look forward to hearing from you!

Overview of methods, tools, and their uses

This table includes all of the methods and tools referenced in this resource. It provides page numbers and worksheet numbers, where you may find out more about them, and tells you quickly the purpose of each, the evaluation stage each is used for, and the difficulty and resource demands of their use.

B = baseline assessment

P = performance evaluation

O = outcome/impact evaluation

If shaded, it means the method is useful for this stage of the evaluation

C = Complexity of the method – rated from 1 = simplest to 5 = very complex

R = Resources needed – rated from 1 = lowest resource demand to 5 = highest resource demand

WS = Worksheet

Method/tool	Purpose	B *	P *	O *	Comment	C	R	Page/ WS #
For secondary data collection								
Census and other household survey data	Secondary source of demographic, socio-economic data	✓			Usually over a larger scale and longer time period	2	2	2.8
Routine service/ official data	Secondary source of service availability and coverage	✓	✓	✓	Consider any barriers to use that may affect validity	3	2	2.11
Local survey/ research reports	Source of a range of evidence, including on inequalities	✓	✓	✓	Useful for interpretation if relevant to the area and population	2	1	2.11
For primary data collection (and some with integrated analysis)								
Surveys (interviewer or self-administered)	Collect quantitative and qualitative evidence on a range of measures	✓	✓	✓	Require good design and sampling and takes time; can be online if focus appropriate and if good digital access	3	4-5	2.11
Exit surveys/ interviews	Implemented after service use to assess client experience	✓	✓	✓	Assess performance satisfaction, but may be risk of bias	2	3	2.12, 2.17
Observational surveys/transect walks	Walk through/observe an area/service to record key features	✓	✓		If provided with a good checklist, can help observe functioning	2	1	2.12
Participatory maps/ observations	Participants mapping of the conditions in the intervention setting	✓	✓	✓	Map existing/new physical and social features (+/-)	2	2	2.12
Service maps	Help to understand which services people use and how	✓	✓	✓	Can be area maps or as concentric circles based on use	2	2	2.17
Key informant interviews	Structured interviews with key respondents	✓	✓	✓	Requires good structure, sampling, and interview skills; can be done remotely	3	3	2.12

Method/tool	Purpose	B*	P*	O*	Comment	C	R	Page/WS #
Diaries	Participant recording of events/experiences		✓	✓	Needs literacy; may lose data if prolonged	2	1	2.12, 3.6
Focus group discussions	Structured theme group discussion with 10-30 participants	✓	✓	✓	Requires good structure, representation and facilitation skills	3	3	2.12
Storytelling/storybanking	To understand experiences and drivers of change		✓	✓	Requires many stories; can be gathered online or using cellphones	3	2	3.6, 4.8
Picture codes	Single pictures used to trigger discussions on conditions, causes, and actions to be taken	✓	✓		Participatory and needs well thought out graphics or photos and good facilitation skills	2	2	2.12
Stakeholder mapping/analysis	To identify the different relevant groups and interests in an issue	✓	✓	✓	Rank their influence and importance, and update in each stage	2	1	2.12
Onion tool	Visual analysis of actors that influence change	✓	✓	✓	Participatory and a simpler visual form of a stakeholder analysis	1	1	2.13
Social network analysis	Explores relationships and participation levels in social networks	✓	✓	✓	Generic term; can be done online/in person; complexity varies	Varies		2.14
Venn/chapati diagram	A form of social network analysis that shows relationships between stakeholders, groups, and institutions	✓	✓	✓	Participatory	2	1	2.14
Relationship map	A visual tool for connections between social networks	✓	✓	✓	Participatory; useful if outcomes are about improving relationships or support networks	2	1	2.14
Power analysis	Maps power relations among actors involved	✓	✓	✓	Generic term; complexity varies	Varies		2.15
Power map	Shows the power relations among key stakeholders	✓	✓	✓	Dynamic; if repeated can show changes	2	1	2.15
Forcefield analysis	Identifies the forces that may influence an intervention's success	✓	✓	✓	Participatory and useful for strategic planning and review	3	1	2.16
Risk analysis	Shows the likelihood and level of risks in engaging power	✓	✓		Useful for assessing pathways and if actions have changed risks	2	1	2.16
Stepping stones	Used to identify key steps to produce a change	✓			Participatory (and fun!) way to identify steps in a pathway for change	1	1	WS2.1

Method/tool	Purpose	B *	P *	O *	Comment	C	R	Page/ WS #
Rating scales, Likert scales	Used to rate and/or rank perceptions of various areas; can be done online		✓	✓	Useful for qualitative measures where there is a continuum; design key to avoid bias; use odd number of options	Varies		3.5, 3.6
Speedo	A participatory visual rating scale of the level of SPH dimensions	✓	✓	✓	Simple and can be repeated in all 3 stages of evaluation			2.7
Smiley face	Used to assess subjective perceptions		✓	✓	Simple way of gauging the mood of a group	1	1	WS1.2
Ranking and scoring	Used to identify collective priorities	✓	✓		Participatory; identifies preferred options	1	1	3.5
Pairwise ranking	To systematically compare and rank each item on a list		✓	✓	Participatory; identifies preferred options; needs good facilitation	3	1	3.6
Spider diagram	A participatory visual rating scale of levels of multiple SPH dimensions	✓	✓	✓	Best used to compare between baseline and performance/outcome stages; accessible	2	1	2.7, 3.7
Timeline	To show the evolution of an intervention, important events, and changes over time		✓	✓	Can be participatory; may use words or symbols; needs good facilitation	2	1	3.7
Citizen report cards	For service users to report on changes in service performance			✓	Participatory; work best when discussed with service providers	2	3	4.8
Outcome star	To assess achievement of goals across multiple dimensions			✓	Visual; can be participatory or use data; can be repeated	3	2	4.9
Wheel chart	For collective review of a range of outcomes over time	✓		✓	Participatory; use to compare against a baseline	1	1	4.9
Photovoice/ photojournalism/ Before + after photographs	Photography to show the changes achieved and how they were produced	✓		✓	Can be participatory; ensure ethics in use of images	3	3	4.14
For analysis and organisation of evidence								
SWOT analysis	Organises evidence on strengths, weaknesses, opportunities and threats to assess conditions affecting interventions	✓	✓		Useful to discuss, adjust, and communicate plans	2	1	2.20
Problem tree/ outcome tree	Visual tool to show factors affecting problems/outcomes	✓	✓	✓	Participatory; useful for discussion/review of factors	1	1	2.20, 3.3

Method/tool	Purpose	B *	P *	O *	Comment	C	R	Page/ WS #
Contribution analysis	To test a theory of change through 'contribution' stories			✓	Stakeholders can assist in analysis of contributing factors	3	3	4.10
Most Significant Change	Uses change stories to assess impact			✓	Uses multiple stories and meetings over time	3	4	4.10
Ripple effect mapping	To identify intended/unintended changes			✓	Participatory; visual and needs good facilitation	3	1	4.10
Progress markers	To monitor progress towards the desired actions, outputs, and outcomes		✓	✓	Participatory; sets the desired and essential targets when the action plans are set	3	1	3.11
Dashboard	Uses traffic light colours to show the level of performance against goals		✓	✓	Visual rating with colours decided by judgement or target levels; useful to explain variance	2	2	3.12
Landscape diagram	To map conditions and factors enabling or preventing an outcome			✓	A visual that combines qualitative and quantitative data	3	1	4.15
Cost-effectiveness quadrant analysis	Qualitative analysis to show the relative levels of output to input costs		✓		Uses a 4x4 matrix of high/low and input/output costs; complexity is in costing some areas	3	2	3.8
Cost benefit analysis	To link cost information to identified outcomes and impacts			✓	Needs a single unit of value for all outcomes to link to financial costs	4	3	4.6
Social return on investment	Balances the sum of benefits of a project with the investment to achieve them			✓	Has a wider lens on the value of outcomes and investments beyond monetary measures	3	3	4.12
Delphi method	Used to manage different views in interpreting findings	✓	✓	✓	Participatory and demands time and facilitation skills	3	3	2.20
Market place	Used to draw out and discuss questions related to findings	✓	✓	✓	Participatory; needs good facilitation	2	1	WS4.2
World Cafe	To structure dialogue on specific evidence or questions for analysis	✓	✓	✓	Participatory; flexible but needs good facilitation	2	1	3.11
Stop drama	Role play findings to draw/interpret proposals for action		✓	✓	Participatory; need to prepare dramas and have good facilitation	2	2	3.12
Ballots in a hat	To share reflections on a process			✓	Participatory; draws out questions or issues in a group	1	1	WS4.3

