HEALTH ISSUES IN THE COMMUNITY (HIIC):
Evaluability Assessment

Health Issues in the Community (HIIC): Evaluability Assessment
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EXECUTIVE SUMMARY

Health Issues in the Community (HIIC), a community educational training programme based in Glasgow and delivered across Scotland has been continuously funded for the last 18 years yet is lacking in a comprehensive longitudinal evaluation of its impact on health improvement and reducing health inequalities. Since HIIC is established upon principles of community development, the findings of an evaluation could be generalised to other community development programmes which is more cost-effective than evaluating each programme individually.

Working in partnership with the key stakeholders of HIIC-including the Scottish Community Development Centre/Community Health Exchange (SCDC/CHEX), NHS Health Scotland (NHS HS) and the HIIC tutors, the Scottish Collaboration for Public Health Research and Policy (SCPHRP) conducted an evaluability assessment of HIIC in order to assess the current state of the programme and to recommend options for evaluation. The evaluability assessment included a review of relevant literature and face-to-face interviews with relevant stakeholders resulting in the development of a logic model. The research team then presented the findings to the stakeholders in person at a workshop where outcomes were prioritised and key evaluation questions were agreed upon. This workshop revealed that stakeholders were most concerned with assessing the impact that HIIC has on individuals and their community and assessing sustainability. This led the research team to conclude that HIIC should focus on an outcomes evaluation.

Consequently, the research team recommends a prospective evaluation plan conducted at several points over a long period of time. This would include surveys that cover both short and long-term measures (*confidence, self-esteem, self-efficacy, and individual mental health and wellbeing*) and case studies that would look at why and how HIIC works for participants and how sustainable it is.

The main limitation of this evaluability assessment is that HIIC participants were not consulted as a stakeholder group due to the complexity of ethical permissions. This has been rectified by the inclusion of HIIC participants in the research team's recommended evaluation plan.

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INTRODUCTION

This report describes the results of an evaluability assessment of Health Issues in the Community (HIIC), an educational training programme based in Glasgow, Scotland aiming to improve the health of individuals and communities and to reduce health inequalities. HIIC started in 1997 and despite nearly two decades of being successfully funded, no extensive evaluation has taken place to date. Evaluations can be time consuming, resource intensive and, in some cases, inappropriate. Therefore, a pre-evaluation activity such as an evaluability assessment can maximise limited resources, and avoid unnecessary evaluations. Evaluability assessments are generally used to inform decision-making in terms of whether or not to evaluate a programme, as well as how to evaluate if appropriate. This is typically done in three stages of: *preparation, workshop and report*. **Preparation** includes a documentary analysis of relevant materials and initial consultation with key stakeholders in order to develop a theory of change (*how the course can lead to certain outcomes*) and an initial logic model. **The workshop** stage is generally when the research team presents their initial findings in person to all the stakeholders in order to get feedback on what is incorrect or missing. **The reporting** stage occurs after the research team revises the logic model and relays the findings of the evaluability assessment as well as proposed evaluation options and recommendations to the stakeholders which is represented here *(Leviton et al, 2010).*

BACKGROUND & POLICY CONTEXT

The HIIC programme is embedded in community development principles, specifically the community-led approach that focuses on enabling participants to be active in the course and share their life experiences. It is a peer-supported programme run by trained HIIC tutors who are often members of the communities themselves. Support for the participants is provided by the HIIC tutors, who are in turn supported by the Community Health Exchange (CHEX). CHEX is part of the Scottish Community Development Centre (SCDC). HIIC is funded by NHS Health Scotland (NHS HS).

