Introduction to Evaluation

Training Module produced for the NSMC by Word of Mouth Research Ltd

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Total Process Planning

Managing the complexity
A set of core stages within which key tasks can be effectively organised
Key features to look for to determine if something is consistent with social marketing

Customer orientation

Behavioural focus

Theory informed

“Insight”

“Exchange”

“Competition”

Segmentation

Methods mix

incorporating Intervention Mix or Marketing Mix

Customer Triangle

incorporating the 8 criteria
3: World Class Commissioning
World Class Commissioning competencies for PCTs

Lead the NHS locally
Work collaboratively with community partners
Engage with the public and patients
Collaborate with clinicians
Manage knowledge & assess current & future needs
Identify & prioritise investment requirements & opportunities
Influence provision to meet demand & secure outcomes
Drive continuous improvement in quality & outcomes through innovation
Deploy procurement skills for contracting
Manage the local health system
Make sound financial investments
# Plan for the day

<table>
<thead>
<tr>
<th>TIME</th>
<th>SESSION</th>
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<tbody>
<tr>
<td>9.30-10am</td>
<td>Welcome, Introduction and warm up exercise</td>
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<tr>
<td>10-11 am</td>
<td><em>Overview of Evaluation: Presentation and discussion</em></td>
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<tr>
<td>11-11.15</td>
<td><strong>Coffee break</strong></td>
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<tr>
<td>11.15-12.10</td>
<td><strong>Group exercise 1</strong></td>
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<td>12.10-1.00</td>
<td><em>Evaluation Methods – Presentation</em></td>
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<td>1.00-1.45</td>
<td><strong>Lunch</strong></td>
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<td>1.45-2.15</td>
<td><em>Sampling, Theory, Models and Logical Frameworks –presentation</em></td>
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<tr>
<td>2.15-3.00</td>
<td><strong>Group Exercise 2- Logical Frameworks</strong></td>
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<td>3.00-3.15</td>
<td><strong>Tea</strong></td>
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<td>3.15-3.35</td>
<td>Feedback on Group Exercise 2 and discussion</td>
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<td>3.35-4.15</td>
<td><em>Commissioning Research and other sources of research guidance</em></td>
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<tr>
<td>4.15-4.45</td>
<td>Discussion and questions</td>
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<td>4.45</td>
<td><strong>Close</strong></td>
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Today

- Look at some of challenges of evaluating/monitoring social programmes
- Understand the value of Process, Outcome/Impact evaluation
- Identify the range of Indicators used by evaluators
- Demystify some of the terminology of evaluation
- Understand the problems of attributing change to your intervention – effect sizes
- Look at the common methods and when to use them
- Understand sampling and sample size issues
- The utility of theory and logic models
- You probably won’t finish today in a position to design and deliver your own evaluation;
  - But you will have a better idea of the pros and cons of various approaches and what you will need to commission from research providers.
• Warm up exercise
Ice breaker

Consider three BBC programmes: Strictly Come Dancing, Panorama, and a newly piloted cookery show, “Prince of Hearts.” With cuts in the pipeline, the budget for one of these series is to be cut by 50-100%.

Make recommendations about which issues should be covered in the evaluation you must commission.

Key facts
“Strictly” can get ratings of around 11.5 million viewers – and sometimes beats ITV’s own flagship shows. The show won the award of Most Popular Talent Show at the 2008 National Television Awards, beating Britain’s Got Talent, Dancing on Ice and The X Factor.

Panorama covers current affairs, and highlights issues such as swine flu, Britain’s dirty beaches and banking corruption.
The programme launched in 1953, has recently [2002-07] run four programmes on Seroxat, the first eliciting 65,000 calls to the BBC Helpline.

The new cookery cooking show [it’s fictitious] did extremely well in its pilot. A handsome new chef, one of Jamie Oliver’s original “15” apprentices, shows the nation how to cope with families’ different needs, including films with real viewers with diabetes, heart disease and food intolerances.
Overview of Evaluation: Presentation and discussion
Why Evaluate

1. Checking how well your intervention is going – is it on track
2. Seeing whether the intervention is making a difference
3. Identifying its strengths and weaknesses
4. Generating ideas/insight into peoples behaviour and how to improve the intervention
5. Supporting advocacy for the continuation or extension of the project
6. Being accountable to funders and stakeholders.
7. INSIGHT into what works and why
The ‘Insight’ agenda

‘Putting the customer at the heart of decision making’

“The best preparation for governing is listening to the British people” Gordon Brown PM

‘Improving public services’

‘Planning on the basis of insight rather than presumed need’

‘Responding to behavioural change challenges’

“Customer Centred Services”

“Ethnography”

“Customer Journey Mapping”

“Deliberative Methods”

“Customer Satisfaction Metrics”
The “Insight” agenda

“A deep truth about the citizen based on their behaviour, experience, beliefs, needs or desires, that is relevant to the task or issue and rings bells with targeted people”

Sir David Varney’s Review of Service Transformation 2006
The “Insight” agenda

“A deep truth about the citizen based on their behaviour, experience, beliefs, needs or desires, that is relevant to the task or issue and rings bells with targeted people”

Sir David Varney’s Review of Service Transformation 2006

“We need to exploit customer insight as a strategic asset”
Do we exploit insight as a strategic asset?
The ‘competition’ exploits insight as a strategic asset?

For example the competition to a *healthy eating* campaign are those that market *unhealthy food*
The “Stacker Quad” Burger
A new Burger King Product

“We’re satisfying the serious meat lovers by leaving off the salad and letting them decide exactly how much they can handle”

Denny Marie Post
Chief Concept Officer
Burger King

“We listened to consumers who said they wanted to eat fresh fruit – but apparently they lied.”

