

Designing a Program to Demonstrate Impact

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Learning Objectives

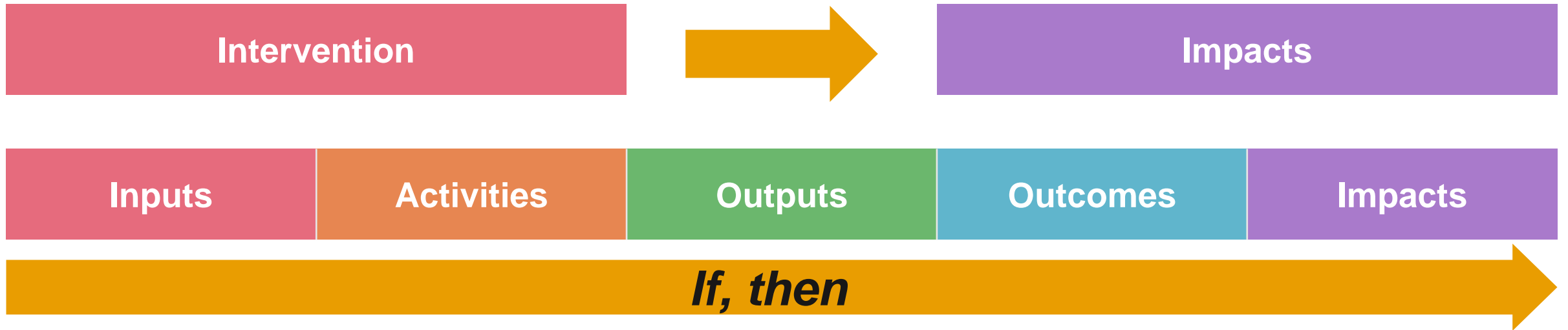
This webinar will include content on the following objectives:

- A. Describe the flow and causal relationships across the logic model.
- B. Define outputs, outcomes, and impact.
- C. Describe methods (quantitative, qualitative, and mixed) for measuring outputs, outcomes, and impact.
- D. Apply the concepts in a case
- E. Identify the ways in which capacity built for demonstrating evidence can be a resource for the organization itself.

A. Describe the flow and causal relationships across the logic model.

The flow of a logic model

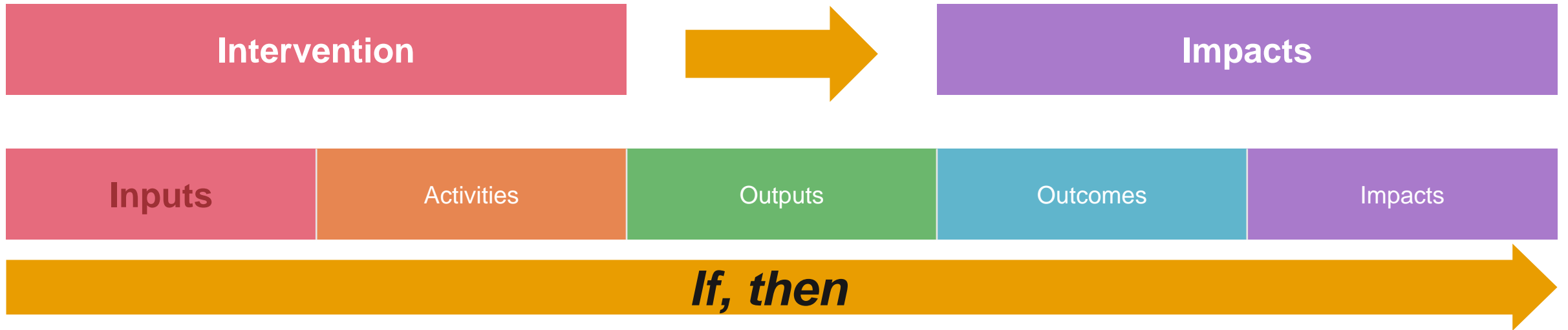
In webinar 1, we introduced the causal relationship between inputs, activities, outputs, outcomes, and impacts. The logic model below was presented in that webinar.



Program planning must assess the relationships among each of the elements.

