The Changing Role Of The Evaluator In Community-based Health Promotion Evaluation

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Abstract

This paper examines how developments in the theory and practice of health promotion and evaluation have contributed to a changing role for evaluators.

Understandings of health promotion are diverse but this paper focuses on a socio-economic model, incorporating a participatory, settings approach. Evaluation has undergone transformative change from positivist to recognition of constructivism and, recently, concepts of complexity and systems approaches. These developments of health promotion and evaluation have influenced how the evaluator's role is conceptualised and realised in practice. The paper analyses evaluator roles from a 'value free' technician, through to judge, theory provider, mediator and full partner to the program.

The principles and values of community-based health promotion have clear implications for evaluation, including the need to be empowering of all stakeholders, able to cope with multiple strategies and layers of action and the 'messiness' of the community context and how this changes over time. To advance theoretical underpinnings of health promotion as a discipline, evaluation needs to contribute to understanding of concepts such as community empowerment, equity and multi-sector collaboration. Perhaps balancing methodological rigour with a participatory, empowerment approach requires the evaluator to develop new skills as a juggler!

Introduction

This paper investigates and reports on the changing role of the evaluator over time, with particular reference to evaluation of community-based health promotion programs and initiatives. I begin by scoping community-based health promotion and highlighting some of the challenges in conducting evaluation of these types of initiatives. I then outline a brief developmental history of modern evaluation, including more recent concepts, such as developmental evaluation and complexity theory. The meaning of these developments for the evaluator role is then discussed. I conclude with some thoughts about the future of evaluation practice.

Method

This paper arises from work undertaken towards a PhD by publication and draws on a review of Australian and international literature, five papers from my previous research and evaluation, and my experience as an evaluator of community-based health promotion programs over some 18 years. One of the research questions that became of interest was how the role of the evaluator has changed over time.

Community-based health promotion initiatives

While health promotion interventions fall along a continuum from individual, family, community and structural (Baum, 2002; Labonte, 1992), this paper focuses on evaluation of those initiatives that aim to work at community level, and that recognise the impact of the social and environmental determinants of health. Community-based health promotion comprises activities that draw on the principles of primary health care and the Ottawa Charter for Health Promotion (WHO 1986). These guiding principles describe ideal health promotion practice as emphasising empowerment and participation of communities in addressing health issues, using a range of strategies and partnerships,

and concerned with equity (Baum 1998; Keleher, 2007; Tones & Green, 2004.

Health promotion activity can occur in a wide range of settings. A settings approach acknowledges the physical, organisational and social contexts in which people live, work and play, as legitimate objects for research (Poland, Frohlich, & Cargo, 2009). An example of a settings approach is the WHO project 'Healthy Cities'. Originally established in 1987, this was the first health promoting settings initiative and is a long-term development project that seeks to place health on the agenda of cities around the world, and to build a constituency of support for public health at the local level. Typically, such initiatives work across sectors, use multiple strategies and try to work with communities to build engagement and capacity rather than providing services with a top-down approach. That is, lay knowledge is valued and the agenda for priorities, issues and activities is identified by community members rather than health professionals.

Numerous commentators (see, for example, Baum, 2003; Neiman & Hall, 2007; Poland, 1996a) have iterated the importance of conducting evaluations, developing indicators and establishing causative theories for Healthy Cities initiatives. Despite this, there have been very few published evaluations that go beyond assessment of process (de Leeuw & Skovgaard, 2005; Neiman & Hall, 2007; Poland, 1996a). Clearly, there are numerous challenges to evaluating Healthy Cities and similar initiatives and these are discussed in the next section.

Evaluation challenges

Empirical research providing evidence of effectiveness of community-based health promotion initiatives is limited. The lack of rigorous evaluation is linked to the challenges this presents, including i) complexity of the settings approach, ii) using appropriate research methods and iii) attribution and demonstrating causality.