Glossary

Term	Definition
Accountability	The obligation to demonstrate to stakeholders to what extent results have been achieved according to established plans.
Accuracy	The extent that collected data measures what they are intended to measure.
Appreciative inquiry	A technique that involves asking questions to understand a system's capacity to apprehend, anticipate, and heighten its potential. A systematic search for what enables effectiveness and constructive response.
Assessment	The systematic collection, review, and use of information about projects/programs to improve learning and implementation.
Assumption	A condition that needs to be met for the successful achievement of objectives.
Attribution	The degree to which an observed or measured change can be ascribed (attributed) to a specific intervention versus other factors (causes).
Baseline	A point of reference ideally established prior to an intervention and against which progress can later be measured and compared.
Benchmark	A reference point against which progress/achievements may be compared.
Beneficiaries	The individuals, groups, or organisations, whether targeted or not, that benefit directly or indirectly from an intervention (project/program).
Bias	Negative effect on the accuracy and precision of a measurement due to the experience, perceptions, and assumptions of the researcher, the sample selection, or the tools or methods used for measurement and analysis.
Community	A group of people linked by social ties, perspectives, actions, geographical locations, or settings.
Community participation/engagement	The level of interactions between government, communities, and citizens in the development and implementation of policies, programs, services, and projects; examples include collective information sharing and decision making.
Context	The broader situation within which something exists or happens, and that can help explain it.
Cost-benefit analysis	Analysis that compares project/program costs (typically in monetary terms) to all of its effects and impacts, both positive and negative.
Coverage	The extent to which population groups are included in or excluded from an intervention.
Effectiveness	The extent to which an intervention achieves its intended outputs.
Efficiency	The extent to which results have been delivered in the least costly manner.
Equity	Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically. Inequity is the opposite of equity.
Evaluation	A process to explore whether and how actions contributed to intended changes. An assessment that identifies, analyses, and reviews the effects of what has been done.
External/independent evaluation	Conducted by evaluator(s) outside of the implementing project/program team, for objectivity and to integrate technical expertise.
Financial monitoring	Tracks and accounts for costs by input and activity within predefined categories of expenditure.
Focus group	A group of between 5 and 30 people who discuss an intervention that affects them.
Formative evaluations	Occurs during project/program implementation to improve performance and assess compliance.
Generalizability	The extent to which findings can be assumed to be true for the whole target population.
Goal	The long-term result that an intervention seeks to achieve.
Impact	The positive and negative, primary and secondary, long-term effect produced by an intervention, directly or indirectly, intended or unintended.

Term	Definition
Impact evaluation	Understanding and assessing the changes brought about in whole or in part by programs and activities. Assessment of the magnitude and strength of causal relationships between the intervention and outcomes.
Inclusion	The level to which key actors take part in processes and networks, and possess the capacity to intervene and find adequate channels for involvement.
Indicator	A unit of measurement that helps determine what progress is being made towards the achievement of an intended result (objective).
Local knowledge	Knowledge based on local lived experience.
Logic model	A framework linking activities and strategies of a project with its goals and objectives. Also called a log-frame.
Messaging	In communications strategy, the content of the information conveyed to the primary and secondary audiences.
Monitoring	An ongoing process to review evidence on progress in planned actions and changes.
Participatory action research	A research approach in which those affected by problems are the primary information source and primary actors in generating, validating, and using knowledge for action.
Participatory budgeting	Participation in decision-making on the prioritization of public spending in a specific area.
Participatory decision making	Decision making that involves and takes the views of stakeholders into account, with multiple ways to achieve this.
Participatory evaluation	Evaluation with the active involvement of all stakeholders involved or affected in the process of designing and implementing an action.
PhotoVoice	A method that uses photographs created by members of a community to activate discourse and participatory action around a common problem.
Power	As power over, the control, authority, or influence over others; as power to or with. the ability to act, produce an effect or to change things, individually or collectively.
Process indicator	A measure of whether planned activities are being carried out and how they are being carried out.
Social participation	Involvement and influence in defining problems and needs; process of collective reflection that enables groups to gather information about and participate in decisions on matters that affect them.
Stakeholder	A person/group/institution with an interest/involvement in or affected by a course of action and who may influence decisions.
Storybanking	Process by which an individual shares their particular story as a valuable resource for achieving advocacy goals.
Strategic knowledge	The tactical positioning of knowledge in political and administrative systems.
SWOT analysis	Situating information in accordance with limitations (weaknesses and threats) and potential capacity (strengths and opportunities).
Summative evaluation	Evaluation implemented at the end of an intervention.
Survey	A structured form or questionnaire distributed to a relevant population group.
Thematic analysis	Identifies major or recurrent themes and summarizes findings under thematic headings. This offers a structured way of dealing with the evidence in each theme.
Theory of change	An organised way of thinking about the assumptions and pathways that will lead to change, especially in unpredictable and complex processes.
Trust	To rely upon and have confidence in someone or something.

IFRC, 2011; Gamble, 2008; NMAC, 2012; Loewenson, et al., 2014; Lennie, et al., 2011; Francés, et al., 2016; Frances and La Parra-Casado, 2019; Aslin and Brown, 2004; MacQueen, et al., 2012; Davies and Dart, 2005; Engage for Equity, 2020; Community Catalyst, undated; WHO, 2021

References

1. Abelson J, Forest P-G, Eyles J, et al. (2003) [Deliberations about deliberative methods: Issues in the design and evaluation of public participation processes](#). *Social Science & Medicine*, 57(2):239-251.
2. Abelson J and Gauvin FP (2006) [Assessing the impacts of public participation: Concepts, evidence, and policy implications](#), McMaster University, Canada.
3. Abelson J, Montesanti S, Li K, Gauvin FP, Martin EL (2010) [Effective Strategies for Interactive Public Engagement in the Development of Healthcare Policies and Programs](#). Canadian Health Services Research Foundation, Ottawa.
4. Aggett S, Dunn A, Vincent R (2012) Engaging with Impact: How do you Know if we Have Made a Difference? Report from the International Public Engagement Workshop. Wellcome Trust, London.
5. Aslin HJ and Brown VA (2004) [Towards Whole of Community Engagement: A Practical Toolkit](#), Murray-Darling Basin Commission, Canberra, Australia.
6. Aubel J (1999) Participatory Program Evaluation Manual: Involving Program Stakeholders in the Evaluation Process. Retrieved from http://pdf.usaid.gov/pdf_docs/PNACH756.pdf
7. Baker AM and Bruner B (2010) [Participatory Evaluation Essentials: An Updated Guide for Non-profit Organisations and Their Evaluation Partners](#). The Bruner Foundation, Cambridge, MA, USA.
8. Banerjee A and Bharadwaj S (2011) [Evaluating the Impact of Participatory Mapping Activities: Participatory Monitoring and Evaluation](#). International Fund for Agricultural Development.
9. Better Evaluation (2014) Rainbow framework. Mimeo, Australia. <http://betterevaluation.org>
10. Beznec P, Maučec G, Nemeš S, Nemeš D (2017) [Case study: Pomurje Region, Slovenia](#). Shaping health program. Centre for Health and Development, Murska Sobota, Slovenia.
11. Brown J (2014) Evaluating participatory initiatives in South Africa: Not just processes but outcomes too. Sage Open. Available at: <https://journals.sagepub.com/doi/full/10.1177/2158244014531966>
12. Building Movement Project (undated) Evidence of change: Exploring civic engagement evaluation. Social Service and Social Change Series, USA. <https://tinyurl.com/y43zb642>
13. Burns D, Heywood F, Taylor M, Wilde P, Wilson M (2004) [Making Community Participation Meaningful: A Handbook for Development and Assessment](#). The Joseph Rowntree Foundation, York, England. Graphic published with permission of the University of the West of England. Available also via the UWE Research Repository
14. Butterfoss FD (2006) [Process evaluation for community participation](#). *Annual Review of Public Health* 27:323-40.
15. Camara L and Silca C (2019) Participatory evaluation [webinar]. Independent Development Evaluation African Development Bank. <https://idev.afdb.org/en/document/webinar-participatory-evaluation>
16. Case, D'A D (1990) The Community's Toolbox: [The Idea, Methods and Tools for Participatory Assessment, Monitoring and Evaluation in Community Forestry](#). Centre for Poverty Analysis, Sri Lanka.
17. Catle A, Burns J, Omeno DA, et al. (2014) [Participatory Impact Assessment: A Design Guide](#). Feinstein International Center, Tufts University, Somerville, MA, USA.
18. Central Statistical Office India (2015) [Manual on Health Statistics in India](#). Government of India, New Delhi.
19. Chambers AH, Tomnay J, Stephens K, et al. (2018) [Facilitators of community participation in an Aboriginal sexual health promotion initiative](#). *Rural and Remote Health* 18(2):1-11.
20. Community Catalyst (nd) [Our Voices have Power: A Storybanking Guide](#). Community Catalyst, USA
21. Center for Community Health and Development, University of Kansas (2017) [Community Tool Box Chapter 36: Introduction to evaluation. USA](#).
22. Consumers Health Forum of Australia (undated) [The Real People Real Data Toolkit](#). Canberra, Australia.
23. D'Ambruoso L, Abbott P, Douglas F, et al. (2017) [Case study: Empowerment approaches to food poverty in NE Scotland in the Shaping health program](#), University of Aberdeen, TARSC
24. Davies R and Dart J (2005) [The Most Significant Change \(MSC\) Technique: A Guide to its Use](#). Monitoring and Evaluation News, UK.
25. Earl S, Carden F, Smutylo T (2001) [Outcome Mapping: Building Learning and Reflection into Development Programs](#). International Development Research Centre, Ottawa
26. Eggen L and Chavez-Tafur J (2019) [Facilitating Experience Capitalization: A Guidebook](#). Wageningen, the Netherlands, CTA
27. ELLA (2012) [Practice Brief: Citizen Participation in Evaluating Health Services](#): The Latin American Experience 1–6.
28. Engage for Equity (2020) Combining knowledge and action for social change. Engage for Equity, New Mexico
29. Engage for Equity (2020b) Promising Practices of CBPR and Community Engaged Research Partnerships Available at: <https://engageforequity.org/>
30. Esteves AM, Franks D, Vanclay F (2012) [Social Impact Assessment: The State of the Art](#). *Impact Assessment and Project Appraisal*, 30(1):4-42. DOI: 10.1080/14615517.2012.660356
31. Evaluation Support Scotland (nd) [Using Visual Approaches to Evaluate your Project](#), Evaluation Support Scotland, Scotland.
32. Falleti, Tulia G, Cunial SG.(2019). [Civic programmatic participation in public health: The case of Argentina](#). *Cadernos de Saude Publica* 35Suppl 2: e00243218.
33. Feedback Labs (2018) [A curated collection of actionable resources to help you improve your feedback loop](#) [website].
34. Fiorati, R C, Arcêncio RA, del Pozo JS, et al. (2018) Intersectorality and social participation as coping policies for health inequities worldwide. *Gaceta Sanitaria* 32(3):304–14. doi: [10.1016/j.gaceta.2017.07.009](https://doi.org/10.1016/j.gaceta.2017.07.009)
35. Food and Agriculture Organisation of the United Nations (FAO) (2016) [Free Prior and Informed Consent: An Indigenous Peoples' Right and a Good Practice for Local Communities](#). FAO: online.
36. Francés F, La Parra D, Román MAM, et al. (2016) [Toolkit on Social Participation](#). WHO Euro, Copenhagen.
37. Francés F and La Parra-Casado D (2019) [Participation as a Driver of Health Equity](#). WHO Euro, Copenhagen.