The flow of a logic model

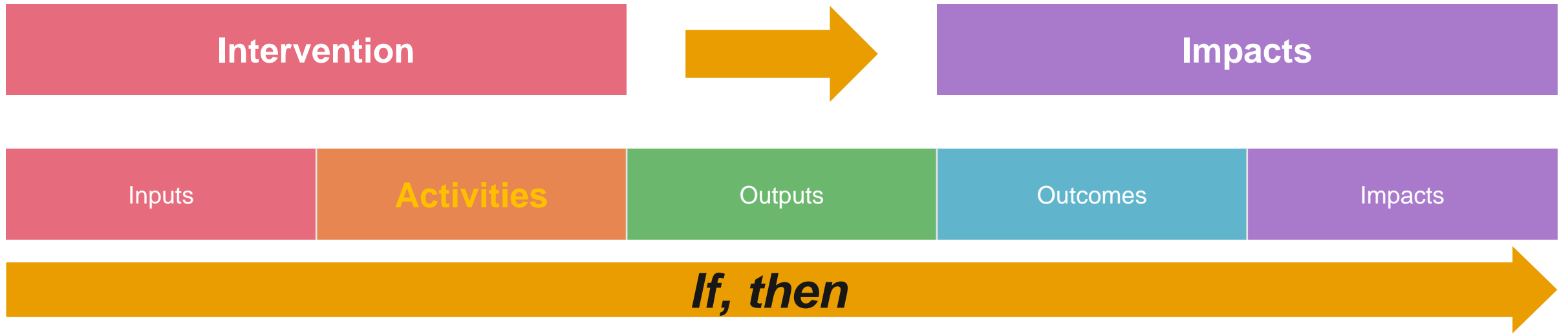
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What inputs (personnel, programmatic capacity, finances) are available?

The flow of a logic model

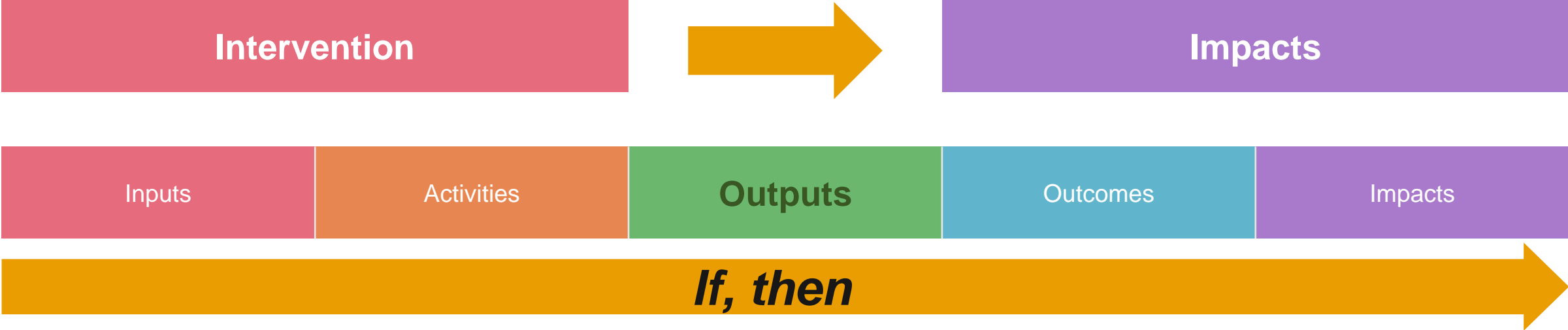
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Are your proposed activities feasible in light of those inputs?