Wendy’s Spokesperson

“A typical buyer isn’t driving in there with a BMW and an expense account. They’ve got a couple of bucks in their pocket and their big objective is to get full”

“Anti fast-food backlash”

“Healthy eating is more a state of intention than it is of action”

Burger King

Research and Insight – plenty of it!

• Industry monitoring
• Social climate monitoring
• Consumer research
• Family shopping behaviour

4 burgers + 4 slices of cheese + 4 slices of bacon – NO SALAD = 70% of your daily calorie intake
Targeting the poor and disadvantaged

• Health promotion and Social Marketing has a challenging task in reaching and changing behaviour among the poor and disadvantaged. We call them ‘hard to reach’, ‘out of touch’ and other terms that demonstrate our lack of engagement.

• Meanwhile, the tobacco industry and junk food industry targets and engages with these same groups very effectively – selling them unhealthy products they don’t need.

• Even the local takeaway is providing integrated services in disadvantaged areas ....
One Stop Shop - all your needs after the club closes

Newcastle
2007
How much do we spend on insight and evaluation?

- Central Office of Information spend 2008/9
  - £33 million
- The commercial market research industry
  - £1.8 billion in 2008/9
Evidence and effectiveness

Cost pressures, coupled with the inability to present conclusive evidence of effectiveness, are conspiring to make health promotion/prevention/social marketing interventions a soft option for budget cuts....
Hierarchy of experimental research evidence

1. Systematic reviews and meta analysis
2. Well –designed randomised controlled trials (RCT)
3. Well designed controlled trials without randomisation
4. Before and After studies
5. Small case studies
6. Opinions of respected authorities
Typical Randomised Controlled Trial design

People are randomly assigned to a test group or a control group.

- **Test Group**
  - Receives a dose of the intervention.
  - Test sample interviewed before intervention.
  - Test sample interviewed again after the intervention.

- **Control Group**
  - Does not receive a dose of the intervention.
  - Control sample interviewed before intervention.
  - Control sample interviewed again before intervention.

Results from test and control groups are compared and any effects can be reliably attributed to the intervention.
• “The Randomised Controlled Trial (RCT) is problematic and typically inappropriate for evaluating health promotion programmes....”

  • Tones K. in ‘Evaluating Health Promotion’

  .....This also applied to social marketing interventions
## Clinical Trials

- Testing a relatively quick cure for specific illness.
- Larger effects achieved quickly.
- Easier to gain agreement from health professionals and individuals to conduct trial.
- Participants are usually seeking a cure/remedy.
- External validity i.e. how generalizable the findings are to the wider population. In clinical trials results are only valid for the groups tested. When applied outside test group can cause problems e.g. SEROXAT.

## Social Marketing Trials

- Prevent ill health in the future (sometimes 40 years in the future).
- Smaller effects achieved over a longer period.
- Approval for trial can be more difficult to secure. There are more players involved and there are ethical issues when the need for social intervention is urgent e.g. HIV campaigns.
- Participants currently well and may not perceive themselves as needing help - recruitment more difficult.
- Participants more likely to be younger, higher social class and more likely to believe in and adopt a healthier lifestyle than non participants - External validity can be compromised. Also testing under unusual conditions may not be reproducible in the real world.
Clinical Trials

• Clinical trials usually have a simpler biological basis (drugs, surgery, physio) and are easier to control

• Unit of randomisation – individual

• Internal validity (a measure of the extent to which the findings are real and not the result of bias). With RCTs this is not a problem. Control group placebo possible. Double blind possible

• Exposure of control group to intervention more easily controlled

Social Marketing Trials

• Social Marketing is generally multi-faceted, complex interventions which diffuse into the population to achieve behavioural change at the individual or societal level. There is a lot of extraneous “noise” to control

• Unit of randomisation, individual, community or nation. Individual randomisation can be difficult

• Difficult to devise a placebo for a community development intervention. Impossible to blind people to the fact they have received a HP intervention

• High risk that the control group (e.g. neighbouring community) is exposed to intervention
• RCTs have a place in the evaluation of Social Marketing, where possible to ‘randomise’ and to ‘control’

• But in many instances, where dealing with complex social systems, RCTs are of very limited value, and therefore other approaches to evidence are necessary.
Medical vs Social Interventions

• Social Marketing and Health Promotion tend to have more complex causal chains than clinical intervention

• Many go beyond individual behavioural change to tackle the Social Determinants of Health.
Medical vs Social Interventions

Evaluation of social interventions can never compete with the rigour that can be successfully applied to medical interventions.

The evidence will always favour the investment in medical rather than social programmes.
Prevention

The need for effective prevention strategies is clear.

The costs of not preventing ill health are considerable.

Just look at the figures …..
<table>
<thead>
<tr>
<th>Behaviour/Illness</th>
<th>Alcohol misuse</th>
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<td>Health Impacts</td>
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# Costs to Society of Preventable Illness

## 2003/2004

### Table 11.2 Comparison of societal health and cost impacts

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<td>18,500</td>
<td>130,000</td>
<td>10,000</td>
<td>17,700</td>
<td>3,100</td>
<td>179,300</td>
</tr>
<tr>
<td>Years of life lost</td>
<td>365,000</td>
<td>307,000</td>
<td>70,050</td>
<td>203,600</td>
<td>11,490</td>
<td>957,140</td>
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<tr>
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<td>£3.2b</td>
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<td>£16.1b</td>
<td>£16.8b</td>
<td>£7.4b</td>
<td>£8.8b</td>
<td>£34.4b</td>
<td>£83.5b</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>£45.6b</td>
<td>£31.5b</td>
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Where is the evidence?
The evidence iceberg

Evidence derived from published research & evaluation

Evidence & learning held in the experience of practitioners & planners who are actively involved in on-going implementation & development of work & related practice in their relevant areas

Can lead to unnecessary duplication of effort:
  e.g.: 140 research studies into 8-19 year olds 2002/4 (undertaken by 15 Govt Depts, through the COI) most of these not published
We know it’s a good thing but is it being implemented well?
We know it’s a good thing but is it being implemented well?