38. Gamble JAA (2008). [A Developmental Evaluation Primer](#). The J.W. McConnell Family Foundation, Canada.
39. Garratt C (2009). The economic benefits of community engagement in health provision in County Donegal, County Donegal, Ireland.
40. Giffin R, Giffin M (undated) [Cost Benefit Analysis: A Primer for Community Health Workers](#). University of Arizona Rural Health Office and College of Public Health, Arizona, USA.
41. Gilson L (ed) (2012) [Health Systems and Policy Research: A Methodology Reader](#). Alliance for Health Policy and Systems Research, WHO, Geneva.
42. Gujit I (2014) [Participatory Approaches](#). UNICEF, New York.
43. Haldane V, Chuah FLH, Srivastava A, et al. (2019) [Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes](#). PLOS ONE 14(5):e0216112.
44. Hamelmann C, Turatto F, Then V, Dyakova M. (2017) [Social Return on Investment](#). WHO Euro, Copenhagen, Denmark.
45. Hargreaves, MB., Verbitsky-Savitz N, Coffee-Borden B, et al., (2016) [Advancing the Measurement of Collective Community Capacity to Address Adverse Childhood Experiences and Resilience](#). Gaithersburg.
46. Harvey P, Baghri S and Reed B (2002) "[Chapter 12: Community Participation](#)" in *Emergency Sanitation: Assessment and program design*. Water, Engineering and Devt Centre Loughborough University, UK.
47. Healthcare Improvement Scotland (2013) *Evaluating Participation: A guide and toolkit for health and social care practitioners*, Scottish Health Council, UK
48. Heritage Z, Dooris M (2009). Community participation and empowerment in Healthy Cities, Health Promotion International, 24, suppl_1, 1: i45–i55 <https://doi.org/10.1093/heapro/dap054>
49. Hindhede AL, Aagaard-Hansen J (2017). [Using Social network analysis as a method to assess and strengthen participation in health promotion programs in vulnerable areas](#). Health Promotion Practice 18:175–83. doi:10.1177/1524839916686029
50. Hodin RM, McGaffigan E, Destrampe M, Green, et al. (2020) [Organisational-Level Consumer Engagement: What It Takes](#). Community Catalyst, USA
51. Hunjan R and Pettit J (2011). *Power: A Practical Guide for Facilitating Social Change*. Andrew Carnegie House, Dunfermline, Scotland. <https://tinyurl.com/y5jqy2j8>
52. Illinois Caucus for Adolescent Health (ICAH) (2018). <https://www.icaah.org/>
53. Institute of Development Studies (2020) [Participatory Methods](#) [website].
54. Institute of Medicine (IOM) (2014) [Analysis through triangulation and synthesis to interpret data in a mixed methods evaluation in evaluation design for complex global initiatives](#): Workshop summary. National Academies Press, Washington, DC, USA.
55. International Federation of Red Cross and Red Crescent Societies (IFRC) (2011). [Project/Program Monitoring and Evaluation \(M&E\) Guide](#). IFRC, Geneva.
56. Involve (2005). [The True Costs of Public Participation](#). Involve, London.
57. Jackson ET and Kassam Y (eds) (1998) [Knowledge Shared: Participatory Evaluation in Development Cooperation](#). International Development Research Centre, West Hartford, CT, USA.
58. Kasmel A and Andersen PT (2011) [Measurement of community empowerment in three community programs in Rapla](#) (Estonia). International Journal of Environmental Research and Public Health 8(3):799-817. doi: 10.3390/ijerph8030799
59. Kelaher M, Luke J, Ferdinand A, Chamravi D (2018) *An Evaluation Framework to Improve Aboriginal and Torres Strait Islander Health*. The Lowitja Institute, Melbourne, Australia.
60. Kramer M, Parkhurst M, Vaidyanathan L (2009). [Breakthroughs in Shared Measurement and Social Impact](#). FSG Social Impact Advisors, Boston, MA, USA.
61. Lansdown G and O’Kane C (2014). *Tools for Monitoring and Evaluating Children’s participation*. Save the Children, London. Available at: <https://tinyurl.com/y27g3v9c>
62. Lennie J (2006). Increasing the rigour and trustworthiness of participatory evaluations: Learnings from the field. Evaluation Journal of Australasia 6 (new series, No.1):27-35. At: <https://tinyurl.com/y53b4mel>
63. Lennie J, Tacchi J, Koirala B, Wilmore M, and Skuse A (2011) [Equal Access Participatory Monitoring and Evaluation Toolkit](#). BetterEvaluation [website].
64. Loewenson R, Kaim B, Chikomo F , Mbuyita S and Makemba A (2006) [Organizing People’s Power for Health: Participatory Methods for a People Centred Health System](#). EQUINET, Harare.
65. Loewenson R, Flores W, Amaya A, et al., (2016) '[Skills building on methods and tools for learning from action in participatory action research](#): Building action learning within affected actors and communities’ Session Report, HSG Conference, November 2016, Vancouver
66. Loewenson R, Laurell AC, Hogstedt C, et al. (2014) *Participatory Action Research in Health Systems: A Methods Reader*. TARSC, AHPSR, WHO, IDRC Canada, EQUINET, Harare.
67. Loewenson R (2016) [Understanding and Organising Evidence on Social Power and Participation in Health Systems](#). Training and Research Support Centre, Harare, Zimbabwe.
68. Loewenson R with Beznec P; Coelho V; D’Ambruso L et al. (2017) *Building social power and participation in local health systems: Learning from practice’*, November 2017, Training and Research Support Centre.
69. Loewenson R, Kaim B, Thole C, et al., (2019) [How does target-driven funding affect comprehensive primary health care in east and southern Africa?](#) EQUINET, Harare
70. Mathur VN, Price ADF, Austin S, Moobela C (2007) [Defining, identifying and mapping stakeholders in the assessment of urban sustainability](#), in Homer M, Hardcastle C, Price A and Bebbington J (ed) International Conference on Whole Life Urban Sustainability and its Assessment, Glasgow,
71. Mayne J (2008) *Contribution Analysis: An approach to exploring cause and effect*. ILAC methodological brief. At <https://tinyurl.com/y4rrs6jy>
72. Mbwili-Muleya C, Lungu M, Kabuba I, et al. (2008) [Consolidating processes for community – health centre partnership and accountability in Zambia](#). EQUINET PAR Paper Series. EQUINET, Harare, Zimbabwe