The flow of a logic model

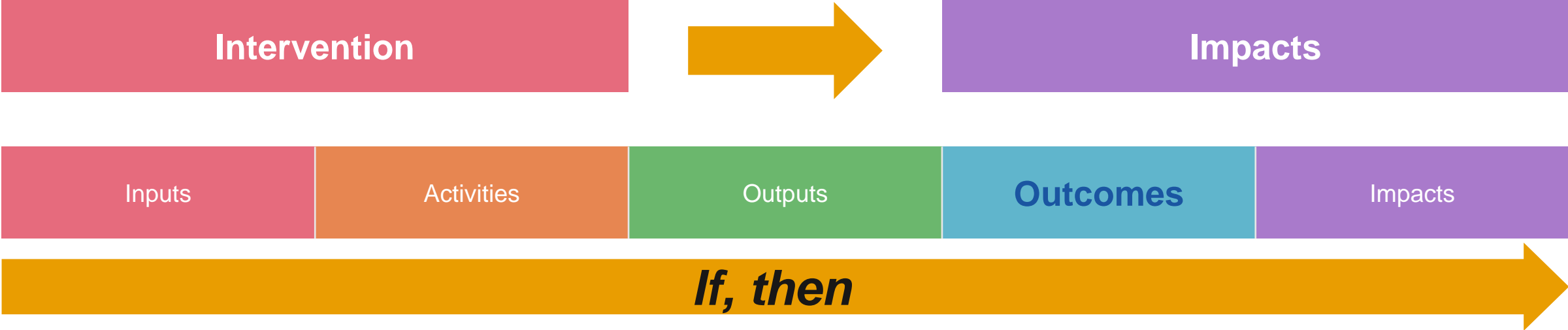
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Do the outputs generated through those activities reflect your organization’s priorities? Your funder’s?

The flow of a logic model

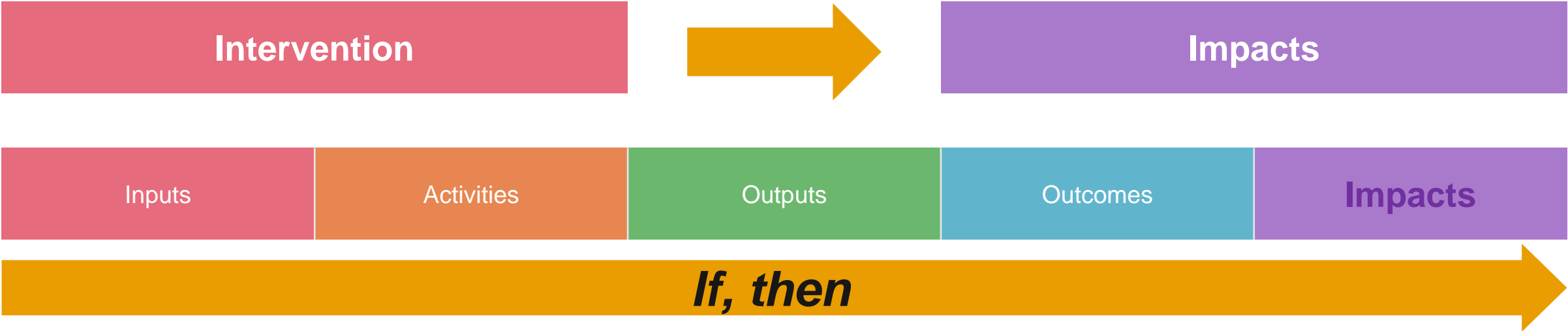
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What short or medium-term outcomes are achieved through the outputs?

The flow of a logic model

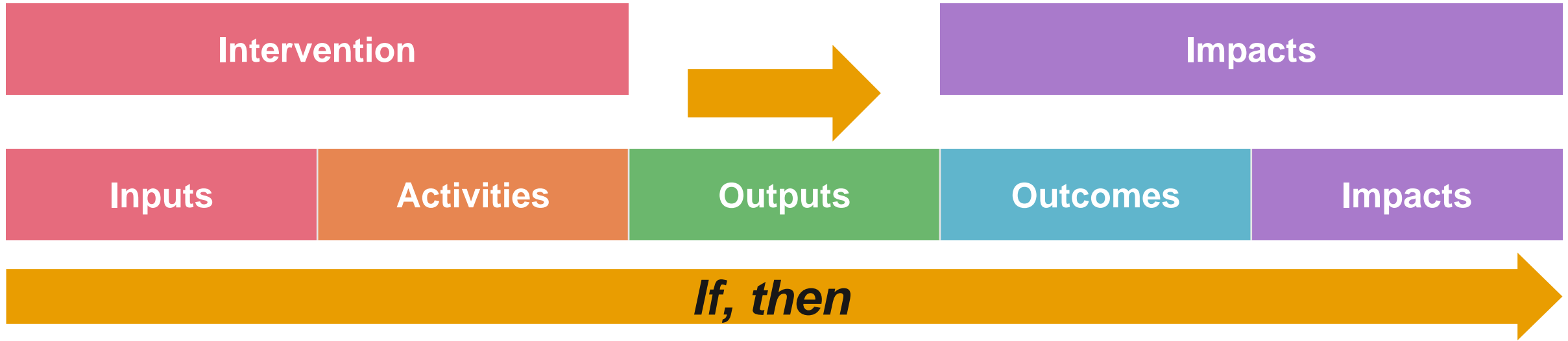
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What are the long-term impacts?