Complexity

Community-based health promotion initiatives are dynamic, complex systems with each setting functioning as an open system in exchange with the wider environment and other settings (Dooris, 2005). They tend to have long-term goals that may change over time, multiple actors and activities, expect outcomes at multiple levels and are active in local contexts that differ from setting to setting (Baum, 2002; Judge & Mackenzie, 2002). Further, many of the social processes underpinning action, such as empowerment and community participation, are poorly theorised or are contested in meaning (Baum 2003; Evans, Hall, Jones, & Neiman, 2007).

Tones and Green (2004) point out that a health promotion setting is culturally constructed, with pre-existing relationships and permeable boundaries. Thus, settings are not discrete, fixed entities but exist as complex systems. The initiative is less amenable to evaluation because it is hard to set parameters and priorities when everything interacts (Green, et al., 2000) and boundaries are unclear (Dooris, 2005). This means evaluation of settings-based health promotion initiatives is not conducive to a simple input-output model of intervention and effect but rather needs to be able to cope with a complex web of interactions (Tones & Green, 2004). As Poland and colleagues (2009) argue, interventions 'wither or thrive based on complex interactions between key personalities, circumstances, and coincidences' p505. Finally, with regard to the complex nature of health promotion interventions, is the need for evaluation at an ecologically whole system level rather than assessing each discrete program or project on its own (Dooris, 2005).

Research methods

Since the 1970s there has been heightened interest in rigorous examination of the effectiveness of medical interventions and evidence-based medicine, with the development of a hierarchy of evidence with the randomised controlled trial at the top. Braveman and colleagues (2011) note that medicine seems to be unique in the primacy given to randomised controlled trials. However, this is problematic for community-based health promotion where randomisation into experimental and control groups, identical except for exposure to the intervention, is unrealistic (Tones & Green, 2004). In general,

setting up control communities and keeping them uncontaminated by the intervention is not practical and, since the initiative is likely to be developmental, it is not possible to predict the exact nature of the intervention or the expected outcomes in advance (Baum, 2002). This means that the notion of the superiority of the randomised controlled trial and other experimental methods has been challenged and a mix of quantitative and qualitative methods to suit the specific evaluation question is proposed by many commentators (see, for example, Baum, 1995; Judge & Bauld, 2001; Nutbeam, 1999).

Another factor hampering research and evaluation efforts is the small resource base for Healthy Cities, and health promotion more generally (Baum, 2003). Further, research grant bodies favour linear, defined approaches to research and evaluation (Israel, Schultz, Parker, & Becker, 1998; Kavanagh, Daly, & Jolley, 2002) so resources and funding for evaluation of these initiatives is limited (Evans, et al., 2007).

Attribution and causality

The complexity of community-based health promotion initiatives and the use of non-experimental methods mean that a linear model of causality cannot be established with any certainty. The long time frame required for achieving outcomes adds to the problems of causality and attribution of effect. According to Judge and Bauld (2001) health promotion programs are rarely designed with evaluation in mind, they lack clear documentation of planning and implementation and often have vague goals. A first task for evaluation is often to articulate with stakeholders the implicit theories and understandings of the program, and identify how the program is expected to contribute to improved outcomes.

Brief history of evaluation

Modern program evaluation began in the 1960s (Chen, 1990). Weiss (1998) marks the 'War on Poverty' in the mid 1960s as the start of large scale government funded evaluation in the United States. In Australia, early attempts at program evaluation began in the field of community education in the 1950s and evaluation practices were adopted in social work and health disciplines in the 1970s (Sharp, 2003). In 1979 the government commissioned the Baume Report, *Through a Glass Darkly*, (Senate Standing Committee on Social Welfare, 1979) which reviewed evaluation in health and social welfare services. This report noted an almost complete absence of formal evaluation in Australian health and welfare services prior to 1973 but was able to list some 43 evaluation reports by mid-1978, mostly by government departments or commissions. The report recommended a definition of evaluation as 'the process of thoroughly and critically reviewing the efficiency, effectiveness and appropriateness of any program or group of programs' (Senate Standing Committee on Social Welfare, 1979 p5) and stated its purpose was to 'provide evidence of the outcome of programs so planners can make wise decisions about those programs in the future' p6. Thus, the focus was on accountability and decision-making rather than program improvement or theory-building. Since then, evaluation theory and practice has continued to develop as outlined in Table 1.

