LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Using theory based evaluation in complex interventions: implications for HERA

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HERA Meeting

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Overview

- Challenges of evaluating complex social interventions
- Define theory based evaluation (TBE)
- Approaches to surfacing intervention theory
- Critique of TBE
- Discuss stakeholder planning workshops

Challenges of evaluating complex social interventions

- Implementing organization
- Multiple target groups
- Inter-organizational transactions
- Possible distortion of intervention intentions
- Dosage of the intervention
- Resources
- Wider context in which intervention is situated

Chen & Rossi

Context of theory based evaluation (TBE)

- Increased discussion, but little use of TBE in violence interventions - **Bacchus et al 2010; Goicolea et al. 2013; 2015; Jamal & Bonnell 2015**
- An *approach* to evaluation, alternative to method-driven evaluations or
- "Black box" evaluations with narrow/ distorted understandings of intervention outcomes

Chen & Rosi; Quinn; Weiss; Aspen Institute; Pawson & Tilley; Bonnell; Moore, Michie and others

Defining TBE

- “Surfacing” of the assumptions on which the intervention is based to identify program theory
- The theory provides the scaffolding for the study
- Data collection at multiple points throughout
- Track each link in the chain of assumptions to find out whether the theories on which the intervention is base are realized

Birckmayer & Weiss 2000

Origins of the theories

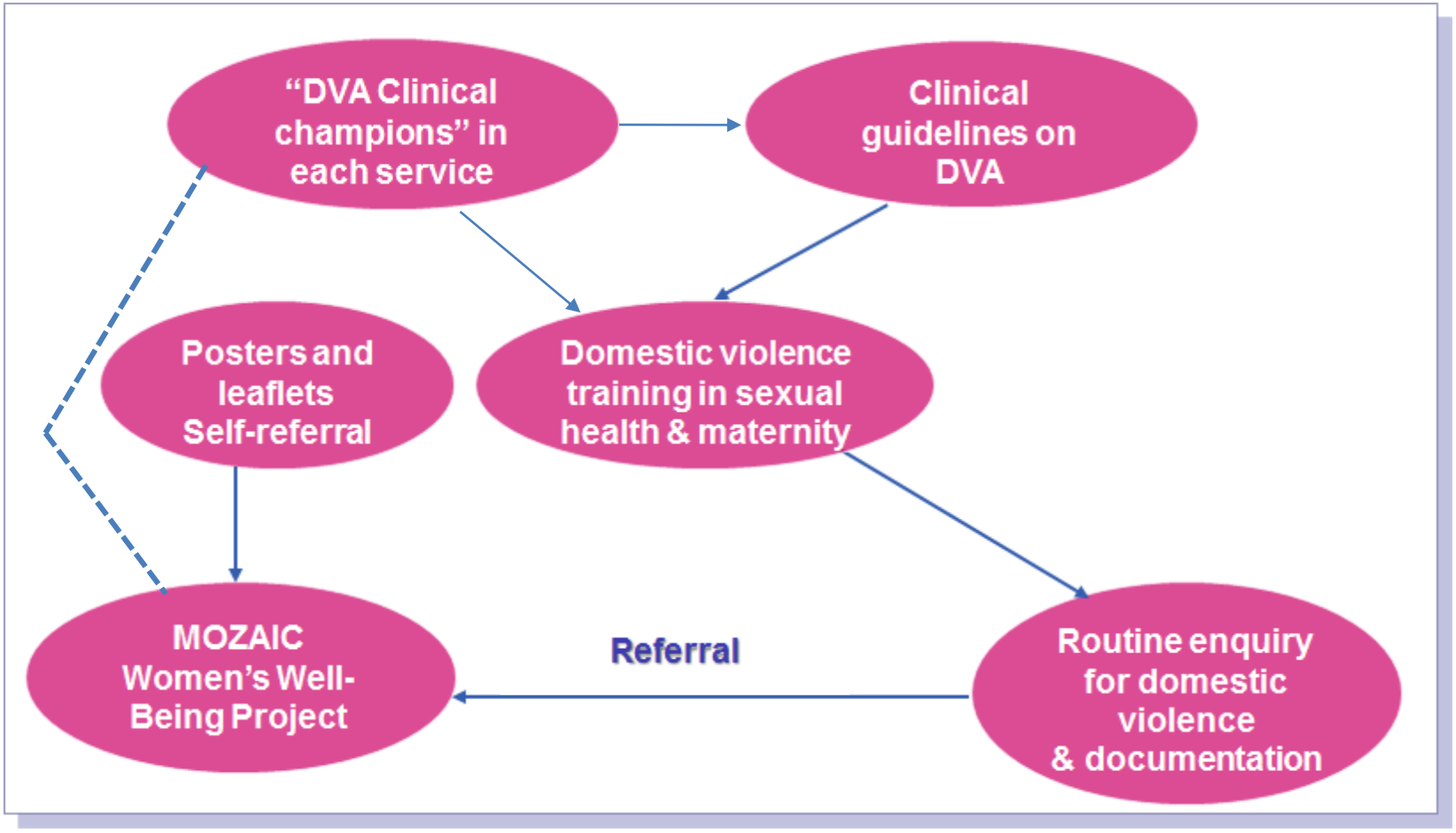
- Previous research on VAW or similar interventions
- Experiential learning (planner/practitioner experience)
- Common sense logic
- Middle range theories from social science