A. Define outputs, outcomes, and impact

The flow of a logic model



- Outputs are the direct effects of activities.
- Outcomes are the changes brought about by the outputs. They are often at individual, local levels.
- Impacts represent systemic changes.

Programs sometimes “over-promise” the effects of their activities, promising impacts when they can only feasibly manage outcomes, at best.

C. Describe methods (quantitative, qualitative, and mixed) for measuring outputs, outcomes, and impact.

Outcome Evaluation

Outcomes can be measured using both quantitative and qualitative assessments.

EXAMPLE:

Your organization receives to equip the staff and organizational partners to work more effectively with people living with HIV.

Your objective: Increase staff knowledge and skills, and ensure staff present respectful and courteous attitudes toward people living with HIV.

A quantitative evaluation may measure change in knowledge and skills; a qualitative evaluation may measure change in attitude or perceptions. Sometimes, we use both—a mixed methods approach—to understand what the program has produced.

Outcome are significant but they are not sufficient to lead to systemic change.

The project may change important elements of your organization but it doesn't ensure that people living with HIV receive high-quality service free of negative attitudes and stigma.

Impact Evaluation

Impact can be measured with mixed-method approaches across various factors. This is essential for generating knowledge of the inter-relationship across factors.

EXAMPLE CONTINUED

In the previous example, your organization changed providers' and partners' knowledge, skills, and attitudes (outcome outputs). Your funder wants to know if these changes improve services for all people living with HIV by lowering barriers into care, increasing retention in care, and improving adherence to ARTs.

Evaluating whether these activities are sufficient to achieve such outputs requires an impact evaluation. To assess these kinds of outputs, we also have to evaluate other factors and will need to carry out activities to address those factors. This is expensive and complex. We might need to carry out activities to build trust among people living with HIV, address stigma in communities (in places of worship, in the broader community), address structural barriers related to access (distance, transport, cost), and assess whether people living with HIV are keeping their medical appointments and taking their ART regimens correctly, consistently, and in a timely manner. Outcome evaluations require a baseline assessment because they are measuring systemic change.

As you can imagine, this second scenario is much more comprehensive, much more complex, and much more costly. Your organization may want to advocate to the funder that such outputs are likely beyond the scope of what your were funded to do.

Quantitative, Qualitative, and Mixed-Methods

Quantitative—Analysis of concrete (e.g, numerical) data—health services, expenditures, unit cost.

Quantitative analysis includes clearly define indicators (the elements of the data to be measured) and metrics (the units by which this measurement will occur).

The objective of a quantitative evaluation is to calculate the data. The results are verifiable (another evaluator should be able to reach the same outcomes with the same set of data). The soundness of the evaluation depends on soundness of the data and accuracy of the calculation.

Quantitative methods are often used to determine either variability or generalizability across contexts, populations, etc. when assessing the function of the same activity. (CD4 rates, viral suppression, retention in care, annual ART cost).

Quantitative, Qualitative, and Mixed-Methods

Qualitative—Analysis of a complex phenomenon that cannot be examined through concrete data.

For example, a qualitative evaluation helps us understand perceptions, beliefs, attitudes, and motivations.

The objective is to describe complexity with depth, not necessarily seeking to determine variability or generalizability.

Qualitative methods help us understand the effects of intangible elements on our activities and they provide insight into distinctiveness and innovation.