73. McHardy(2003) [Metaphor of the Strauss waltz as the dance of collaboration for negotiating and resolving differing interests](#). Case Study Perimenopause project
74. McNamara C (2017) Field Guide to Nonprofit Program Design, Marketing and Evaluation, Authentric consulting, USA <https://managementhelp.org/evaluation/outcomes-evaluation-guide.htm>
75. Minnesota Department of Health (2017). [Community Engagement Guide](#): Statewide Health Improvement Partnership, Office of Statewide Health Improvement Initiatives, Minnesota,
76. Nabatchi T (2012) [A manager's guide to evaluating citizen participation](#). IBM Center for the Business of Government, Washington
77. Naccarella L. (2016) [Impact Evaluation of the Opening Doors Community Leadership Program for Social Inclusion](#). University of Melbourne,
78. National Institute of Health (NIH) (2011) Principles of community engagement: Evaluation phases and processes, https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf
79. National Recreation and Parks Association (NRPA) (undated) [Community Engagement Resource Guide: Creating Equitable Access to High Performing Parks](#). NRPA, USA
80. North American Association for Environmental Education (NAAEE) (2017) [Guidelines for excellence: Community engagement](#). NAAEE, Washington DC
81. Obando F and Loza R (2017) Proyecto Espacios Saludables. Municipio del Distrito Metropolitano de Quito, Ecuador.
82. Peabody M (undated) [Understanding communities and their dynamics. Foundations of practice in community development, Community Situational Analysis](#). Powerpoint. New Mexico State University, USA.
83. People in Health West of England and West of England Academic Health Science Network (2016) [Working together: A toolkit for health professionals on how to involve the public](#).
84. Perrin B (2012) [Linking monitoring and evaluation to impact evaluation](#). InterAction and the Rockefeller Foundation, USA
85. Preskill H and Jones N (2009) [A practical guide for engaging stakeholders in developing evaluation questions](#). FSG online, Princeton, New Jersey.
86. Rifkin S, Hewitt G, Draper A (2007) Community participation in nutrition programs for child development and anemia. doi:10.13140/RG.2.2.29065.65120. <https://tinyurl.com/yxl59w76>
87. Ritchie L, Kousky C, Domingue S, et al. (2019) [Assessing the feasibility of conducting social return on investment analyses for "whole community" engagement activities](#). Risk Management and Decision Processes Center, USA
88. Rowley KG, Daniel M, Skinner K, et al. (2000) Effectiveness of a community-directed 'healthy lifestyle' program in a remote Australian Aboriginal community. Australian and New Zealand Journal of Public Health 24(2): 136–144.
89. Saferspaces (2020) [Participatory monitoring and evaluation](#). saferspaces website.
90. Sah DC and Kumar Y (2015) [Client satisfaction exit interviews: Assessing quality of public health institutions through generated feedback](#). Sage, India
91. Sero R, Hansen D, Higgins L (undated) [In-depth ripple effects mapping: A participatory evaluation tool](#). Powerpoint, Washington State University, USA
92. Slocum N (2003) [Participatory methods toolkit: A practitioner's manual](#). King Baudouin Foundation and the Flemish Institute for Science and Technology Assessment, Belgium
93. Tachhi J and Lennie J (2014) A participatory framework for researching and evaluating communication for development and social change. In: Wilkins KG, Tuftte T, and Obregon R (eds). The Handbook of Development Communication and Social Change. Wiley Blackwell, Oxford, UK. <https://tinyurl.com/y6hfe2rv>
94. Tamarack Institute (2017) [Tool: Developing evaluations that are used](#). California, USA
95. Tamarack Institute (2020) [Cellphilmimg: A visual arts-based way of engaging people in evaluation](#). California, USA
96. Techo Internacional. (2019). [Informe de evaluación de la Mesa de Trabajo del Campamento de Santa Teresa](#)
97. Third Ecology et al. (undated) [How we ran a behaviour change pilot program and the lessons we learnt](#) Australia.
98. UNESCO (2009) On target: A guide for monitoring and evaluating community-based projects. UNESCO, Paris, France. <http://unesdoc.unesco.org/images/0018/001862/186231e.pdf>
99. United Nations Development Program (2009) [Handbook on planning, monitoring, and evaluating development results](#). UNDP, New York, NY.
100. UNICEF CEE/CIS Regional Office (2005) [Useful tools for engaging young people in Participatory Evaluation](#), UNICEF, New York
101. New South Wales (NSW) Health (2010) [The NSW SmokeCheck Aboriginal Tobacco Prevention Project 2007-2008](#). NSW Health, Cancer Institute, The University of Sydney: New South Wales
102. van Es M, Guijt I, Vogel I (2015) [Hivos ToC Guidelines: Theory of change thinking in practice: A stepwise approach](#). Monitoring and Evaluation News. The Hague, Netherlands.
103. Vermeulen S (2005) [Power tools: Handbook to tools and resources](#). IIED, London, UK.
104. Vinogradova T (2002) Participation in Budget Process in Russian Cities. St.Petersburg Humanities and Political Studies Center, Strategy" Participatory Planning Initiative, International Workshop on Participatory Planning: Approaches for Local Governance, held in Bandung, Indonesia. <https://tinyurl.com/y64enga7>
105. Wallerstein N (2006) [What is the evidence on effectiveness of empowerment to improve health?](#) WHO Regional Office for Europe Health Evidence Network, Copenhagen, Denmark.
106. World Health Organisation (WHO) (2006) [Evaluation in health promotion: Principles and perspectives](#), in Rootman I, et al. (eds), WHO Regional Office for Europe, Copenhagen, Denmark.
107. WHO Euro (2002) [Community participation in local health and sustainable development: Approaches and techniques](#), WHO Euro, Copenhagen

Resources for more information and support

1. The [Action Evaluation Collaborative](#) uses evaluation and collective learning in social change work
2. Better evaluation at <http://www.betterevaluation.org> has approaches to evaluation and case studies
3. Beyond Intractability website https://www.beyondintractability.org/essay/theories_of_change
4. Building Healthy Places website <https://buildhealthyplaces.org/about-us/#Team>
5. Communities CLD Learning Partners Group [discussion paper](#) on measuring and evaluating change from a community-led perspective.
6. Community Catalyst website www.communitycatalyst.org/resources/tools/roadmaps-to-health
7. Culturally Connected website <https://www.culturallyconnected.ca/>
8. [Capturing Magic, Ireland](#) provides tools for evaluating outcomes in youth projects
9. The [Center for Theory of Change](#) has resources on how to implement a theory of change
10. The [Community Health Assessment and Group Evaluation tool](#) is used by community members to define, prioritize, set, and assess strategies for areas of health improvement
11. Community Tool Box website at <http://ctb.ku.edu/en/> is a service of the Center for Community Health and Development at the University of Kansas
12. Community Sustainability Engagement provides [evaluation tools](#) and a page to help you to [decide which tool to use for your project](#)
13. [EQUINET portal](#) of resources on participatory action research.
14. European Public Health Alliance at <https://epha.org/> links public health actors in Europe
15. From Community Engagement to Ownership by Facilitating Power, Movement Strategy Center, and National Association of Climate Resilience Planners features a range of [tools and case studies](#)
16. [Global health learning](#) has a [free online course on evaluation](#) with a certificate
17. Heads up simulation resources at <https://www.heads-up.online/en/outputs/o1-simulation-resources/>
18. IFRC M&E www.ifrc.org/MandE
19. Institute of Development Studies has resources on participatory methods at www.participatorymethods.org/method/power and <http://www.powercube.net/>
20. Interaction.org has [resources on impact evaluation](#)
21. Involve website has [resources on cost effectiveness and cost benefit analysis](#) and also has a range of interesting participation tools, and guides for evaluating and reporting community engagement
22. Knight Foundation <https://knightfoundation.org/>
23. Learning for Action <http://learningforaction.com>
24. OECD innovative citizen participation network at <https://www.oecd.org/gov/innovative-citizen-participation.htm> explores new forms of deliberative and participatory decision making globally
25. [Participedia](#) provides examples of diverse forms of public participation and their benefits
26. Participatory methods: <http://www.participatorymethods.org/resources/themes/monitoring-and-evaluation-37> has searchable resources on monitoring and evaluation and social change
27. Public Agenda has compiled a number of [tools for digital/online engagement](#) and provides advice and support on implementing them
28. [Racial Equity tools](#) provides links to credible organisations that maintain useful databases, as well as some tools and tip sheets that can help in their use
29. Robert Wood Johnson Foundation works to [expand evidence on the factors shaping health](#)
30. Rural Health Information Hub (2020) [Community Health Worker-based Chronic Care Management Program](#) USA
31. Searchable e-Library <https://www.interaction.org/resources/document-library>
32. Shaping health www.shapinghealth.org is a network of local and national health actors sharing evidence and experience on SPH
33. The [Evaluation page](#) of the National Coordinating Centre for Public Engagement
34. The [Public and Patient Engagement \(PPE\) Collaborative](#) provides support for evaluation of patient and public engagement in health, with a portal for tools and resources
35. The US Department of Health and Human Services' Principles of Community Engagement (2011) has a [chapter on Evaluating the Community Engagement Process](#)
36. Theory of change resources at <http://learningforsustainability.net/theory-of-change/>
37. Theory of Change approaches at www.theoryofchange.nl/resource/theory-change-thinking-and-actionapproach-navigate-complexity-social-change-processes (Also available in Spanish)
38. [Virtual Town Halls](#) community engagement platforms provide a tool for partners in public health collaboratives to measure and monitor their activity over time
39. [WHO and the Alliance for Healthy Cities](#) is a global movement working to put health high on the social, economic, and political agendas of city governments
40. [WHO Regions for Health Network \(RHN\)](#) involves people in working together to improve health and well-being through prioritizing equity, developing strategic delivery alliances and fostering good governance



Worksheet 1.1: Stakeholder assessment

With your team, identify the different stakeholders who may be interested in or benefit from your SPH evaluation and discuss what they may want to know.