• The importance of early years for tackling health inequalities cannot be underestimated.

• The independently produced National Evaluation of Sure Start shows clear benefits for children and their families living in Sure Start areas.

• Rapid change is not always possible in tackling such issues. Head Start in the USA, reveals that these type of interventions often take time to bed in and do not usually have immediate, measurable, beneficial effects.
Some interim findings

- In 2006 the national evaluation of Sure Start reported that many projects were failing to engage with these most disadvantaged families.

- In 2006 the National Audit Office found fewer than a third of Sure Start children's centres were reaching out to the neediest families they were intended to target, with most failing to identify the most disadvantaged families in their area and offer them support.

- "Most Sure Start local programmes failed to develop a sustained and strategic approach to working with ethnic minorities." Good practice existed in some projects but it tended to be isolated examples and this experience was not widely shared throughout the programme.

  Gary Craig, professor of social justice at the University of Hull.
• In response, the then children’s minister Beverley Hughes announced that every Sure Start children’s centre would be required to run a home visiting and outreach programme for parents of all new babies and evaluate the service they provide to the most disadvantaged groups.
Evaluation and Effectiveness
The evidence iceberg

Evidence derived from published research & evaluation

Evidence & learning held in the experience of practitioners & planners who are actively involved in on-going implementation & development of work & related practice in their relevant areas

Can lead to unnecessary duplication of effort:

- e.g.: 140 research studies into 8-19 year olds 2002/4 (undertaken by 15 Govt Depts, through the COI)
- most of these not published
What do the Government use as evidence?

- A broader conception of evidence is used by government than by academics, & that a wide range of methods for gathering & appraising evidence for government is required.

- Influences on government other than evidence including
  - experience,
  - expertise
  - judgement of policy officials and Ministers
  - values and ideology
  - available resources
  - habits and tradition
  - lobbyists, and pressure groups
  - media
  - the pragmatics and contingencies of everyday political life.

"Is Evidence based Government possible" – P. Davies, Cabinet Office 2004
Evaluating Social Marketing.
The Research projects that will help

- **Process evaluation**
- Analysis of unpaid Media coverage
- Stakeholder views
- Helpline data
- Media Buying Audit
- **Qualitative research**
  with the Target audiences, the Key “Segments”
- **Quantitative evaluation**
  of progress towards objectives.
  Surveys of Awareness, Knowledge, Attitudes, Beliefs, Intentions
  BEHAVIOUR
- Service user data, customer satisfaction surveys
- **OTHER DATA SOURCES**
  (stuff that is already there and collected by someone else)
  - Clinical data
    e.g. HIV prevalence data, Immunisation uptake
  - Sales data
  - Market research data
  - Other Government/national surveys

- ROI analysis

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Indicators

- **Epidemiological indicators?**
  - Mortality and morbidity time lag between input and output too long (decades)

- **Behaviour – reducing risk factors e.g.**
  - Smoking behaviour
  - Immunisation uptake
  - Condom use with casual partners

- **Intermediate indicators** (believed to be precursors to behaviour change)
  - Awareness (of your Initiative and the Competition)
  - Knowledge
  - Beliefs
  - Attitudes
  - Skills acquisitions/empowerment

- **Other Indirect indicators** (may be viewed as process or outcome indicators)
  - Quality of materials used
  - Affect on policy decisions / the law
  - Affect on opinion formers and health workers
  - Analysis of media coverage of the programme
  - Change in the social climate – e.g. a campaign to reduce stigma against people with HIV
  - Sales data- Condom sales, cigarette sales, healthy food sales
  - Service use
  - Clinical Data - tests performed and conditions detected
Reviewing the evidence

• NSMC Commissioned 3 Reviews of Effectiveness of Social Marketing:
  » Nutrition
  » Physical activity
  » Alcohol, Tobacco and Substance misuse

• Studies reviewed met certain methodological standards

• Studies needed to demonstrate that they had tried to address the 6 SM criteria
  – Behaviour change, Consumer insight, Segmentation, Marketing mix, Exchange, Competition

• Searching 8 electronic databases resulted in 88 studies selected for inclusion - most of these non-UK based
Behaviour Change – Set realistic objectives
Realistic Expectations

A review of campaigns was conducted by the National Centre For Social Marketing in 2006. It found….

• In some campaigns the level of change in knowledge, attitude and behaviour was not clearly articulated or not articulated at all

• For those that did set clear targets for change, a number set unrealistic behaviour change targets.

• In many cases the evaluation put in place was insufficient to accurately measure the predicted change. Sample sizes too small, methodology lacking rigour

Realistic Expectations

What is a realistic behaviour change to expect from your intervention?
Realistic Expectations

• A recent narrative review of reviews by Snyder et al which included US, European and developing world interventions used meta analytic methods to estimate the average effect sizes for media campaigns.