Quantitative, Qualitative, and Mixed-Methods

Mixed-methods evaluations

As the name implies, mixed-methods evaluations employ both quantitative and qualitative approaches. Mixed-methods approaches:

- are more comprehensive
- support cross-validation (unless the findings contradict), providing stronger evidence of inter-relationships among factors (keep in mind the relationship may be correlative, not causative).
- offer stronger evidence to make conclusions, over time. Conclusions start as hypotheses which have to be tested through targeted evaluation.

How is data generated?

- Quantitative: Surveys. Chart records. Fiscal review or audit.
- Qualitative: focus group discussion, key informant interviews, observation. Analysis of participant responses (usually in the form of a transcript to identify themes)

What kinds of methods work best for these activities?

- A secondary analysis of existing health service data on numbers of people living with HIV receiving ART by health facility.
- Convening volunteers who belong to key population groups, asking them to describe their perceptions of faith-based organizations, the relationship between stigma and religion, and the role of religion in their own lives.
- A comparative case study of a large faith-based facility offering inpatient and outpatient HIV services and psychosocial support and a large governmental facility in the same district offering the same services.
- Frameworks for Dialogue workshops.
- Changes in knowledge and attitudes through contextual Bible study.
- The religious leaders advocacy campaign for HIV testing

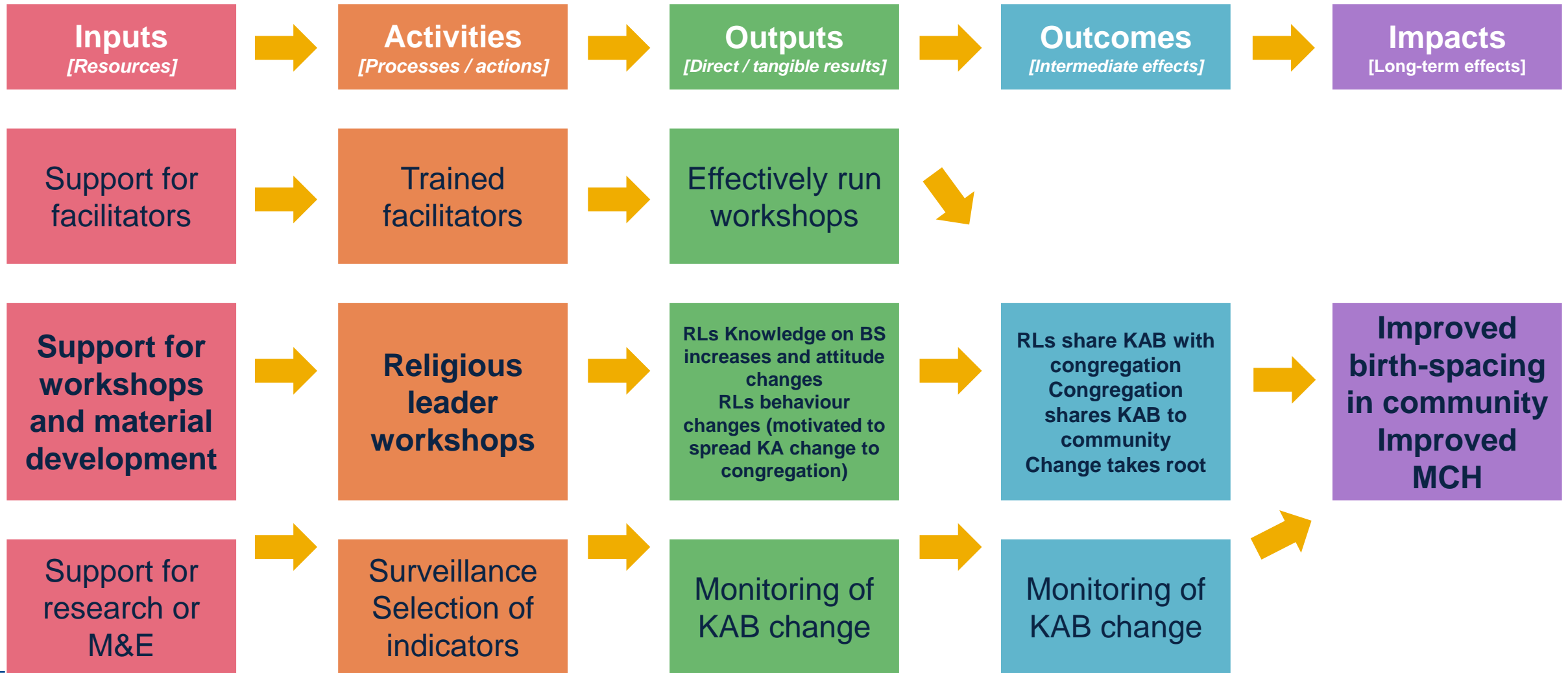
Do any of these allow us to evaluate outcomes? Do any of these allow us to evaluate impact?