Approaches to making program theory explicit

Strategic Assessment Approach

- *Assumption surfacing and analysis* – Mason & Mittroff; Leeuw 2003
- Used in MOZAIC Women's Wellbeing Project – hospital based, maternity and sexual health intervention for DVA
- Discussion with key stakeholders to identify and make explicit the intervention theory and detailed assumptions about how it is expected to "work" at different stages
- Consider *who* or *what* might affect adoption, execution or implementation of the intervention

MOZAIC Women's Wellbeing Project



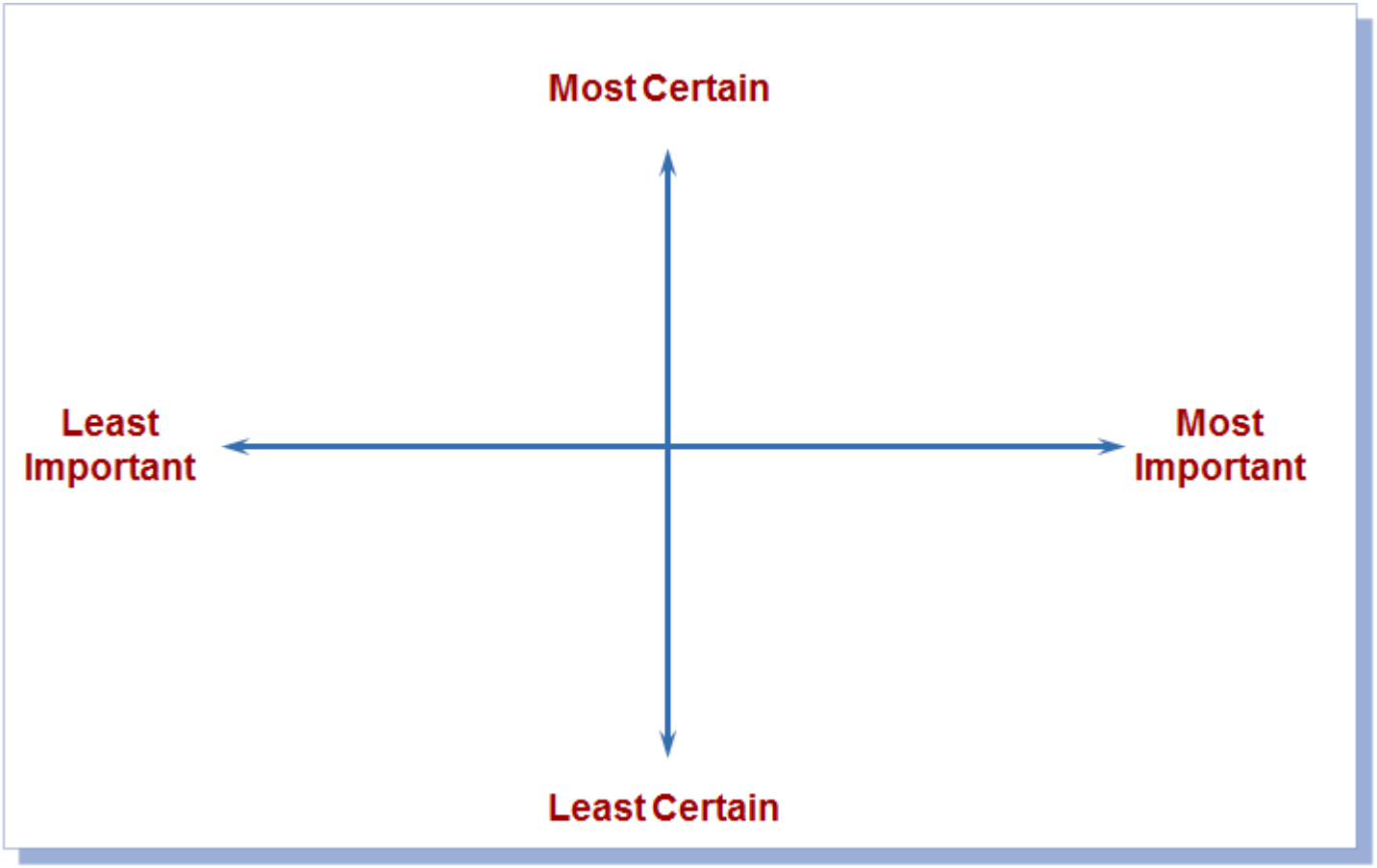
Example training assumptions

1. Health care providers (HCP) are motivated to address DVA as they see it as part of their role
2. Training will effect changes in practice (routine enquiry, documentation, referral to MOZAIC advocate)