• The effects reported were the changes in behaviour from pre intervention to post intervention for specific behaviours:
## Effect Sizes

<table>
<thead>
<tr>
<th>Campaign</th>
<th>Effect Size</th>
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<tbody>
<tr>
<td>Seatbelt campaigns</td>
<td>15%</td>
</tr>
<tr>
<td>Dental care</td>
<td>13%</td>
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<tr>
<td>Adult alcohol reduction</td>
<td>11%</td>
</tr>
<tr>
<td>Family planning</td>
<td>6%</td>
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<tr>
<td>Youth smoking prevention</td>
<td>6%</td>
</tr>
<tr>
<td>Heart disease reduction</td>
<td>6%</td>
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<tr>
<td>(which include nutrition and physical activity)</td>
<td>5%</td>
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<tr>
<td>Sexual risk taking</td>
<td>4%</td>
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<tr>
<td>Mammography screening</td>
<td>4%</td>
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<tr>
<td>Adult smoking prevention</td>
<td>4%</td>
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<tr>
<td>Youth alcohol prevention and cessation</td>
<td>4-7%</td>
</tr>
<tr>
<td>Tobacco prevention</td>
<td>4%</td>
</tr>
<tr>
<td>Youth drug and marijuana campaigns</td>
<td>4%</td>
</tr>
<tr>
<td>had the least affect</td>
<td>1-2%</td>
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</table>

Snyder LB Health communication campaigns and their impact on behavior.  
Health Campaigns/Community Interventions

- Across all these studies Snyder found that targeted behaviors increased above baseline by an average of about 5%

- Many of the studies reviewed in meta-analyses cannot provide evidence on whether these levels of behaviour change can be sustained beyond the immediate post intervention as the research studies did not include long term follow up measures.
Logic Model for Treating Tobacco Addiction in Adults

Inputs
- Coalition members
- Time
- Funding

Activities
- Establish baseline information about worksite cessation resources, policies, and benefits
- Identify receptive worksites and build relationships
- Assist worksites to improve insurance coverage for cessation and strengthen worksite policies
- Inform employees about benefits and facilitate access to existing resources

Reach
- Worksite managers/ owners
- Union representatives
- Worksite employees
- Worksite employees
- Health care consumers**
- Community members
- Media

Outcomes - Impact

Short
- Increased number of worksite managers/ owners who:
  - understand potential cost savings and productivity gains from employee (and family members) cessation
  - understand how worksite policies support quit attempts*

Medium
- Increased # of worksites with plan to improve worksite resources, policies and benefits
- Increased knowledge of existing cessation resources, policies, and benefits

Long
- Increased number of adults who successfully quit using tobacco
- Increased number of patients, employees and other community members receiving evidence-based treatment for nicotine addiction
- Reduced tobacco-related morbidity and mortality
- Reduced tobacco-related health disparities
- Increased # quit attempts
- Increased use of cessation resources

*Voluntary smoke free worksite policies
**Includes medically uninsured and underinsured
*** Examples: Feedback/recognition to providers, placing a nicotine treatment pharmaceutical on formulary

UW-Extension-Cooperative Extension, Local evaluation project. DRAFT, Fall 2003
## Plan for the day

<table>
<thead>
<tr>
<th>TIME</th>
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<td>Discussion and questions</td>
</tr>
<tr>
<td>4.45</td>
<td>Close</td>
</tr>
</tbody>
</table>
Coffee Break
15 minutes
Group Exercise 1

30 minutes and 10 minutes feedback from each group (total minutes = 50)
Evaluation Methods
Evaluation research draws from two basic forms of information/data

• **Quantitative**
  - Seeks to measure – normally large numbers of respondents
  - How many? How often?
  - Consistent structure, pre-defined questionnaire
  - Methods: sample surveys, census, databases

• **Qualitative**
  - Seeks to understand – normally fairly small numbers of respondents
  - How? Why?
  - Flexible, response oriented discussion guide
  - Methods: focus groups, deliberative, observation etc
Evaluating Social Marketing.
The Research projects that will help

**Social marketing Intervention**

- **Process evaluation**
- **Qualitative research** with the Target audiences, the Key “Segments”
- **Analysis of unpaid Media coverage**
- **Stakeholder views**
- **Helpline data**
- **Media Buying Audit**
- **Quantitative evaluation** of progress towards objectives. Surveys of Awareness, Knowledge, Attitudes, Beliefs, Intentions BEHAVIOUR
- **Service user data, customer satisfaction surveys**
- **OTHER DATA SOURCES** (stuff that is already there and collected by someone else)
  - Clinical data
    - e.g. HIV prevalence data, Immunisation uptake
  - Sales data
  - Market research data
  - Other Government/national surveys

**Internet**
- street
- In home
- telephone
- Postal

**Customer Relationship Marketing (CRM)**

**ROI analysis**
Quantitative evaluation

• Surveys of the target group/wider population - sample size to measure the change

• KABP’s (knowledge, attitudes, beliefs and practice) – and other lifestyle indicators – if possible replicate existing measures

• Regular Monitoring (every month? 6 months? 2 years?) OR larger less frequent studies

• Quality rather than quantity of data points (could use existing surveys – depending on the scale of the intervention)

• Representative samples vs random samples
Quantitative Outcome data

E.g.

• How many used the service – was this a significant increase.

• The number who went for test

• Behaviour Change

• Other societal indicators e.g. Crime rate goes down in the area. Unemployment goes down, Reports of domestic violence goes down.