D. Applying these concepts in real-world scenarios

Mini case (from webinar 1)

- There is a problem in rural settings, with women having too many children too closely together, which impacts poorly on **maternal and child health**
- You have an idea that if you work with **religious leaders** – who are very influential in their local communities – you can spread healthy messages about **birth-spacing** from religious leaders, to their congregations, to their broader communities, and improve this situation.
- You decide to **train local facilitators**, and **run workshops** with religious leaders, which utilises specific religious texts (theology), and public health messages about birth-spacing.
- You will **count** the number of people that attend the workshops, and get them to answer a brief questionnaire, about whether they have been **influenced** by the workshop, and whether they **plan to spread the messages** in their local congregations

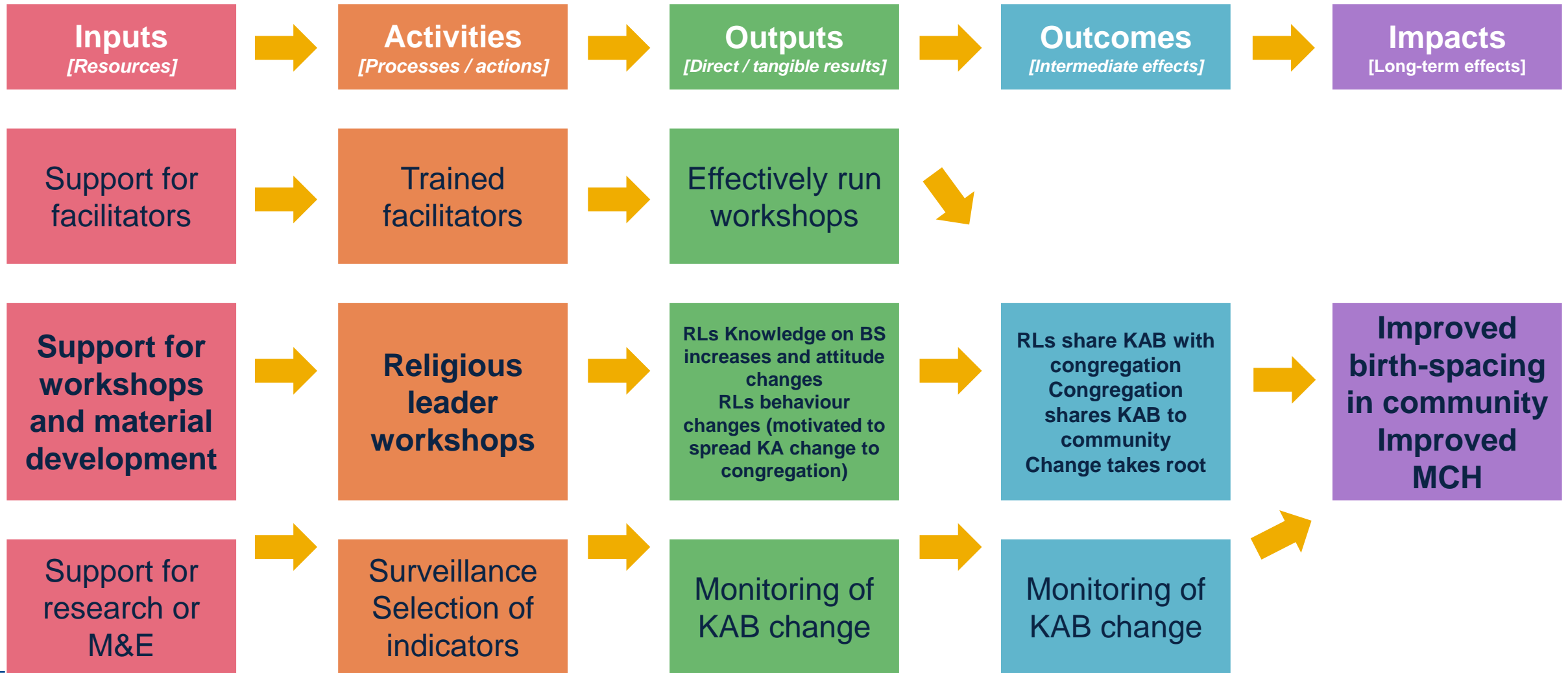
Logic Model



Real-world: Designing programs to demonstrate impact

- “**impact**” is understood and measured differently in different disciplines and by different funders
- Make sure your programme and team are clear on the difference between “impact” and “effect”
- **When you design your program, you need to be thinking about how you will show effect and impact – it is NOT something you add on at the end by bringing in an evaluator**
- **In this case**
 - there are multiple opportunities to demonstrate “effect”
 - but multiple challenges for demonstrating “impact” (e.g. population scale birth-spacing)

What could you demonstrate? How would you measure it?



Real-world scenarios

When doing program design – make sure you have considered the *pragmatics* of evaluation

- Different types of measurement have different purposes ... different usefulness ... different costs ... different timing
- *Can* the items on the logic model be measured? (and how)
- How much will it cost to do so? (have you budgeted for it)
- *When* will it need to be done? (does that timing suit the end-game or the implementation?)

When doing program design – make sure you have considered the *politics* of evaluation

- Measurement for whose sake?
- Does this measurement meets the needs of the intervention and/ stakeholders?
- (Do you need expertise during the program design phase to design the evaluation, or speak truth to power for you)

Where do you have the (sustainable) capacity to do this measurement?

E. Ways in which capacity built for demonstrating evidence can be a resource for the organization itself

Why would you put scarce resources/energy into demonstrating impact?

- Most often, this happens at the end, when seeking further funding
- Or when the funder requires it