Table 1: Timeline of major evaluation developments

Approximate date	Evaluation type	Theoretical perspective and focus of evaluation
1930	Descriptive	Positivist; extent of goal attainment, technical measures
1967	Judgement	Positivist; development of program goals, extent of goal attainment, technical measures
1989	Fourth generation	Constructivist; dialectic and responsive

1980s	Theory-driven	Shift of focus from methods to theory, pluralist methods, sequential chain of events
1990s	Proceed-Precede Program logic models	Focus on links between planning and evaluation, sequential
1997	Realistic	Realism; what works for whom and in what circumstances
2000	Developmental	Accepts turbulence and adapts to realities of complex, non-linear dynamics

The timeline illustrates a shift from methods-based judgement to theory-based interpretive approaches. Recent concepts of complexity theory and developmental evaluation (Patton 2011) point to the importance of context, the need for evaluation to respond to programs as complex adaptive systems and the dynamic interactions that drive change.

Role of the evaluator

As different approaches have come to be used in evaluation research, so the role of the evaluator has changed over time to reflect the definition or purpose of the evaluation. Drawing on a range of evaluation literature and my own experience, I summarise eight different evaluator roles along a continuum (see Table 2).

Table 2 Evaluator roles

Descriptor	**Role**
Technical measurer	seen as a value and content-free role, the only requirement is competence in measuring the extent of achievement of pre-determined outcomes
Describer	seen as value-free, the evaluator describes the initiative and the apparent outcomes arising
Judge	judge of worth where 'evaluation entails making informed judgements about a program's worth, ultimately to promote social change for the betterment of society' (Grembowski, 2001 p13) or a judge against a standard or standards where 'Intrinsic to evaluation is a set of standards that (explicitly or implicitly) define what a good program or policy looks like and what it accomplishes' (Weiss, 1998 p320). This judgement role assumes an objective, value-free evaluator who bases their judgement on specialist knowledge or agreed standards.
Hypothesis tester	testing the hypotheses upon which the program is based (Green & Kreuter, 1999). An agreed set of testable hypotheses and an objective evaluator are assumed.
Negotiator	creating a consensus of reality and values among all the stakeholders. In this approach, evaluation is 'a process whereby evaluators and stakeholders jointly and collaboratively create (or move towards) a consensual valuing construction of some evaluand' (Guba & Lincoln, 1989 p263). In this role, the values and characteristics of the evaluator

	become more explicit and may or may not carry greater weight than that of other stakeholders.
Theory provider	filling the gaps in the theory of action, that is describing what must happen to get to the next stage of the program (Patton, 2002). In this role the evaluator draws on their own values and expertise, but may also enlist other stakeholders, and recognises the diversity of values and interests.
Mediator	source of information to stakeholders, a negotiator and consensus generator, bringing professional expertise to mediate between different stakeholder interests (Chen, 2005). In this role the evaluator is an active member of the program team, addressing issues of power differentials and relative stakes.
Partner	embedded within the program and a partner to the evaluation user or program personnel (Patton, 2011). This role requires the evaluator to bring evaluation thinking to the program stakeholder group while supporting the values and vision of the program.

Moving along the continuum changes the evaluator role from that of a content and value-free measurement approach to a more collaborative exercise to identify and build consensus about underlying program theory and to work in partnership with the program stakeholders. As we move down the continuum, the evaluator needs more content knowledge and understanding of the program and stakeholders' values and perspectives. Of course, for a particular evaluation, any of the above roles may be appropriate. Further, these roles are not mutually exclusive, and may overlap, so that a mix of roles is likely.