Those invested in advancing SPH may come from different sectors beyond health. Stakeholders who should have a role in evaluating SPH efforts belong to one of two groups as below.

- **Primary stakeholders** are those directly involved with the SPH intervention, including implementers (such as health practitioners, program managers, community leaders) and beneficiaries (such as community members and their organisations).
- **Secondary stakeholders** are those who support, manage, or have an interest in SPH efforts, including health system executives and managers, researchers, program trainers, facilitators, and planners; government officials and their staff members; staff of private and non-profit organisations, funders, and others.

Review *Table 1* in the Implementers' Resource. It outlines the baseline, performance, and final outcome stages of a full program evaluation. Keep these stages in mind as you work through this worksheet because various stakeholders may want different information at each stage.

Discuss as a team who the primary and secondary stakeholders are for your SPH intervention. These are people who should have a role in or are a target audience for the evaluation.

1. List these stakeholders, including their names, roles, and/or organisations in the first column of a table that you make, using the blank one below as a template (and adding as many rows as you need).
2. Identify and note what you and your team think each stakeholder listed may want to know from the evaluation and fill in this information in the second column of the table.
3. In the third column, identify and note at what stage(s) of the evaluation (baseline, process, or outcomes) you think the stakeholder would need this information.

You may conduct this discussion in several ways. As a full team, you might ask each team member to write down a primary or secondary stakeholder on an index card, collect all the cards, and then review and discuss them as a group, using the results of the discussion to complete the table. Alternatively, you could break the team into two groups and instruct one to discuss primary stakeholders and the other to discuss secondary stakeholders. Bring the full team back together to share and review the results and complete the table.

As you complete subsequent worksheets, you may come back to this table and add to or modify it, so keep it handy!

STAKEHOLDERS	WHAT THEY MAY WANT TO KNOW FROM YOUR EVALUATION	AT WHAT STAGE(S)?
Primary stakeholders		
Secondary stakeholders		



Worksheet 1.2: Capacities for evaluation

With your team, discuss the evaluation-related knowledge, skills, and capacities you and your colleagues already possess, those you still need and how to fill the gaps. You may return to this as you clarify plans for the evaluation.

Prepare a flip chart with three columns.

- At the top of the first column, write: KNOWLEDGE, SKILLS, AND CAPACITIES WE NEED FOR AN EVALUATION
- At the top of the second column, write: THOSE WE HAVE
- At the top of the third column, write: THE GAPS WE NEED TO FILL

Place the flip chart where everyone can see it. (Continue on a new flip chart if you run out of space in implementing the next steps and include these columns and headings on new pages).

For the first column:

With your team, identify the knowledge, skills, and capacities that you think you will need to implement each stage of an evaluation, from the baseline assessment to the performance evaluation to the outcomes/impact evaluation.

For the second column:

1. As a team, identify which of the knowledge, skills, and capacities on Column 1 you already have in those working directly on the SPH intervention and evaluation. Write down in Column 2 in the same row as the specific area of knowledge, skill or capacity the team member name(s). If anyone finds this difficult, think about what people do in their daily work and use this to identify the skills and capacities they use every day.
2. When you have completed this list, identify any knowledge, skills, or capacities you can easily draw on from within your organisation or others already indirectly involved in your SPH work. Add these names of people or organisations to the list in Column 2, in the same row as the specific area of knowledge, skill, or capacity in Column 1.

For the third column:

3. Look at the knowledge, skills, and capacities in Column 1 that do not yet have a name or organisation against them. If you can identify an organisation where you may find these add its name in Column 3.

Look at and compare the lists in the three columns. As a team:

4. Discuss the skills, knowledge, and capacities listed on Column 2 that you already have or can easily draw on. Does this make the evaluation seem more feasible?
5. Look at the gaps in knowledge, skills, and capacities—that you may still need to find for an evaluation. For the options that you have identified to fill these gaps in Column 3 assign these to team members to reach out and identify if they may be available to assist when needed. Team members doing this outreach should report back on their efforts at your next team meeting.
6. Look at the remaining gaps. Do you have ways of addressing each of these? If there are gaps that you cannot fill, discuss how you might take these gaps into account in the methods you later choose to use for the evaluation from those listed in Parts 2-4 of the resource. For example, if you can't access high-level computing, or GIS-mapping techniques, you should avoid using evaluation methods that demand these skills.

Reflect on how confident team members feel in moving ahead with doing an evaluation at this time. You may use a [smiley face ranking tool](#) like the one pictured. Recreate this on one of your flip charts and have team members make a mark using a pen under the emoji that best reflects their feelings about the evaluation. Discuss what concerns them. Don't worry if team members have concerns this early because many issues will be addressed as you progress through the resource. You may now progress to designing your baseline assessment (discussed in Part 2). You may want to redo this smiley ranking after you and your team complete each part of the resource to review and discuss how confidence is changing.





Worksheet 2.1: Setting a theory of change

With your team, set goals for your SPH work, including identifying what you know about the situation, your assumptions, and your theory of change. Identify what evidence you need to collect as part of the baseline assessment.

Re-read in Part 2 the steps you can follow when developing a theory of change.

With team members, identify the goals and theory of change for your SPH intervention:

1. Make a table like the one below.
2. Discuss the questions and note your answers in the table. For each question, think about equity and diversity—are there differences in changes, features, pathways, assumptions, and information to collect for different population groups?

To identify the steps/pathways in question 3 on the table below, you can use a participatory activity, such as the 'stepping stone' method.

- i. On a blank sheet of paper, write the words WHERE WE ARE NOW at the top and under that a sentence that describes the current situation in your community that your SPH work aims to address. Place this paper face up on the floor on one side of the room.
- ii. On another blank sheet of paper, write WHERE WE WANT TO BE at the top and a sentence on the change you want to achieve with your SPH effort. Place this paper face up on the floor on the other side of the room and a good distance away from the first.
- iii. On blank cards, ask team members to write down what needs to be done, by whom, and for what purpose if your intervention is to move from what is written on the first paper to what is written on the second. Each action step should be written on its own card.
- iv. Then, as a group, read through the action steps on the submitted cards. As you lay them on the floor, discuss the order in which they should be placed. When all the cards have been placed on the floor, you will have created a pathway from the 'where we are' paper to the 'where we want to be' paper.
- v. When you think you have identified all of the steps, discuss the pathway. Are the steps correct? Are they in the right order? Are they sufficient? Add, amend, or delete cards until you have a pathway that you all agree will take you from where you are today to the change you want to achieve. More guidance on this the stepping stones method can be found in the [Organising People's Power for Health toolkit](#) (Activity 18, page 54).

You may need more than one sitting to complete the table, and that's fine! Take all of the time you need. Where you need to obtain further information or talk to others to answer the question, agree on who will do this and when you will meet to finalise the inputs.

QUESTION	RESPONSE
1. What change(s) do you intend your SPH intervention(s) to achieve? For whom? (These will be the key <i>outcomes</i> you will later evaluate.)	
2. What features of the current situation (the area, the community, services, etc.) may motivate or affect achievement of these goals?	
3. How will you achieve the changes to which your SPH intervention aspires? Set out step-by-step how you will move along a pathway of interim changes, going from the current situation to the final outcome. These steps will point to the key <i>outputs</i> you will use later to assess performance of your intervention.	
4. What assumptions, including about the timing of various steps, have you made in setting your pathway for change?	

When you have completed this table, you may make a large chart listing your program's goals, desired change(s), and the steps (and timings) that describe the pathway that will be followed to achieve the change. This is your theory of change. You should refer to this chart as you make progress. Return to Part 2, which focuses on what measures to collect for your baseline assessment.