3. HCP will bring different levels of knowledge and experience of DVA to the training
4. Mandatory training will ensure HCP's participation
5. Training will enhance HCP's confidence and comfort in asking about and responding to DVA
6. Experiential learning will enhance acquisition of skills and is needed to effect a changes in practice
7. Reinforcement training is needed to sustain a change in practice

Example routine enquiry assumptions

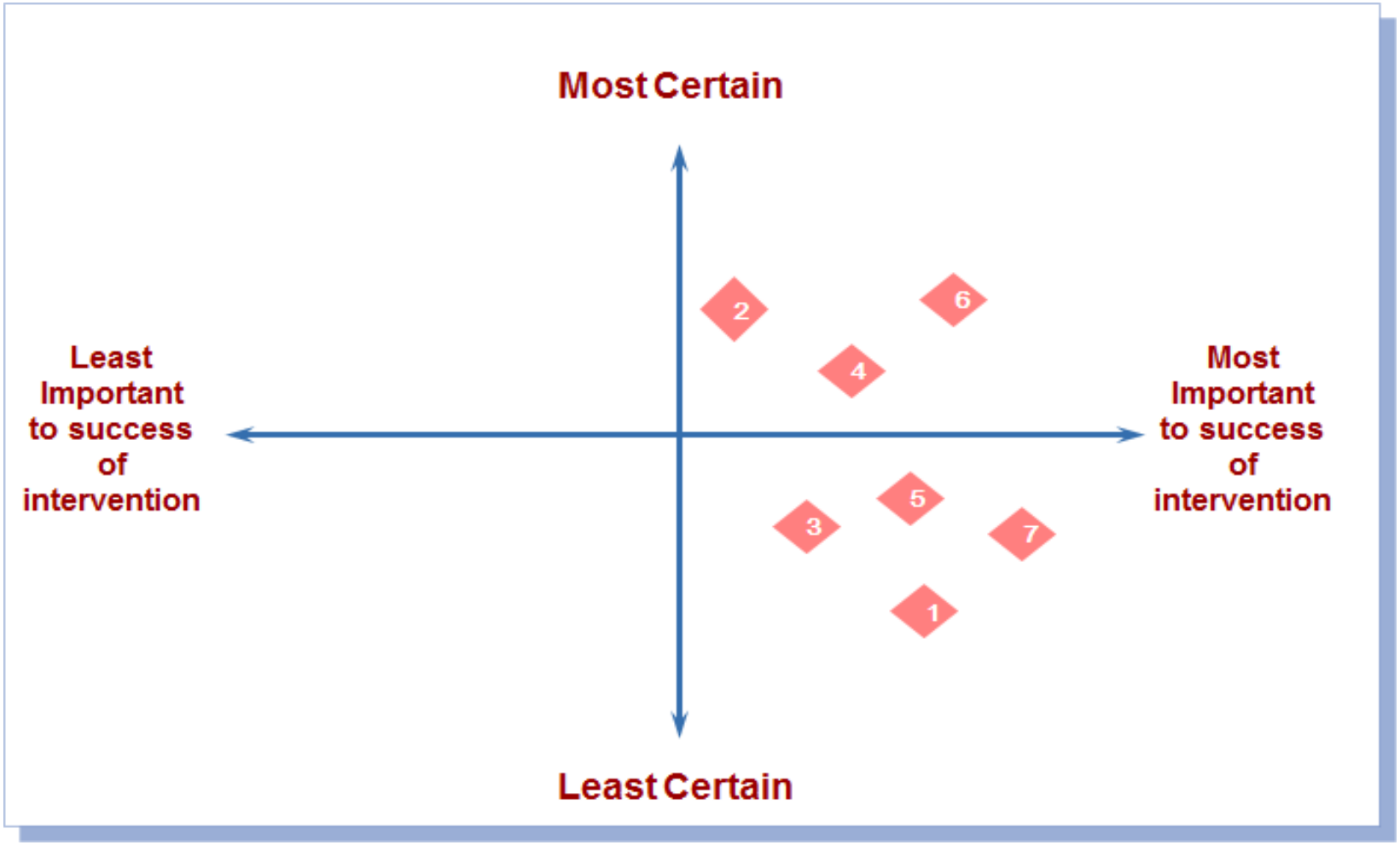
1. Health care providers (HCP) can enquire about DVA in a way that is helpful
2. There are opportunities during consultations in maternity and genitourinary medicine to enquire about DVA safely
3. Routine enquiry will increase the identification of DVA
4. The availability of MOZAIC Women's Wellbeing service will make HCP more comfortable about asking about DVA
5. Women are likely to have trust in and want to confide in HCP