• Sales data - e.g condom sales increase. Fruit and veg sales increase

• Noticed behavioural change in others (e.g. a person with mental health problems perceives less stigma from other people)
If an evaluator concentrates on outcomes only:-

“it’s rather like a critic who reviews a production on the basis of the script and the applause meter readings, having missed the performance”

Hamilton and Parlett “Beyond the numbers game”
Process evaluation

• Process evaluation provides a description of all aspects of the implementation of a health promotion intervention

• Understanding of *how* and *why* an intervention has achieved or failed to achieve its objectives is the central concern of process evaluation

• Qualitative methods (focus groups, in depth interviews) and Quantitative methods (surveys, collecting cost data and sales, media analysis)
Key Components of process evaluation

• **Context**
  – The wider social, cultural, political and economic environment in which the intervention is embedded

• **Reach**
  – Awareness and uptake of the intervention outputs by the target population

• **Dose delivered**
  – the amount of intervention provided by the intervention team

• **Dose received**
  – the extent of engagement with the intervention shown by the target population

• **Fidelity**
  – the extent to which the intervention was delivered as planned
Process evaluation

• **Media Analysis**
  – Media coverage, column inches, quality of coverage, campaign mentions

• **Helpline analysis**
  – Number and quality of calls

• **Stakeholder Analysis**
  – The views of people delivering work on the ground
    • health workers, local services
Process evaluation

• Service Data
  
  – Who is using the service, what they think of it, would they recommend it to others

  – Did you over-stimulate demand?
1987 UK AIDS campaign

Key campaign message:

"Anyone can get it, gay or straight, male or female. Already 30,000 people are infected."
Watch for unintended consequences/effects

Example

• PROBLEM
  – Parents turning up late to pick up their kids from school.

• SOLUTION
  – School decides to fine the parents for every quarter of an hour over time

• School hoped the financial penalty would improve punctuality.

• It did in some cases but in others it got worse
  – These parents didn’t see it as a penalty – they redefined it:
Watch for unintended consequences/effects

Example

- PROBLEM
  - Parents turning up late to pick up their kids from school.

- SOLUTION
  - School decides to fine the parents for every quarter of an hour over time

- School hoped the financial penalty would improve punctuality.

- It did in some cases but in others it got worse
  - These parents didn’t see it as a penalty – they redefined it:

  “they were paying for a service - worth every penny”.

© Word of Mouth Research Ltd
Sources of Evaluation Data
Evaluation Data
There may be existing data you can use – to set targets and baseline

When starting to design an evaluation, consider conducting an “insight audit”

- Find out what already exists
  - Within your organisation
  - Within stakeholder organisations
  - Within regional or national bodies
  - Within academic institutions
Primary and secondary data

• Primary data
  – Collected for the purpose of your evaluation
  – e.g. surveys, focus groups that you commission

• Secondary data (desk research) and other indicators
  – Collected for other purposes/ by other public bodies and commercial organisations but available to contribute to your investigations
  – e.g. published information on the internet, or obtained from partners such as local authorities, NHS Information Centre, etc
Sources of Quantitative Data

- Randomised controlled trials
- Controlled trials
- Longitudinal studies – panel surveys
- Before and after studies
- Surveys and Customer panels
- Management information (e.g. databases, complaints analysis, enquiry statistics, website traffic, etc)
- Public & customer surveys (telephone, postal, web, face-to-face)
- Questionnaire based consultation (public, patients, community groups, stakeholders, experts)
- Helpline data
- Sales data
Sources of Qualitative Data

- Qualitative interviews with staff, customers, public etc
  - Focus groups, mini groups, friendship groups, paired interviews, one-to-one interviews, etc
  - Ethnography
- Customer journey mapping
- Accompanied shopping
- Mystery shopping (can also be quantitative)
- Immersion (spending time with target group)
- Open response based consultation (public, patients, community groups, stakeholders, experts)
- Deliberation and co-creation
- Process/formative evaluations
- Usability testing
Main sources of insight: Secondary/desk research

- Using all of the aforementioned sources, captured through........
- Management info (e.g. databases, website traffic)
- Literature reviews
- Systematic reviews of effectiveness
- Existing social surveys
- Existing Evaluation of SM intervention
- Existing service performance indicators
- Written correspondence (e.g. committee reports)
- Media coverage (informal review)
- Media analysis (formal analytical process)
THE SOURCES OF EVALUATION RESEARCH and their different characteristics

See “Sources of Insight” Document in the training pack
Research ethics

• If people are chosen for the research because they are patients (past & present) ethics committee approval likely to be needed

• National Research Ethics Service
  http://www.nres.npsa.nhs.uk/

• SHA will know about committees in your area
• These factors may have massive implications
  – Legal, resources, timescales
**Differentiating audit, service evaluation and research**

<table>
<thead>
<tr>
<th>Research</th>
<th>Clinical audit</th>
<th>Service evaluation</th>
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<tbody>
<tr>
<td>The attempt to derive generalisable new knowledge, including studies that aim to generate hypotheses, as well as studies that aim to test them.</td>
<td>Designed and conducted to produce information to inform delivery of best care.</td>
<td>Designed and conducted solely to define or judge current care.</td>
</tr>
<tr>
<td>Quantitative research – designed to test a hypothesis. Qualitative research – identifies/explores themes following established methodology.</td>
<td>Designed to answer the question: &quot;Does this service reach a predetermined standard?&quot;</td>
<td>Designed to answer the question: &quot;What standard does this service achieve?&quot;</td>
</tr>
<tr>
<td>Addresses clearly defined questions, aims and objectives.</td>
<td>Measures against a standard.</td>
<td>Measures current service without reference to a standard.</td>
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<td>Quantitative research – may involve evaluating or comparing interventions, particularly new ones. Qualitative research – usually involves studying how interventions and relationships are experienced.</td>
<td>Involves an intervention in use ONLY (the choice of treatment is that of the clinician and patient according to guidance, professional standards and/or patient preference).</td>
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<td>Usually involves collecting data that are additional to those for routine care, but may include data collected routinely. May involve treatments, samples or investigations additional to routine care.</td>
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<td>Quantitative research – study design may involve allocating patients to intervention groups. Qualitative research uses a clearly defined sampling framework underpinned by conceptual or theoretical justifications. May involve randomisation.</td>
<td>No allocation to intervention groups: the healthcare professional and patient have chosen intervention before clinical audit. No randomisation.</td>
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**ALTHOUGH ANY OF THESE THREE MAY RAISE ETHICAL ISSUES, UNDER CURRENT GUIDANCE:**

| RESEARCH REQUIRES REC REVIEW | AUDIT DOES NOT REQUIRE REC REVIEW | SERVICE EVALUATION DOES NOT REQUIRE REC REVIEW |
Triangulation
Triangulation (1)

- Also known as "cross examination".