Worksheet 2.2a: Baseline information

We will complete Worksheet 2.2 in two parts. For this part, identify with your team the key features of the context, community, and stakeholders for the SPH intervention and its evaluation.

In Part 2, read the section titled 'Evidence to include in a baseline assessment,' as well as Table 2a. Make sure you have your chart with your theory of change handy (created using Worksheet 2.1). Recreate the table below.

Given your intervention's goals and theory of change, identify with your team the questions you want to answer and the information you need to collect as part of your baseline assessment. Do this for each of the six rows in the table below, including for your later evaluation of the goals (outcomes) and performance (actions and outputs). Make note of differences between areas and people that may need to be included.

You may want to divide your team into groups, giving each smaller group one of the areas in the table below to discuss. For each group's assigned area, they should identify the different types of information relevant to that particular area that needs to be collected.

Ask the small groups to present their proposals to the full group for discussion and review. In the full group discussion, keep asking *why do we need this information?* as a way to check that it is relevant. Also ask: *is this the correct information for what we are trying to find out?*

When the team has reached agreement on the areas, record them in the table.

AREA	INFORMATION TO COLLECT
CONTEXT General and disaggregated demographics, socio-political situation, community health status	
COMMUNITY Diverse social features of and variations in the target community for the SPH intervention	
CONDITIONS affecting or determinants of the priority health issues	
SERVICES and their functioning for different groups, including the perceptions of workers and users	
INSTITUTIONS and STAKEHOLDERS	
LEVEL and QUALITY OF SPH From Table 2a in the Resource, choose the most relevant issues	

Keep this completed table handy to help you and your team complete Worksheet 2.2b on the indicators to use (and what sources to use) for these areas of information



Worksheet 2.2b: Baseline indicators

With your colleagues, continue to identify what you want to include in your baseline assessment and the sources of that information, including the measures to ensure quality and equity.

Make your own copy of the table below. Have available the table you prepared in [Worksheet 2.2a](#) and read 'How do I decide what to collect from where?' in Part 2.

Identify the indicators to collect. As a team:

1. Identify the specific indicators/evidence to use for the baseline information that you need to plan or evaluate your SPH intervention (as you identified in Worksheet 4a). You may do this as a whole group or divide up the work among subgroups and follow with a full team discussion.
2. For each proposed measure, keep checking if you need it for planning your intervention or for later evaluation, and ask:
 - *Is it clearly defined? Is it relevant to planning the program or to assessing its performance or outcomes/impact?*
 - *Is it qualitative or quantitative? Is it feasible, simple, and easy to collect?*
 - *Is it easy to understand and credible for communities and stakeholders to interpret and use?*
 - *Can it be tracked over time if needed? Is it sensitive to changes?*

Remember to keep it simple and manageable! Don't collect what you don't need.

3. For each indicator, identify if it can come from existing (secondary) sources—and if so, which ones—or if it needs to be gathered as primary data.
4. Note any ethical requirements as discussed in [Part 1](#) of the resource.

Once you have agreed on the indicators, enter them in the table.

AREA	INFORMATION TO COLLECT	INDICATORS/ EVIDENCE TO GATHER IN THE BASELINE SURVEY	WHAT SOURCES? (Indicate if primary or secondary data. If secondary, note information source)
CONTEXT – demographic, socio- political, health	Enter the information here from your previous table in worksheet 4a		
COMMUNITY	Enter the information here from your previous table in worksheet 2.2a		
CONDITIONS affecting or determinants of the priority health issues	Enter the information here from your previous table in worksheet 2.2a		
SERVICES and their actual and perceived functioning	Enter the information here from your previous table in worksheet 2.2a		
INSTITUTIONS and STAKEHOLDERS	Enter the information here from your previous table in worksheet 2.2a		
LEVEL and QUALITY OF SPH	Enter the information here from your previous table in worksheet 2.2a		

Once you have the different indicators, your next task is to identify the methods that will be used to collect them. In Part 2 of the resource, re-read 'Methods for a baseline assessment.' Or, if you are familiar with different collection methods, you may go straight to [Worksheet 2.3](#).



Worksheet 2.3: Baseline methods

With your team, complete the table below, by listing the indicators you plan to collect, the methods you will use for collecting them, and whether you plan to repeat them for the performance and/or outcome evaluations.

Prepare a table like the one below and enter the first two columns using information from Worksheet 2.2b. If needed, refer to 'Methods for a baseline assessment' in Part 2 of the resource.

As a team, identify the methods you will use in the baseline assessment to gather the evidence / indicators you have proposed, and from whom (which target groups). Keep in mind the need to gather disaggregated evidence for different groups/areas in order to assess equity and diversity.

You may use the same method for more than one area of evidence (e.g., a survey or focus group may be used to collect quantitative or qualitative evidence, respectively, in different areas). Keep things simple and manageable, avoid using too many different methods, and choose methods that are feasible given your skills and resources, socially appropriate for the target groups, and that will give you the best accuracy and quality of evidence.

If there is debate around methods to use for any particular set of indicators, you could list the different options and use the ranking and scoring method to identify preferred methods and discuss which of the preferred options are most feasible, appropriate, and provide high-quality evidence. You can find the ranking and scoring method in the [Organising People's Power for Health toolkit](#) (Activity 12, page 37).

Enter the methods in the table. In the final column, indicate whether you will need to collect it again for the performance evaluation to assess progress *in the actions and outputs*, or in the outcomes/impact evaluation to assess what *outcomes were achieved and what contributed to them*. Write 'PERFORMANCE' or 'OUTCOME' or both in the final column. Keep in mind that you may do more than one performance evaluation at periodic time intervals to track progress.

AREA	EVIDENCE TO GATHER IN THE BASELINE ASSESSMENT	WHAT SOURCES?	WHAT METHODS? USED WITH WHAT TARGET GROUPS?	REPEAT IN THE 1. PERFORMANCE 2. OUTCOME EVALUATION?
	In these two columns, enter information you already have from Worksheet 4b			
CONTEXT				
COMMUNITY				
CONDITIONS				
SERVICES				
INSTITUTIONS and STAKEHOLDERS				
LEVEL and QUALITY OF SPH				

Using this table, identify the specific area(s) and target populations for each method as well as who will implement it and prepare the tools and the checklist of resources needed for each method.

You are now ready to plan and implement your baseline assessment. It is a good idea to share your plans and methods with a selection of key stakeholders for their advice or input.



Worksheet 2.4: Reporting baseline findings

With your colleagues, continue to identify what to include in your baseline assessment and the sources of that information, including what to do to ensure quality and equity.

Draw a table like the one below (add more rows as needed).

Identify who will receive the baseline information.

1. As identified via Worksheet 1.1, revisit your list of stakeholders and what they may want to know from the evaluation. Enter the information for these stakeholders and any others that you identified in the course of team discussions, locating them in the primary or secondary group as relevant.
2. As a team, discuss who will receive the results of the baseline assessment. Keep in mind that you don't need to share baseline information with everyone, so it is important to determine why those identified might need the information and why it may be important to engage them early in the process.
3. Think about how and with what evidence you will engage those who may disagree with the work, and how you will ensure privacy and confidentiality of any primary evidence.
4. Record the outcomes of this discussion in the third column of the table.

Once you have an agreed upon list, discuss what forums and what formats you could use to present the findings to each stakeholder or group of stakeholders, keeping in mind what will be accessible, engaging, convincing, and timely. When you have team consensus on this, enter the information in the final column of the table.

KEY STAKEHOLDERS GROUP	WHAT THEY MAY WANT TO KNOW FROM YOUR EVALUATION	DO THEY NEED THE BASELINE INFORMATION? WHAT FOR?	IF YES, HOW SHOULD RESULTS BE PRESENTED TO THEM? (What forum and format)
Primary stakeholders			
Secondary stakeholders			

Keep the target audiences and this format in mind when you write up the results of your baseline survey, as discussed in 'Organising, using, and communicating baseline information' in Part 2.

You should be ready now to conduct your baseline evaluation. If you aren't sure about anything, discuss it with your team members and/or ask others for advice.

This could be a good time to use the [smiley face ranking tool again](#), asking team members to indicate which face emoji best represents how confident they feel moving ahead with the baseline assessment. Discuss what team members are confident about, what concerns they have, and what can be done about the issues that are worrying people.





Worksheet 3.1a: Performance evaluation measures

With your team, and referring to a completed Worksheet 2.3, identify the different measures you will use for your performance evaluation.

The performance evaluation collects information on measures of *progress in implementation of an SPH program* (i.e., context, acceptance of the program, inputs, costs, organisation performance, and outputs). These are summarised in the first column of the table below. You can find more information in Part 3 of the resource.

Prepare a table like the one below.

Identify the measures for the performance evaluation.