Community-based health promotion and the evaluator role

Health promotion principles outlined above lead to the premise that the way evaluation is carried out is critical to its appropriateness and validity. In writing about evaluation of Healthy Cities and similar programs Poland (1996a) argues that evaluation should be integrated into the program, value and use multiple methods, focus on process and outcomes, and provide timely feedback. In community-based health promotion evaluation the complexity of the setting, with many stakeholders and power differentials, suggests that the negotiator/mediator role, working in partnership, is likely to be most effective in uncovering multiple perspectives and in reflecting health promotion principles of empowerment and participation. My role has tended towards the latter end of the continuum as my experience and confidence as an evaluator has developed, and congruent with developments in evaluation theory and practice. In reviewing the literature and my evaluation experience a number of factors are identified that influence how the evaluator role is played out.

Power differences

With the move to theory-driven evaluation has come increasing recognition of the need to engage with stakeholders who have different values and interests. This raises the issue of the comparative power of the evaluator. For example, Chen (1990) argues that, to increase objectivity, the evaluator should use their own expertise and knowledge to develop evaluation questions because stakeholders may miss causal processes and have vested interests. Moreover, Grembowski (2001) suggests that the evaluator should cross-check that there is a good fit between program theory, objectives and evaluation questions before proceeding to the next stage. Thus, this approach acknowledges the position of the evaluator as an 'expert' and privileges this role over other stakeholders, if only to ensure that the evaluation moves forward. The evaluator is privileged by holding resources, status and a leader or facilitator role (Gregory, 2000) and by controlling what information is to be obtained and its interpretation (Laughlin & Broadbent, 1996). Indeed as the only person with access to sufficient

data to form a well-rounded view of the situation, the evaluator is assured a position of superiority (Gregory, 2000).

With respect to power differences between stakeholder groups Gregory (2000) points to the risk that those with more powerful voices will be disproportionally heard compared to other community members unless the evaluator is highly skilled in facilitation and takes an ethical stance to engage those with less power. Again this elevates the power of the evaluator, and relies on those with least power being willing, and enabled, to participate. Pawson and Tilley (1997) are particularly scathing of the role of evaluator as negotiator. They maintain that this fails to appreciate the asymmetry of power between different stakeholder groups. Abma (2005), in discussing the role of fourth generation evaluation in health promotion, notes that the requirement for the evaluator to relinquish control and tolerate ambiguity is presented as unproblematic but actually needs particular skills in interpersonal communication and negotiation.

My experience demonstrates some practical ways to reduce power differences between the evaluator and stakeholders. In a meta-analysis of community health project evaluations (Jolley et al. 2007) the services contributing reports were invited onto the review team to assist with designing the analysis tool and reviewing reports. Training was provided to all reviewers and evaluation workshops conducted for the services' staff. In this way what might have been seen as somewhat threatening was made a more collaborative learning exercise, echoing Brown's (1995) concept of the evaluator as an educator and co-learner rather than judge and expert.

Participation

As a mediator or partner, one role for the evaluator is to promote stakeholder participation and increase capacity (Goodstadt et al. 2001). Participatory research is defined as a collective project of researchers and people affected to produce knowledge (Poland 1996b). The evaluator brings expertise but aims to transfer this to the community affected by the issue so they can use the findings and develop their own agenda (Potvin and Richard 2001). Other benefits are that participants come to experience and recognise the complexity of the issues, clarify goals and develop realistic expectations of the evaluation. However, using a participatory approach is likely to make the process longer and more labour-intensive and this may conflict with funding body expectations (Brown 1995; Poland 1996b). Participatory approaches risk loss of (perceived) credibility (Brown 1995), however Potvin and Richard (2001) argue that wide participation is critical to building the validly of findings.

The issue of social heterogenesis is raised by Gregory (2000) in her critique of participation in fourth generation evaluation and a further issue concerns the selection of participants from potentially hundreds of stakeholders – who to engage with and who has priority? (Fishman, 1992). While Guba and Lincoln (1989) attempt to deal with this by suggesting that the evaluators should make every effort to engage with and take into account all stakeholder groups, the resource implications leads them to introduce the notion of 'relative stake' that can be determined by negotiation (Gregory, 2000). However, Laughlin and Broadbent (1996) argue that giving the evaluator the final say in deciding who has the capacity to participate and their relative stakes goes against the philosophical position of this approach.