- Using two or more methods to check results

- To support the findings from your primary data source – or not

- Can add credibility to the results - offers the prospect of enhanced confidence.
Triangulation (2)

- Quantitative Research (your survey and other surveys)
- Qualitative research
- Helpline data
- Sales data
- Service Use data
- Media analysis

• Build up the evidence picture
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13-13.45 Lunch
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13.45-14.15 Sampling, Theory, Models and Logical Frameworks
Sampling and Sample Size

Sampling

- Random Sampling

- Quota Sampling or “Convenience” sampling

Sample Size

- How many people should I interview?
Sampling

Random Sampling

People randomly select from a sampling frame e.g
- Post Code Address File
- Electoral Register
- Patient register / database
- Telephone – Random Digit Dialling
- Workplace staff list

Then, if the respondent is not available when you try to contact first time you try to contact them another 3 times to achieve an interview.

- Most reliable, most robust form of sampling – gives you the most accurate assessment of a populations attitudes and behaviour – Good for estimating Prevalence of attitudes and behaviours in your area.
  - but
- Usually the most expensive cost per interview as respondents can distributed widely across your area making them more expensive to reach
- Stratifying the sample can help
Sampling

Quota or “Convenience Sampling”

With Quota sampling Interviewer judgement is used to select respondents to meet a certain quota with pre-defined characteristics.

E.g. we need a 50 men aged 25-35 with social grade C2DE and we need 100 women aged 35 -35 social grade C2DE.

Depending on the type of survey and the client requirements the interview can select respondents by:

- Approaching people in the street,
- using a telephone database,
- recruit via the internet,
- knocking on doors until they reach their quota

When the quota for a given demographic group is filled, the researcher will stop recruiting subjects from that particular group
Sampling

Quota or “Convenience Sampling”

Quota sampling is useful when time is limited, the sampling frame is not available, and research budget is very tight.

BUT

The selection of the sample is non random and can be unreliable. Interviewers may be tempted to only approach people they think are most helpful or people who happen to be nearby. These judgements can introduce significant biases into the sample.

Interviewers need to be trained and given the right kind of incentives to minimise these biases.

Random Location Sampling – is a quota sampling method that minimises interviewer selection bias.
How many people should we interview

• About 50% of people in my PCT eat 5 a day.
• I want to increase this by 5% in a year to 55%.
• How many people do I need to interview a baseline and how many people do I need to interview in a year to detect a statistically significant 5% change on this measure?
Sample size

Some account of sampling error can be taken by calculating a confidence interval for an estimate, which is an interval within which it is fairly certain the true population figure lies. The following table gives approximate 95% confidence intervals for percentages based on a particular sample size (the width of the interval depends on the value of the estimated percentage and the sample size on which the percentage was based). For example, an estimated percentage of 25% based on a sample of 1,000 has a 95% confidence interval of +/-2.7% (i.e. 22.3% - 27.7%).

<table>
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<td>70%</td>
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<td>75%</td>
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</table>
THEORIES and MODELS and Logical frameworks
Theory and Models (1)

• Social marketing operates to a large degree on the social-psychological elements of behavioural models

• The essential factor in most social-psychological models is attitudes, which tend to be conceived as the product of a deliberative calculation weighing an individual’s beliefs about behaviour with the value they attach to those characteristics
Theory and Models (2)

Good models include more than just attitudes and behaviour

• Intentions

• Norms

• Contextual factors beyond an individual’s control including access to services, levels of deprivation, and other environmental indicators - seldom taken into account in evaluations

• Habits and emotion - less common but important factors
Theory and Models (3)

Theory of Planned Behaviour (Ajzen)

- Attitudes Toward Improvement (perceived favorability of outcomes)
- Perceived Social Pressures for Improvement (expectations by important others)
- Perceived Behavioral Control (beliefs about improvement capability)

Intentions to Improve ± Improvement

NOTE: ● indicates that intentions and control beliefs interact
NORMS

Children (8-13) significantly overestimate the proportion of their classmates who smoke.

An intervention aimed at children must address these false norms.

- and an evaluation should measure them
Theory and Models (5)

Sheeran (2006) looked at 200 studies

- Attitudes, norms and self efficacy had a causal impact on people intentions and behaviours

- Social cognitive-behavioural theory and learning theory gave the best returns
Theory and Models (6)

• Models can be an “outcomes roadmap”

• Logic models - logical framework for the intervention
Logic Model for Treating Tobacco Addiction in Adults

**Inputs**
- Coalition members
- Time
- Funding

**Activities**
- Establish baseline information about worksite cessation resources, policies, and benefits
- Identify receptive worksites and build relationships
- Assist worksites to improve insurance coverage for cessation and strengthen worksite policies
- Inform employees about benefits and facilitate access to existing resources
- Promote existing cessation resources in worksites and in the community
- Establish baseline information regarding to what extent health care providers use recommendations from the Clinical Practice Guideline
- Identify clinical partners and build relationships among opinion leaders
- Promote Clinical Practice Guideline: Treating Tobacco