1. Revisit Worksheet 2.3 and identify which indicators gathered for the baseline also belong to the different areas of the performance evaluation depending on their role in your theory of change. Enter them in the second column of the table.
2. In the final column, record the indicators for each key area for the performance evaluation. Look at the indicators in the second column and double check that each is still relevant, clear, feasible, and sensitive to change and, if so, add it to the third column.
3. Now check to see if what you have in the third column covers all the information needed (using the descriptions in the first column). If not, add other relevant indicators. *For any new measures, keep checking if you need them asking of they are relevant, feasible, accessible, sensitive to change, valid, and potentially useful for a later evaluation.*
4. If there are debates among team members, you may use the discussion carousel described in the [Toolbox of participative tools](#) (page 15) to explore the pros and cons and reach consensus.

AREA (and what is included)	EVIDENCE FROM THE BASELINE SURVEY	MEASURES FOR THE PERFORMANCE EVALUATION
CONTEXT. Changes in the context, risks, and assumptions as well as unexpected situations that affect the work as it is implemented	Relevant indicators from Worksheet 2.3	
ACCEPTANCE OF THE PROGRAM. Time spent in activities, representation and inclusion, levels of active participation in meetings and decisions, trust and perceptions of the process and its benefit and challenges	Relevant indicators from Worksheet 2.3 on levels of SPH	
INPUTS. Measures of knowledge and capacities of those in key roles; adequacy and quality of the inputs (data, time, funds, personnel, materials); resource distribution and access; clarity of tasks, roles, and plans; perceptions of and satisfaction with program implementation by those involved; and changes in the level/depth of SPH	Relevant indicators from Worksheet 2.3 related to inputs	
COSTS. Costs of interventions, by input and activity, and the timing and way resources are allocated and spent in relation to the budget and time frame	Budget measures from your plans	
ORGANISATIONAL PERFORMANCE.* Institutional commitment and capacity building for and resulting from the program; levels of communication, collaboration, and growth among coalitions; the stakeholders involved and perceived benefit of their involvement; and the sustainability of the processes	Relevant indicators from Worksheet 2.3 related to services, institutions and stakeholders	
OUTPUTS. Tangible products and outputs; milestones or intermediate outcomes* achieved (expected and unexpected) that are important for further implementation of the program	Relevant indicators from Worksheets 2.2b and 2.3 related to outputs	

* Intermediary outcomes may also be repeated as final outcomes in the impact evaluation.

Your next task is to identify the methods and sources to use to collect these measures. If needed, return to Part 3 for the resource to read about different methods.



Worksheet 3.1b: Performance evaluation methods

Building on Worksheet 3.1a, identify the sources/methods to use for the different measures in your performance evaluation and who will implement them.

Prepare a table like the one below. Revisit Worksheet 3.1a and enter the measures from that table in the second column of the table below. Also revisit the methods you chose for the baseline (Worksheet 2.3) as well as those discussed in Part 3 of the resource.

Identify with your team the methods you will use in the performance evaluation to gather proposed evidence and from whom.

1. As with the baseline assessment, you may use the same method for more than one area of evidence, and repeat methods that you used in the baseline assessment where this is relevant. If available, you may use secondary data as a source.
2. For any measure that is repeated from the baseline assessment, please use exactly the same method with the same target groups (keeping different social groups in mind) to collect the information for the performance evaluation. This enables the information gathered to be compared. You may only modify or improve the method if you found significant problems with it during the baseline, and then you need to note what changes you made and what effect they may have on the data.
3. As before, try to keep things simple and avoid using too many different methods. For example, if you used a spider diagram for some measures in the baseline, you may add legs to the spider to accommodate additional performance indicators. If you used a survey and want to add a few more indicators, you may add questions to the survey, and so on.
4. As with Worksheet 2.3, if there are debates about different methods to use, you can use the ranking and scoring method to draw out opposing views and discuss what to choose—thinking about the feasibility, accuracy, and quality of the evidence.
5. Once you are ready, add the agreed upon methods to the 'what methods?' column of the table below.

AREA	MEASURES FOR THE PERFORMANCE EVALUATION (*)	WHAT METHODS? USED WITH WHAT TARGET GROUPS?	IMPLEMENTED WHEN (HOW OFTEN?)
CONTEXT			
ACCEPTANCE OF THE PROGRAM			
INPUTS			
COSTS			
ORGANISATIONAL PERFORMANCE			
OUTPUTS			

(*) Enter here relevant indicators from Worksheet 3.1a

Discuss how often you may need to gather the measures to assess progress—whether once, weekly, quarterly, every six months, etc.—depending on the nature and timeline of as well as the plan for your SPH intervention and the outputs. Enter the details regarding frequency in the final column.

Discuss a plan for how you will implement your methods, who will gather the information, and what resources and materials you will need. This serves as a reality check, allowing you and your team to adjust the measures and methods accordingly, until you all agree that what you have is necessary, relevant, and feasible. Finally, keep in mind how you will record and report any unintended/unplanned effects of your intervention in any of the areas in the table.

You should now have a plan for your performance evaluation and can progress to planning how and to whom you will report your findings.



Worksheet 3.2: Reporting the performance evaluation

With your team, list the different audiences for your performance evaluation findings, as well as how and when you will report your results.

Prepare a table like the one below. Revisit your primary and secondary stakeholder lists (see Worksheets 1.1 and 2.4). Enter the information from these worksheets in the table below. Also add any other primary or secondary stakeholders that have been identified during the course of your evaluation efforts.

Discuss with your team who should receive the results of the performance evaluation.

1. Discuss the possible stakeholders you will report the results of the performance evaluation to. You don't need to share this information with all stakeholders, so keep asking why each group (or individual) stakeholders will need the information. Discuss why it may be important to engage them in a review of progress, including the risks and benefits of sharing the information. If they need only certain information, make note of which information.
1. Record the outcomes of this discussion in the third column of the table below. If you are repeating the performance evaluation several times, indicate when is best to report findings (after all rounds are complete? At the half way mark and again upon completion?). This may depend on formal reporting requirements. Note the timings in the third column.
2. Once you have an agreed upon list, discuss what forums and formats you might use to present the findings to each audience, keeping in mind what will be accessible, engaging, convincing, and timely. Also keep in mind the confidentiality of individuals' information. When you have a consensus, enter the information in the final column of the table below.

KEY STAKE-HOLDERS GROUP	WHAT THEY MAY WANT TO KNOW FROM THE EVALUATION	DO THEY NEED THE PERFORMANCE EVALUATION FINDINGS? WHEN? WHAT FOR?	IF YES, HOW SHOULD THE RESULTS BE PRESENTED AND DISCUSSED?
Primary stakeholders			
Secondary stakeholders			

Keep your target audiences and this format in mind when you write up the results of your performance evaluation, as discussed in Part 3 of the Implementers' Resource.

You should be ready now to conduct your performance evaluation! If you aren't sure about anything as a team, discuss it in the team and/or ask others for advice.

This may also be a good time to use the [smiley face ranking tool](#) again with team members, assessing their confidence and concerns about moving ahead and discussing what to do about the areas that are worrying people.





Worksheet 4.1a: Outcome evaluation measures

Use the worksheet to identify questions for your outcomes/impact evaluation and the measures to use for them.

An outcomes/impact evaluation assesses what changed after an intervention, who benefited, the outcomes and the factors affecting them, and the benefit relative to the resources invested, as shown in Part 4 of the Resource and in the first column of the table below.

Prepare a table like the one below and **identify the measures for the outcome evaluation.**

1. From the list of measures used in your baseline assessment and performance evaluation (Worksheets 2.3 and 3.1b), identify which can be used in the outcomes/impact evaluation. Enter these indicators in the second column of the table below. The final performance evaluation will give you the information you need regarding the indicators of inputs, actions, processes, and outputs, so you do not need to repeat this.
2. In the final column below, identify and write in the indicators for each key area for the outcome evaluation. Look at the indicators in the second column and check if each is still relevant, clear, feasible, and sensitive to change. If so, add it to the third column.
3. Refer to your theory of change to see if the indicators included will help you understand the factors that are expected to lead to the changes the intervention aimed to achieve. If you see gaps in this, add indicators to assess these factors in the final column.
4. Check if the last column includes all of the information needed to evaluate the outcomes of your SPH intervention (see Part 4 of the resource). Where needed, add additional indicators. *Keep checking if your indicators are relevant, feasible, sensitive to change, and valid, and note if there has been sufficient time to achieve them.*
5. If there are debates among team members, use one of the participatory tools suggested in earlier worksheets to help reach consensus.