The course is broken down into two parts totalling sixteen modules, with Part 1 being the predominantly used component. Part 1 consists of eight facilitated modules with topics relevant to health inequalities and communities including Poverty, Inequality and Health and Participation and Power. It concludes with the participants giving a group presentation on a researched issue in their community to the group and invited community members. They also submit a written report on the issue they researched and reflect on their experiences as part of the course. Part 2 builds upon the foundation of Part 1 and has eight modules including Community Research and Making Democracy Work, and features a more intensive research and written component. The course format is flexible and tutors are not required to facilitate every module, instead they are encouraged to tailor the course modules to their participant groups. Both Parts 1 and 2 are eligible for SQA accreditation, an option available to each participant at their own discretion.

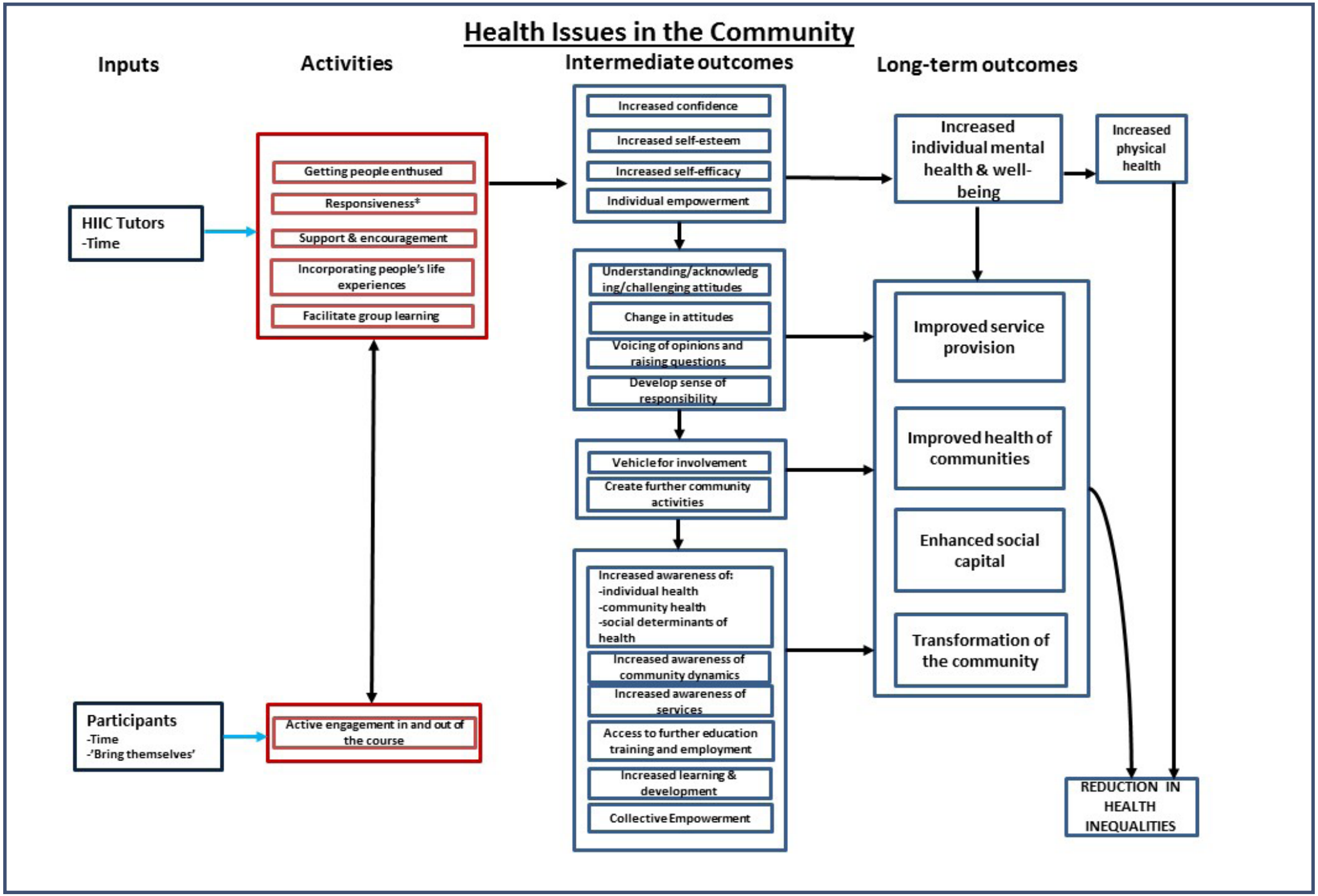
Both parts of the HIIC course incorporate several different policies including the Healthcare Quality Strategy for NHS Scotland 2010, Towards a Mentally Flourishing Scotland 2009, Scottish Community Empowerment Action Plan 2009, and the Curriculum for Excellence 2009. The incorporation of the Curriculum for Excellence is particularly relevant since the HIIC course is being increasingly delivered in schools (*CHEX, 2014*). Overall, embracing policies such as these shows the acknowledgement of political inputs and the willingness to engage with and attempt to improve the applicability of HIIC within Scotland's political and social context.