**Reach**
- Worksite managers/owners
- Union representatives
- Worksite employees
- Worksite employees
- Health care consumers**
- Community members
- Media

**Outcomes - Impact**

**Short**
- Increased number of worksite managers/owners who:
  - understand potential cost savings and productivity gains from employee (and family member) cessation
  - understand how worksite policies support quitting attempts*

**Medium**
- Increased # of worksites that implemented or improved worksite resources, policies, and benefits
- Increased # of worksites with plan to improve worksite resources, policies, and benefits
- Increased knowledge of existing cessation resources, policies, and benefits

**Long**
- Increased number of adults who successfully quit using tobacco
- Increased use of cessation resources
- Increased # of quit attempts
- Reduce tobacco-related morbidity and mortality
- Reduce tobacco-related health disparities
- Increased number of patients, employees and other community members receiving evidence-based treatment for nicotine addiction
- Increased number of health facilities or systems with a plan to implement
- Increased number of administrators and providers who:
  - understand benefits of Clinical Practice Guideline to consumers, health plans, health care systems
  - know how to implement the Clinical Practice Guideline, including recommended policy changes
  - are committed to "champion" the effective treatment of nicotine dependence

---

*Voluntary smoke free worksite policies
**Includes medically uninsured and underinsured
*** Examples: Feedback/recognition to providers, placing a nicotine treatment pharmaceutical on formulary
Outcomes - Impact

**Short**
- Increased number of worksite managers/owners who:
  - understand potential cost savings and productivity gains from employee (and family member) cessation
  - understand how worksite policies support quit attempts*
- Increased # of worksites with plan to improve worksite resources, policies* and/or benefits
- Increased knowledge of existing cessation resources, policies, and benefits
- Increased number of administrators and providers who:
  - understand benefits of Clinical Practice Guideline to consumers, health plans, health care systems
  - know how to implement the Clinical Practice Guideline, including recommended policy changes
  - are committed to "champion" the effective treatment of nicotine dependence
- Increased number of health facilities or systems with a plan to implement

**Medium**
- Increased # worksites that implemented or improved worksite resources, policies and/or benefits
- Increased use of cessation resources
- Increased # quit attempts
- Increased number of patients, employees and other community members receiving evidence-based treatment for nicotine addiction
- Increased # facilities implement the Clinical Practice Guideline

**Long**
- Increased number of adults who successfully quit using tobacco
- Reduce tobacco-related morbidity and mortality
- Reduce tobacco-related health disparities

* indicates additional benefits and impacts.
Developing indicators – Using Logic Models

• Multiple indicators are needed for tracking the implementation and effects of a program

• However, defining too many indicators can detract from the evaluation's goals

• The logic model can be used as a template to define a spectrum of indicators leading from program activities to expected effects

• One of the virtues of a logic model is its ability to summarise the program's overall mechanism of change by linking processes (e.g. lobby for a change in legislation on smoking in pubs), to eventual effects (e.g. reduced smoking prevalence).

Developing indicators – Using Logic Models/logical Frameworks

• For each step in the model, qualitative/quantitative indicators could be developed to suit the concept in question, the information available, and the planned data uses.

• Relating indicators to the logic model allows the detection of small intermediary changes in performance faster than if a single outcome were the only measure used.
Developing indicators – Using Logic Models/Logical Frameworks

Basing decisions on systematic evidence based judgments instead of unfounded assumptions.
Define and refine

• Define a causal pathway - use theory to help map this out

• If the intervention managed to move 10% of smokers from “never considered” quitting to “contemplating” quitting making a first attempt, what proportion do you think will make the first attempt?

• E.g if we encourage 20% of smokers who are “contemplating quitting” to actually trying to quit what proportion will remain quit after 4 weeks. What would prevent relapse? Is there something in place? Is it working?

• If you encourage their partner to quit at the same time what % who attempted to quit would remain quit after 4 weeks?

• How would the provision of free help and assistance improve rates?

• What extra impact would opening the stop smoking service at a more convenient time have on the quit rate?

• Use the evaluation to refine your intervention and next time redesign and recalculate the estimates on the causal pathway
Evaluating Social Marketing.
The Research projects that will help

Process evaluation
Analysis of unpaid Media coverage
Stakeholder views
Helpline data
Media Buying Audit

Qualitative research
with the Target audiences, the Key “Segments”

Quantitative evaluation
of progress towards objectives. Surveys of Awareness, Knowledge, Attitudes, Beliefs, Intentions BEHAVIOUR

Service user data, customer satisfaction surveys

OTHER DATA SOURCES (stuff that is already there and collected by someone else)
- Clinical data e.g. HIV prevalence data, Immunisation uptake
- Sales data
- Market research data
- Other Government/national surveys

Social marketing Intervention

© Word of Mouth Research Ltd
Plan for the day

<table>
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<tr>
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</tr>
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<tr>
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</tr>
<tr>
<td>3.35-4.15</td>
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</tr>
<tr>
<td>4.15-4.45</td>
<td>Discussion and questions</td>
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2.15-3.00
Group Exercise No. 2- Develop a Logical Framework
30-45 minutes
3.00-3.15

• Tea
3.15-3.35

• Feedback on Group Session 2 and open discussion
# Plan for the day

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Final Session

• Commissioning

• Sources of Questions and Questionnaires

• Do people tell the truth in interviews?

• Summary points

• Sources of Guidance

• Questions and Discussion
Quantitative face to face interviews; RULE OF THUMB PRICES 2009

- Price per face to face interview (including, producing a paper questionnaire, paying the interviewer, inputting the data into a spreadsheet and producing data tables, can range from £10 and interview to £80 per interview (sometimes more)

- Depending on

  • The sampling methods used (random samples most expensive, whereas interviewing people at the point of service is much cheaper)

  • The length of the interview (in home interviews should not go on for more than an hour – respondents won’t like it. In the street people won’t do more than 15 minutes.