My experience in evaluation of an action research workforce development project (Jolley 2008) illustrates the benefits and challenges in acting as a mediator. In this role, I was external to the project but closely aligned. This gave the participating organisations an opportunity to make their perspectives heard outside of the project structure. While organisations were committed to engagement in evaluation of their own progress there was much less participation in the evaluation of the broader aspects of the project and this limited opportunities for more generative findings.

Resource and structural factors

Participatory and responsive evaluation comes with an inability to design the evaluation in advance and this makes it difficult to tender for commissioned evaluations and estimate the dollar resources and time required (Guba and Lincoln 1989). Unpredictable interactions and feedback loops, and

changes in response to stakeholder input, means the evaluation needs to be flexible in design and timelines.

The evaluation role played will be both constrained and mediated by the circumstances of the evaluator's engagement and organisational position. Evaluators can be engaged: as an internal evaluator (personnel and resources from the organisation or project); as a contracted consultant (usually for-profit); from a government agency; through an academic /research consultancy (may be for-profit or funded through a grant). My position is as an academic researcher within an organisational unit of a university. Thus, my evaluation role is usually undertaken as a consultant acting within an agreed contract and budget from the program management. I have found that evaluation contractors and managers of health promotion programs are usually sympathetic to the concept of evaluation grounded in the health promotion principles and approaches I have described. However, contracts are bounded by time and resource constraints and the practical outcome of this is that priorities have to be set and decisions made according to what is realistic. Thus, evaluation design is a balance between the ideal and the pragmatic with the focus generally decided according to the purpose and resources of the evaluation.

Grant-funded research is rare in health promotion evaluation but the design is less constrained by a specific program and its resources. This increases opportunities for theory development but also removes the evaluator from direct involvement with the program so care needs to be taken to ensure relevance to the health promotion practice community. For these studies, my co-researchers and I have placed emphasis on engaging with stakeholders to increase the relevance and usefulness of findings.

Discussion and conclusion

As health promotion theory and practice evolved over time, so too has evaluation. Evaluation has moved from a 'black box' approach, to a theory-based approach that attempts to unpack the intermediate steps and the mediators between inputs and outcomes. Instead of being focussed on choosing a method to demonstrate causation (with all the difficulty that brings in a community setting), the evaluator's task is to uncover the theory or program logic that underpins the steps within a program and then find appropriate ways to test the theory.

Community-based health promotion initiatives are often viewed as complex interventions in complex settings. As such, they are challenging to evaluate and need new ways of thinking. Ideally, evaluators need skills in using multiple methods and approaches, and in negotiation with multiple players. They need to understand health promotion's value-base and be prepared to share power with differing groups of stakeholders to ensure that all voices are heard. Complexity theory tells us that evaluators need to be open to uncertainty, dynamic interactions and changing contexts. In a complex setting, the evaluator role is to monitor emerging actions, decisions and contexts, facilitate reflexive practice and provide rapid feedback so that the initiative can be responsive and adaptive (Patton 2011). Evaluators may also need to 'educate' funders and other stakeholders about what an evaluation can and cannot do within the given resources and timeframe (Brown 1995). Patton (2011) proposes that evaluators act in the 'middle ground' bringing together expert-derived evidence with local knowledge in order to make sense of program processes and impacts. This developmental evaluation approach is synergistic with community-based health promotion.

In conclusion, evaluators are recognising the dynamic interactions and networks at play in community-based interventions and are beginning to search for empowering evaluation approaches that satisfy the different interests of evaluation commissioners, health promotion practitioners and community members. Perhaps balancing methodological rigour with a participatory, empowerment approach requires the evaluator to develop new skills as a juggler!

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