THEORY OF CHANGE

A theory of change, which is synonymous with programme theory or programme logic, represents the casual chain of how an intervention (*a programme and/or policy*) is understood to contribute to a series of outcomes which produce the intended or actual impacts (*Pawson and Tilley, 1997*). A theory of change can be represented visually by a logic model, a diagram that shows how program inputs (*stakeholder groups*) contribute resources that then lead to outcomes, ultimately resulting in impact. A logic model can help to simplify a theory or likewise can represent a complex dynamic (*Pawson and Tilley, 1997*). Together the theory of change and logic model can be used to assess the evaluability of HIIC by examining if changes in outcomes have occurred and if those changes are a result of the course (*Sanson-Fisher et al, 2014*) or other external factors (*e.g. political reforms which could create a similar change in outcomes*). This would lead to developing an outcomes based evaluation for HIIC, assessing the programme's ability to produce change, rather than a process evaluation, looking at how the changes are achieved. Both forms of evaluations are useful but, based on feedback from the stakeholders, it seems most pressing to see what impact HIIC has by evaluating the programme's outcomes. Because this course is based on principles of community development, it is also important to think about impacts that it will have on individuals operating within communities as well as the communities as a whole.

To address these questions, a theory of change model displaying how inputs of the HIIC course can lead to certain outcomes was created through analysis of relevant documents and materials, and face-to-face interviews with stakeholders. Stakeholders were members of NHS Health Scotland, SCDC/CHEX, HIIC tutors, and academics with knowledge of community development. Within the documentary analysis there were two previous theory of change models, one of which depicted a particular community's journey through HIIC and a more recent version that situated HIIC within a larger community development model (*SCDC, 2013*). The present theory of change acknowledged the programme's past processes as represented by these logic models, and updated the model to reflect HIIC as it is perceived today. This preliminary theory of change was then revised and expanded upon further during an interactive workshop with a cohort of the relevant stakeholders.

The model depicting the revised theory of change is shown on next page.


Health Issues in the Community
Inputs
Activities
Intermediate outcomes
Long-term outcomes
HIIC Tutors
-Time
Participants
-Time
-'Bring themselves'
Getting people enthused
Responsiveness*
Support & encouragement
Incorporating people's life experiences
Facilitate group learning
Active engagement in and out of the course
Increased confidence
Increased self-esteem
Increased self-efficacy
Individual empowerment
Understanding/acknowledging/challenging attitudes
Change in attitudes
Voicing of opinions and raising questions
Develop sense of responsibility
Vehicle for involvement
Create further community activities
Increased awareness of:
-individual health
-community health
-social determinants of health
Increased awareness of community dynamics
Increased awareness of services
Access to further education training and employment
Increased learning & development
Collective Empowerment
Increased individual mental health & well-being
Increased physical health
Improved service provision
Improved health of communities
Enhanced social capital
Transformation of the community
REDUCTION IN HEALTH INEQUALITIES