Assumption rating



Leeuw (2003)

Assumption rating for training



Data collection

- Focus groups/semi-structured interviews with HCP/stakeholders
- Pre and post training (6 mth) survey with HCP
- Non-participant observation of training
- Audits of patient records pre and post training
- Semi-structured interviews with women and quantitative measures (DVA/health)
- Data from MOZAIC advocacy service database

Data analysis & interpretation

- **Testing intervention theory:**

  - What mechanisms produced intended/unintended outcomes?

  - Did planned activities achieve the expected outcomes?

- **Process evaluation:**

  - Did implementation occur as expected (need to distinguish between implementation failure and theory failure)

  - Sub-group analysis (did intervention work differently for different people/settings)

- **Contribution to generalizable knowledge** about how complex social interventions work

- **Development of new/modified theory**

Problematizing TBE

- Propensity to select '*off-the-shelf*' or theory *du jour* which may be inappropriate
- e.g. Prochaska's Transtheoretical Model
- Reliance on individual level theorizing instead of community/organizational/system level
- Mechanisms of change contingent on ***context*** – past theory and evidence may not be relevant

West 2015; Moore & Evans 2017; Sniehotta et al 2014; Prestwich et al 2014; Howe 2009; Bonnell et al 2012

*Interventions are fundamentally attempts to disrupt mechanisms which perpetuate and sustain a problem **in a given time and place**, and cannot be understood in isolation from the **systems** whose functioning they attempt to change.*

Hawe et al 2009

Theory of Change Approach – inspired by work of the Aspen Institute

Participatory approach with key stakeholders:

1. **Agree the *longer-term outcome* that the intervention will achieve**

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4. **Articulate *'assumptions'* about why each precondition is necessary**
5. **Rationale – 'evidence'**