AREA And the questions to address in the analysis	MEASURES USED IN THE PERFORMANCE EVALUATION	MEASURES FOR THE OUTCOME/ IMPACT EVALUATION
CONTEXT. Changes in the socio-political context; in health, health care, and other services and conditions not related to the intervention; unexpected events. What changes in context are relevant to the SPH intervention?	Relevant indicators from Worksheets 2.3 and 3.1b	
INPUTS, ACTIONS, PROCESSES, AND OUTPUTS. Inputs, actions, performance and outputs in the program. Did the intervention progress as planned? What were the gaps, successes, strengths and weaknesses? What does this imply for the assumptions made.	Relevant indicators from Worksheet 3.1b	Information from the final performance evaluation
PARTICIPANTS AND BENEFICIARIES. Changes in the social features and power of participants and wider beneficiaries; equity and distribution in change, benefit or satisfaction. Who did the program served and what affected this?	Relevant indicators from Worksheets 2.3 and 3.1b	
OUTCOMES. The scale and level of the change/impact in health, health care; in power and participation; within and across different groups and personnel; in institutions and in their relationships with people. What outcomes were achieved (intended and unintended) and how did people perceive them?	Relevant indicators from Worksheets 2.3 and 3.1b	
FACTORS. The factors that led to the outcomes. Which outcomes resulted directly from the SPH intervention?		
COST BENEFIT. Distribution of costs and benefits across program areas, beneficiaries. What was the monetary and non-monetary value of the benefits achieved relative to the costs of the intervention?	Relevant measures from Worksheet 3.1b	

In the next step, you will identify the methods to use to collective evidence on these measures.



Worksheet 4.1b: Outcome evaluation methods

Continuing with the outcomes/impact evaluation measures from Worksheet 4.1a, identify the methods for gathering each and who will implement them.

Prepare a table like the one below and enter information from Worksheet 4.1a in the second column.

As a team, identify the methods you will use to collect evidence.

1. Identify what is available from secondary data sources.
2. Draw on the methods you used for the baseline ([Worksheet 2.3](#)) and the performance evaluation ([Worksheet 3.1b](#)) and the methods you read about in Part 4 of the resource to identify methods that you will use for each of the indicators in the outcomes/impact evaluation.
3. As before, you may use the same method for more than one area of evidence. For any measure that is repeated from the baseline assessment or performance evaluation, please use exactly the *same* method with the *same* target group for the information to be comparable. You may only modify or improve the method if you found significant problems with it and, if so, you need to note what changes you made and what effect they may have on the data.
4. As before, keep things simple and avoid using too many different methods. You may add new indicators to existing methods.
5. Add cross-cutting tools, such as the outcomes star, wheel chart, and/or other tools that help to identify factors (timelines, contribution analysis, causal flow diagrams, etc.).
6. Where you need more advice or support on deciding on a method, agree who to get this from and who will contact that person. Share the feedback at the next team meeting.

Don't rush this process. Start planning for it early in your SPH intervention and discuss the options over several weeks if needed. If debates occur regarding different methods for the same measure, use a participatory tool, such as one of the ones suggested in earlier worksheets, to draw out differing views and reach a decision. Always think about the feasibility, accuracy, and quality of the evidence. Once you are ready, list the agreed methods in the last column of the table.

AREA	MEASURES FOR THE OUTCOMES/IMPACT EVALUATION (*)	WHAT METHODS? USED WITH WHAT TARGET GROUPS?
CONTEXT		
INPUTS, ACTIONS, PROCESSES, AND OUTPUTS	Use measures from the final performance evaluation	List the methods and target groups from the final performance evaluation
PARTICIPANTS AND WIDER BENEFICIARIES		
OUTCOMES		
FACTORS		
COST BENEFIT		

*Enter relevant indicators from Worksheet 4.1a in this column

Discuss a plan for how you will implement your methods, who will gather the information, and what resources and materials you will need. This serves as a reality check on what is feasible, so you may adjust the measures and methods accordingly until you all team members agree that what you have is necessary, relevant, and feasible.

You should now have the plan for your outcomes/impact evaluation and may advance to planning how to analyse the findings against your program goals. If needed, return to Part 4 of the resource for information on this.



Worksheet 4.2: Analysis of outcomes

With your team, use this worksheet to identify the structure for your analysis against your program goals.

In Part 4 of the resource, we outlined various ways of organising and analysing the evidence gathered during your outcomes/impact evaluation. It will be important to have read it before you work on this worksheet. This worksheet poses a series of questions for you to work through as a team to help decide how to organise and analyse the gathered information.

Before you start, look again at the chart you used to develop of your theory of change (see [Worksheet 2.1](#)) for reminders of:

- The intended change(s) to be achieved and for whom, as a result of the SPH intervention(s);
- The pathways and action steps that were expected to lead to the intended changes; and
- The assumptions made in setting this theory of change.

Be sure to take notes as you and your team members answer the questions below. You may use a table like the one below or take notes on a flip chart(s). One way to do this is to write each question at the top of a on a flip chart, using one flip chart per question, as in the market place method described in the [Organising People's Power for Health toolkit](#) (see Activity 29, page 85).

Where you need to obtain further information or talk to others to answer a question, you and your team members should agree on who will do this and when you will meet to finalise the inputs.

QUESTION	RESPONSE
1. How can we use the difference between the findings on the same measures in the baseline and outcome evaluation to show whether each of the intended change(s)/goal(s) were achieved? How do I show what change was/was not achieved and for whom?	
2. How can we use the differences between the findings on the same measures in the baseline and outcomes evaluation to show any changes in the situation, community, or services that may have affected the outcome?	
3. How can we use the evidence gathered in the performance and the outcome evaluation to show which steps in the intervention's pathway to change contributed to the intended changes aspired to, and which may not have contributed?	
4. How can we use findings gathered from all three stages of the evaluation to show what may have enabled or acted as a barrier to the outcomes? How can we show which of these factors were directly linked to the SPH intervention (to show the impact of the intervention)?	
5. How can we use findings to report the monetary and non-monetary cost-benefit of the SPH intervention for different groups/areas?	

This exercise should help you organise the evidence you gathered from all stages of the evaluation in a way that answers the questions that stakeholders may have and that are relevant to your SPH intervention. You should now be ready to advance to your analysis. It is always useful to review the draft analysis as a team and with other advisors and experts, if needed, before you finalise and report on findings, which is the next step.



Worksheet 4.3: Reporting outcomes

With your team, use this worksheet to identify the targets for reporting and the format and key content for each.

Read: 'How do I report on progress?' in Part 4 of the resource and revisit [Worksheet 3.2](#) for the stakeholders and reporting format you identified for the process evaluation. Prepare a table like the one below.

Identify who you want to report your results to and what to include.

1. Review the primary and secondary stakeholders you identified earlier as well as any others that have emerged along the way. Review what you think they may want to know from the evaluation. Use this information to complete the first and second columns in the table below.
2. To fill in the third column, discuss who will receive the outcome/impact evaluation results. You don't need to share all of the gathered information with all groups. Keep asking why each group may need the information and why it may be important to engage with them around the findings. If they need only certain information, note the specific information needed.
3. Once you have those answers, discuss what forums and formats you might use to present the findings to each group, keeping in mind what will be accessible, engaging, convincing, and timely.
4. Keep in mind the confidentiality of individual evidence.
5. When you have a team consensus, complete the final column in the table.

KEY STAKEHOLDERS	WHAT THEY MAY WANT TO KNOW FROM YOUR EVALUATION	DO THEY NEED THE OUTCOME / IMPACT EVALUATION FINDINGS? WHICH? WHAT FOR?	IF YES, HOW & WHERE SHOULD THE RESULTS BE PRESENTED AND DISCUSSED?
Primary stakeholders			
Secondary stakeholders			

Keep the target audiences and this format in mind when you write up the results of your outcome/impact evaluation, as discussed in Part 4 of the resource.

You should be ready now to conduct your outcome/impact evaluation! If you aren't sure about anything, discuss with your team members and/or ask for advice from others. This may also be a good time to use the [smiley face ranking tool](#) again to assess team members' confidence and concerns about moving ahead, including what to do about the areas that are worrying them.



You may also use the opportunity after the evaluation to share reflections on the exercise as a whole. The 'ballots in a hat' method described in the [Organising People's Power for Health toolkit](#) (see Activity 34, page 107) could be one way to identify key questions and prompt team members to reflection on the evaluation experience as a whole.



Making Change Visible

Evaluating Efforts to Advance Social Participation in Health

If you are responsible for—or engaged or interested in—advancing social/community participation in health in your local area, we developed this resource for you.

"This resource is truly a one-stop shop of knowledge and information on how to operationalize SPH evaluation."

Melissa Thomas, Ohio University, USA

"This resource is very easy to use independently or as part of a training."

Roberta Delgado, PIH Health, USA

"The resource is an excellent, valuable, and timely tool to contribute to higher quality SPH projects."

Pia Vracko, National Institute of Public Health, Slovenia

"I wish I'd had access to a document like this decades ago to help me in evaluating some of the work I was involved in then."

Barbara Kaim, EQUINET PAR network, East and Southern Africa