  • The incentives you pay (£5 pound Boots voucher, or enter them into a prize draw)

  • The geographical area that has to be covered If the interviewing is clustered around a smaller then there is less time spent travelling and fewer travel costs between interviews – but it can affect reliability. Reducing the number of service sites you evaluate can help contain the evaluation cost.
Commissioning Research

Qualitative interviews; RULE OF THUMB PRICES 2009

In-depth interviews

For a single interview with an individual respondent for 1-1.5 hours, including a venue hire, travel costs, analysis and reporting, an agency will charge approx £400-£800 per interview. This will depend on the costs of the researchers time, the difficulty recruiting the respondent, and the amount the agency mark up the interview price.

A good, well established, freelance researcher will give the same service for £200-400 per interview – but it will probably take longer to turn the work around and get results back.

For in-depth interviews after about 10 interviews you may get diminishing returns in terms of new findings.
Commissioning Research

Qualitative interviews; RULE OF THUMB PRICES 2009

Focus groups
6-8 people in a 2 hour focus group in the evening.
For recruitment, venue hire, conducting the groups, analysing and reporting the findings an agency will charge you £1,500-£3,000 per group. This will depend on the costs of the researchers time, the difficulty recruiting the respondents to the group, and the amount the agency mark up the price.

A good well established freelance researcher will give the same service for £800-£1,500 per group- but it will probably take longer to turn the work around and get the results back.

_____________________

Depending on the number of target groups you are dealing with, conduct about 4-6 groups for each target group. After about 6 groups you may find that fewer and fewer new findings are coming through.
Sources of Questions and Questionnaires

- Knowledge
- Attitudes
- Behaviour
- Customer Satisfaction Questions
- Established scales

  - UK Data Archive / ONS
  - NSMC Compendium of Research Surveys
When people tell you what they do are they telling the truth?

- Some behaviours are very private
- Some behaviours are illegal
- People can give *socially desirable* responses
- Bio-chemical markers – Cotinine for smoking, Drugs tests etc
  - Expensive, intrusive
Summary Points
Summary Points

• Programmes should have clear and measurable objectives.

• Some objectives are just not achievable – be realistic about what can be achieved. What effect size is realistic.

• Interventions should be based on a model of change or be conceptualised with a clearly articulated process of change or causal pathway. Logic Model help.

• Before you start the study think about what sort of analysis you will be doing.

• Understand your target group and audience before you commit to anything.
  – Don’t lose sight of the target group. If you are targeting “hard to reach” groups make sure the research concentrates on them and recruits them into your samples. Make sure you are not widening the gap in health inequalities.
  – Where possible involve the target group early on in the process.
Summary Points

• Methodological pluralism – essential
  – Make use of a wide range of data on lifestyles, attitudes, aspirations
  – Where possible use established questions from Government surveys so you can compare National and Local outcomes
  – Familiarise yourself with new research methods – On-line surveys are getting more reliable and they are cheap – but use them cautiously.

• Develop a “rich” description of what has gone on and check for negative side effects.

• Triangulate with other data to check and strengthen your findings.

• Scan the environment to check for unforeseen events and what the competition is doing

• Get in place adequate research governance for your evaluation.

• Keep the programme makers involved and stimulated by the research.

• Try and collect enough cost data to attempt a return on investment (ROI) calculation

• Publish and disseminate findings – if the programme works or if it doesn’t.
OTHER SOURCES

- NSMC – SHOWCASE and the NSMC website
- Word of Mouth Research - Guide to Sources of Insight – October 2009
- SRA Commissioning Guidance
- Geodemographic Systems.
- NICE
- Health England
- UK data archive
- DH Website
- CDC Synergy Social Marketing CD
- Association of Public Health Observatories
- Behavioural Models – Darnton
- Government Social Research Unit (GSRU)
- Coming soon…
  - One stop shop for customer insight research
Geodemographics are increasingly being used to target specific groups and are to a lesser extent used to draw samples for evaluation.

The Association for Public Health Observatories and the National Social Marketing Centre have produced a short technical briefing on the main geodemographic systems.

Available at:

Sources of Insight - an overview of methods

Word of Mouth Research Ltd have provided the document *Sources of Insight* which describes the various research methods discussed today.

Available at: [www.womresearch.org.uk](http://www.womresearch.org.uk)
Commissioning Research

The Social Research Associate (SRA) produced a useful guide to commissioning social research.

This is available as a PDF at:

www.the-sra.org.uk/documents/pdfs/commissioning.pdf
NICE guidance

The National Institute for Clinical Excellence have produced Public Health Guidance on a number of relevant issues including:

Available at
www.nice.org.uk/Guidance/PHG

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<td>Mar 2007</td>
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<td>Four commonly used methods to increase physical activity</td>
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<td>Identifying and supporting people most at risk of dying prematurely</td>
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<td>Needle and syringe programmes</td>
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<td>Feb 2007</td>
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Cost Effectiveness and ROI

Assessing Costs Effectiveness and Return on Investment

- Prevention Interventions give high rates of return to society e.g.
  - Aerobic exercise economic rate of return £36 per £1 spent
  - Alcohol reduction economic rate of return £20 per £1 spent

*It is better to be roughly right than precisely wrong*”  
**JM Keynes**

- Cost Effectiveness and ROI requires more time than we have today.
- A useful link to explore this issue in more depth:

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Discussion and Questions
NSMC social marketing regional
training programme 2009/10
CLOSE