OUTCOMES

During the workshop stakeholders were presented with the logic model (*in large poster form*), consisting of short-term and long-term outcomes. The stakeholders prioritised the short-term outcomes by voting on outcomes they viewed as most important to evaluate (*using adhesive dots to allow visual voting for all stakeholders to see*) and those receiving the highest prioritisation were organised into three clusters. They appear in the prioritised order below:

Short-term outcomes clusters

1. Increased confidence, Empowerment, Self-efficacy
This cluster was prioritised as the most important set of intermediate outcomes to assess. The outcomes were perceived by stakeholders as a group of individual-based outcomes that establish the foundation for other community and long-term outcomes to occur. Increased confidence was perceived by stakeholders as one of the key outcomes that, coupled with an increase in self-efficacy (*one's belief in their ability to achieve an outcome*), leads to participants feeling empowered at an individual level. This individual empowerment can then result in improved individual mental health and wellbeing (*Mann et al, 2004*). This can also lead to a collective community empowerment that has been linked to incorporating group dynamics and utilising interactive learning (*Israel, 1994; Wallerstein 1992*).

2. Understanding attitudes, Voicing of opinions and raising questions
This set of outcomes emphasizes the ability and willingness of participants to critically think and vocalise their thoughts. These outcomes are associated with a higher retention of knowledge and an increased uptake of critical thinking skills (*Dale, 1969*).

3. Increased awareness, Increased learning and development
This last pair of outcomes incorporates learning about health with an increased awareness of health, including awareness of individual health, community health and the social determinants of health. Consequently, this increase in awareness mirrors an increase in learning and development (*Marton and Booth, 2007*).

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Accordingly, the-long term outcomes were then prioritised and the three outcomes that received the highest prioritisation are listed in order below.

Long-term outcomes

1. Increased individual mental health and wellbeing
Measuring the change in mental health and wellbeing was important to the stakeholders because it has been shown that an improvement in health can have positive effects and elicits other changes (*Prince et al, 2007*). It can also be a precursor to improved physical health which could contribute, with improved mental health, to the reduction of health inequalities (*Prince et al, 2007*).

2. Enhanced social capital
Social capital refers to social networks and the resources that are available through these links (*Kawachi, and Berkman, 2000*). Gaining social capital is associated with improved mental health and wellbeing and increased interaction in the community showing a sense of social cohesion (*the willingness of groups/communities/societies to interact and cooperate with each other*) among the individuals and the community agencies and other members. One example of enhanced social capital in HIIC is at the end of Part 1 when participants work together to research an issue in their community. In order to engage fully with the issue, participants often contact other members of the community for example, to try to keep a local park free of safety hazards such as broken glass and syringes, they they may contact police to enquire if the area is patrolled at night, which then allows for the possibility for the participants to invite the community members to their presentation thus establishing social cohesion through the outreach.

3. Increased health of communities
This outcome reflects the community-wide changes that come from the course with potential outputs being increased volunteering, further activity in community projects, and increased physical health. Community health can be improved by engaging participants in an intervention and using the data to shape plans for further community goals which reflects HIIC's community-led approach (*Goodman et al, 2014*).

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KEY EVALUATION QUESTIONS

During the workshop, three key evaluation questions were formed that were applicable to each of the outcomes of interest for both the intermediate and long-term outcomes.

1. Has HIIC improved [INSERT OUTCOME HERE] (*e.g. 'increased confidence'*)?
2. If yes, how has HIIC improved this outcome? If not, why not?
3. What has followed from this outcome?

These key evaluation questions have been taken into consideration while developing the evaluation options.

POSSIBLE DATA SOURCE

Since there has not been any extensive evaluation of HIIC prior to this evaluability assessment, there are no pre-existing data to draw from. All subsequent data will have to be collected through primary data collection (*See Evaluation Options*).

EVALUATION OPTIONS

When making evaluation recommendations, it is vital to consider the context within which the course is implemented in order to address limitations and strengths. Summarised below are the main constraints that will impact the evaluation of HIIC.