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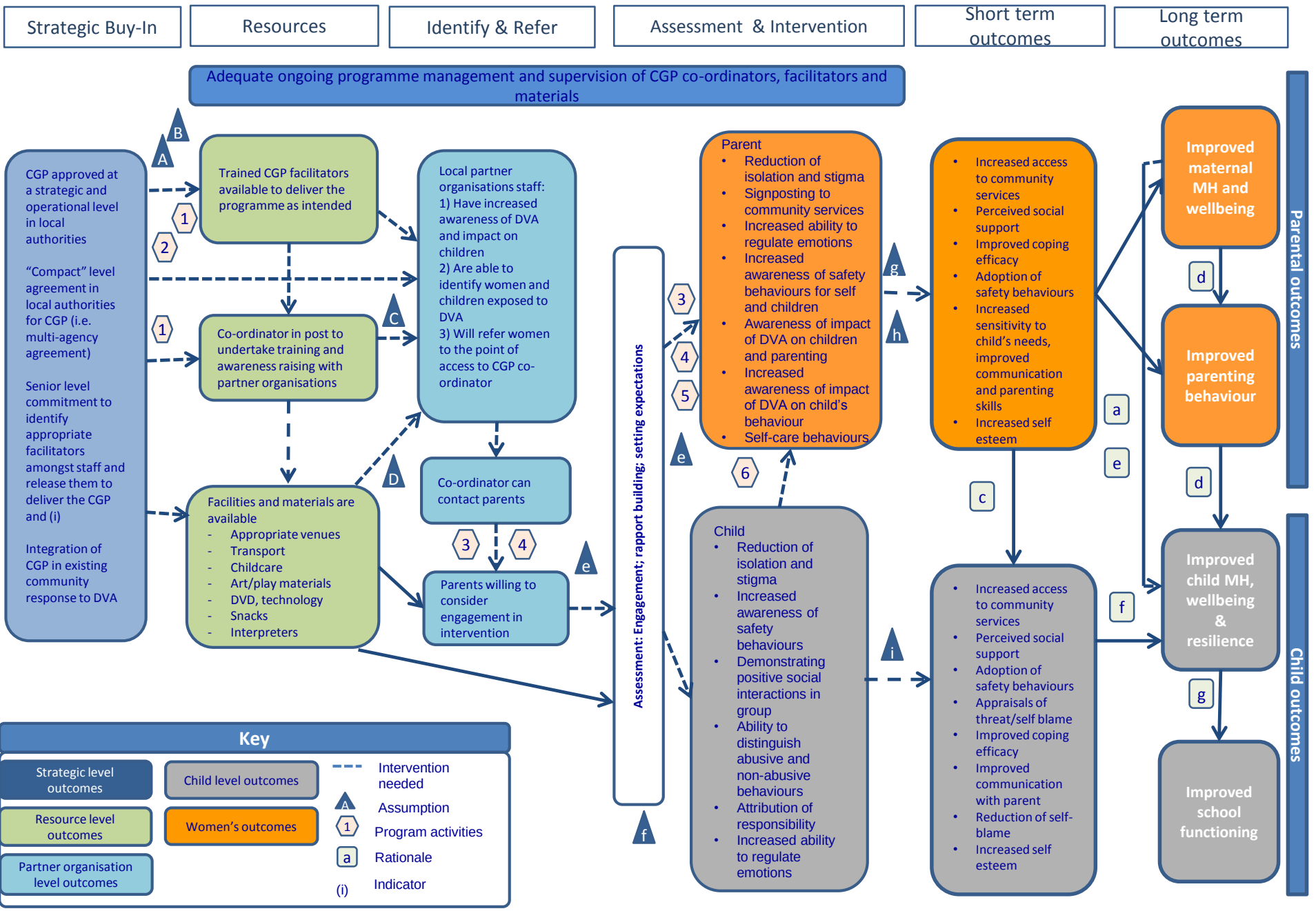
5. **Rationale – 'evidence'**
6. ***Define indicators* – that we measure to track progress and determine success**

Theory of Change Example for Community Group Programme for children exposed to Domestic Violence