- There are also lots of calls for it on the macro scale (e.g. to make the case for FBOs on a global scale)
- **It very rarely happens as it is supposed to – to support program implementation, to make it work better (more effectively, with better impact, to achieve more)**
- **Increasing demand to get back to this – to have measurement that accompanies the intervention**
- E.g. process/implementation evaluation approaches
- E.g. Theory of Change Approaches
- E.g. Embedded Research/Evaluation Approaches
- **These all have benefits and challenges**

Building capacity for measurement within the intervention

- The measurement approaches that **accompany** have an added value – they also **build capacity** for within the intervention or organisation
- Measurement capacity does mean that staff should be able to run randomised control trials (RCTs)
- It means the implementation staff have a clear understanding of the program logic, and how the counting supports that logic
- E.g. we don't just count participants 'for the funder' but because it tells us something important about what we are doing
- Note, even when there are internal M&E staff/capacity – they can sometimes be separated from the implementation by organisational systems
- There are also multiple 'light' measurement approaches that – when done well – can effectively show impact (participatory, reflective, community-based monitoring etc)

Announcements

We invite you to join us for webinars 3 and 4. Generating Evidence on the Distinctives of Faith-Based Organizations in the HIV Response

These webinars will occur in a series with webinar 3 focused on faith-based health facilities and webinar 4 focused on faith-based community organizations or local faith communities. The webinars provide an overview of the literature on the distinctive characteristics of FBOs that can affect HIV services. Participants will learn how to identify and employ distinctive religious health assets to address HIV. Topics include: 1) distinctive FBO resources including trust, longevity/sustainability in communities apart from funding, access to supplemental funding, and access to volunteers; 2) distinctive FBO challenges including religion as a driver of stigma (and how FBOs can address this), and tensions between religious priorities and health priorities. In addition, the webinar will address ways to build the evidence for these distinctives and strategies for FBOs communicating those distinctives to different audiences.

Please invite your colleagues within your organization or colleagues from other organizations to join us. The webinars are free of charge. Registration is required.

The webinars are being recorded so anyone can access content after it is completed.

Registration and recorded webinars can be found at: <http://ihpemory.org/webinars/>