Constraints

The method widely considered as the most robust design or the 'gold standard' is a randomised control trial (RCT). This experimental design requires randomising participants into two groups, one which receives the intervention, and a control group that would not receive the intervention. This method would not be appropriate because it deprives the participant population, those of 'high risk', of the potential benefits of the course. This stems from an ethical concern of keeping a programme that is known to have positive outcomes from participants who fit the criteria of participation (*Sanson-Fisher et al, 2014)*. Lastly, there is the consideration that experimental designs (*which includes* RCTs) tend to be costly which leads to the conclusion that a non-experimental design, i.e. an observational design, would be a more appropriate option for this evaluation.

Another constraint is the lack of routinely collected data. Often, the only information collected from the participants is their name for attendance purposes and a brief post-course survey. No demographic information (*age, sex, education etc.*) is collected and often the attendance numbers at the beginning and end of the course, which can fluctuate due to participants dropping out, are not reported by the HIIC tutors. In addition, there is currently no follow-up data collected for participants who complete the course. The last, and probably largest constraint for evaluation, is the lack of resources in terms of staff time and monetary funds. Many stakeholders expressed the desire to have an evaluation of HIIC done, but they have several other pressing projects and responsibilities within and out with HIIC, making it difficult to devote any additional time to collecting and evaluating data. The monetary issue is reflected in the lack of routinely collected data and was discussed as being only a fraction of what it used to be several years ago. This leads to the conclusion that most of the evaluation would need to be conducted externally, budget permitting. With these constraints in mind, four evaluation options are made below. They are presented in order of affordability and ease of execution.

Options

1. Individual Prospective Study *(Short-term outcomes)*

Expand current information gathered before and after the course into a survey that would be able to measure individual short-term outcomes utilising pre-existing scales. This option could specifically look at outcome measures such as self-confidence, self-esteem and self-efficacy, as well as being able to factor in variability within and between groups. Potential scales that measure these outcomes include the Rosenberg Self-Esteem Scale and the General Self-Efficacy Scale (*Rosenberg, 1965; Schwarzer and Jerusalem, 1995*). Both scales are easy to access but permission may be required to use them and time to score and compile data needs to be taken into consideration. In order to assess the outcomes in the long-term, a follow-up survey could be administered via email, telephone or face-to-face interview in order to see if the intermediate outcomes of the programme are sustained. This could be conducted annually for three to five years in order to measure impact across a longer time scale.

PROS: Most affordable and easiest to incorporate into pre-existing actions. Pre-course data would help to establish and identify baseline trends and the demographic variations; this baseline would allow for changes to be seen while taking other factors into account.

CONS: There is a potential for response bias, that participants may select the response that is most socially favourable (*Tourangeau, Rips and Rasinski, 2000*). Also this option only provides data on short-term outcomes where initial change may not be reflected in longer-term, sustainable change in behaviours and health.

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2. Individual Prospective Study *(Long-term outcomes)*
Using a before-and-after survey design once again, utilise pre-existing scales to measure long-term outcomes of increased mental health and wellbeing, and increased social capital. Potential scales that would measure increased mental health and wellbeing include the Warwick-Edinburgh Mental Well-being Scale and the General Health Questionnaire (*Tenannat et al, 2007; Banks et al, 1980*). In order to measure social capital, General Social Surveys that have been adapted by Putnam could be utilized (*Lochner, Kawachi, and Kennedy, 1999*). These scales are all fairly easy to access but permission may be required to use them and time to score and compile data needs to be taken into consideration. Since the measures of interest in this option are long-term outcomes, it would be essential to look at them longitudinally (repeated measuring of outcomes in the same individuals) so perhaps before and after the course as well as annually over five years.

PROS: Affordable and able to access data quickly.

CONS: As in Option 1 there is the potential for response bias.

3. Retrospective Case Studies
Interview participants about their experience of HIIC after they have completed the course in order to understand why the course worked or did not work for the participant. Since this option would measure both intermediate and long-term outcomes, it would be essential to look at them longitudinally. This could be done by continuing to follow-up with case studies annually for three years.

PROS: Interviewing participants who have already completed the course in the past would give quick access to data.

CONS: Depending on the length of time between the completion of HIIC and the interview, there is an increased risk of recall bias (*incomplete or inaccurate recall of events, common in studies when asking people about past events*) (*Tourangeau, Rips and Rasinski, 2000*).

4. Prospective Case Studies
Interview participants at the end of the course (*either in person or over the telephone*) and follow-up with another interview six months later to see if the effects are sustainable. Since the measures of interest in this option are both intermediate and long-term outcomes, it would be essential to look at them over time so case studies would need to be followed up at several points.

PROS: There is a low risk of recall bias. Chance to collect information on demographics of current participants.

CONS: There is an increased risk of drop-out since there would be multiple interviews with each participant who takes part.

While any of the four options above could be completed before and after the course or singularly after the course, it is important to acknowledge the strategy behind incorporating longitudinal research methods into each option. Measuring before the course gives a baseline to compare the results collected after the course to, to see if anything has changed in terms of the outcomes. Evaluating at multiple points across a period of time would show the level of sustainability of the outcomes and if there is a particular drop off point or a period of time that the impact lasts (*Sanson-Fischer et al, 2014*). The number of, and duration between, these data collections will vary depending on the outcomes being measured and budget/time constraints.

RECOMMENDATIONS

In order to get the most out the evaluation, it is recommended to conduct an evaluation that includes **Option 2, Individual Prospective Study** (*long-term outcomes*) and **Option 4, Prospective Case Studies**. By choosing **Option 2**, the long-term outcome of increased mental health and wellbeing will be assessed and, based on the choice of survey, the corresponding intermediate measures of increased self-confidence and increased self-efficacy can be extracted from the data as well. This option incorporates both short and long-term outcomes that were identified as top priorities by the stakeholders. Additionally, adding **Option 4** to the evaluation will allow for a collective look at the HIIC course and incorporation of the participant's perspective. By choosing the prospective over the retrospective option, a more current and accurate representation of the participants will be represented, aiming to include the different types of participants from geographic communities, communities of interest and youth in schools. Both of these options should be done longitudinally in order to assess if HIIC is sustainable and to see which outcomes are only improved for a certain period of time and which outcomes endure. This satisfies the stakeholder's priority of looking at the long-term impact of HIIC.

CONCLUSIONS

This evaluability assessment has shown that the HIIC course is popular among participants as well as the other stakeholders. Since it has been around for almost two decades, it is due for a more comprehensive evaluation in order to see if it sustainably produces the outcomes it claims. HIIC is an extension of community development theory, so evaluating the course would help the field by being able to generalise the findings to other similar programmes based on community development that are peer-supported such as Navigate Life and the Love Milton Project (*SCDC, 2011; Lovemilton.org, 2015*). If the evaluation shows that it is these underlying principles such as engagement and networking which are necessary to gain the desired outcomes, then community development- based programmes need to be maintained in order to continuously achieve these outcomes.

Although evaluation brings about a sense of promise for the future of HIIC, it is essential to realise that often there is a difference between what is desirable and what is affordable at an internal level. Although some money is set aside by CHEX, it may be beneficial to seek out external funding for a more comprehensive evaluation.

Overall, an evaluation of HIIC would be a valuable way to determine the next steps for the course, but the evaluation would also be valuable for the wider area of peer-supported programmes and community development.

Conflicts of Interest

CHEX commissioned this unfunded evaluability assessment which was carried out by SCPHRP. As a key stakeholder, CHEX was consulted throughout the process but had no influence on study design, data collection or analysis. CHEX was asked to comment on the draft report before publication to ensure clarity, that all information regarding HIIC and CHEX was correct and that the report would be accessible to all CHEX stakeholders.

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