compact service level Agreement in local authority for CGP - formalise
follow on services for children after CGP - if they need further services
Get Buy-in at a Arategic level (operational) management endorsement to identify facilitators
MEETINGS with people at strategic and operational level
Need buy-in
Need funding for intervention
DVA awareness training with local agencies
need trainers to provide DVA awareness training
Partner agencies will identify and make referrals to central organisation
conversation about what women are being referred to.
Venue/transport/ permission from school to release children/ creche or children's centres
materials
- Snacks
- play things
- Arb things
- Games (combo copies)
- technology/DVDs
Point of access organisation to take referrals and refer to CGP.
Trainers to train the CGP facilitators
Trained facilitators to deliver CGP as intended
Supervision of CGP facilitators (once a month)
Back fill facilitator's posts if it is advisable in current role
Interpreters
Buddy system who to go to with questions (And?)
Children know where to go for help
Women have a support network
→ community agencies
- friends / family
Recognition that DVA is not their fault (children)
Improvement in Children's mental Health and Wellbeing
improve children's functioning at School
Children's increased self esteem
Improved family functioning
Schools release children from schools to attend CGP
Children will attend all CGP sessions as intended
Providing mothers with skills to talk to + respond to children → improved parenting
Getting mothers invested in the CGP
Reduction in children's PTSD symptoms
COST Effectiveness of CGP
Getting children off protection plans
follow on services for women and children who need this after the CGP
Intervention
Outcomes
Assumptions
Indicators


Voice of Child
Signposting to Services
Ensure accessible Venues → Assessment of need.
Right Venue @ right time of day
Onward Referral
Improved Mental Health (Children)
Programme is seen as Strategy relevant
Facilitator to Deliver Programme
Families are successfully engaged into intervention
Change in knowledge + attitudes of Children
Children develop adaptive Coping Strategies
Increase Children's Self esteem
Effective assessment process
Children feel listened to.
Agencies able to make effective app referrals
Knowledge of help Seeking
Children gain insight into experience
Children develop Secure attachment to mother
Mother – child relationship improved
Improved School functioning
Increase mothers understanding of impact of DVA on child.
Staff are app trained to facilitate prog
Facilitators trained in risk Assessment + referral to MARAC + other services
Facilitators are trained in Safeguarding procedures
Agencies follow up with DVA
Money ↓ Isolation
Recruit facilitators with app background knowledge.
Managerial buy in to release workers to facilitate
Community Services & Referral pathway Audit
Interagency Collaboration
All Vulnerable adults & Children are Safeguarded


Strategic Buy-In
Resources
Identify & Refer
Assessment & Intervention
Short term outcomes
Long term outcomes
Adequate ongoing programme management and supervision of CGP co-ordinators, facilitators and materials
CGP approved at a strategic and operational level in local authorities
"Compact" level agreement in local authorities for CGP (i.e. multi-agency agreement)
Senior level commitment to identify appropriate facilitators amongst staff and release them to deliver the CGP and (i)
Integration of CGP in existing community response to DVA
Trained CGP facilitators available to deliver the programme as intended
Co-ordinator in post to undertake training and awareness raising with partner organisations
Facilities and materials are available
- Appropriate venues
- Transport
- Childcare
- Art/play materials
- DVD, technology
- Snacks
- Interpreters
Local partner organisations staff:
1) Have increased awareness of DVA and impact on children
2) Are able to identify women and children exposed to DVA
3) Will refer women to the point of access to CGP co-ordinator
Co-ordinator can contact parents
Parents willing to consider engagement in intervention
Assessment: Engagement; rapport building; setting expectations
Parent
• Reduction of isolation and stigma
• Signposting to community services
• Increased ability to regulate emotions
• Increased awareness of safety behaviours for self and children
• Awareness of impact of DVA on children and parenting
• Increased awareness of impact of DVA on child's behaviour
• Self-care behaviours
Child
• Reduction of isolation and stigma
• Increased awareness of safety behaviours
• Demonstrating positive social interactions in group
• Ability to distinguish abusive and non-abusive behaviours
• Attribution of responsibility
• Increased ability to regulate emotions
• Increased access to community services
• Perceived social support
• Improved coping efficacy
• Adoption of safety behaviours
• Increased sensitivity to child's needs, improved communication and parenting skills
• Increased self esteem
• Increased access to community services
• Perceived social support
• Adoption of safety behaviours
• Appraisals of threat/self blame
• Improved coping efficacy
• Improved communication with parent
• Reduction of self-blame
• Increased self esteem
Improved maternal MH and wellbeing
Improved parenting behaviour
Improved child MH, wellbeing & resilience
Improved school functioning
Parental outcomes
Child outcomes
Key
Strategic level outcomes
Resource level outcomes
Partner organisation level outcomes
Child level outcomes
Women's outcomes
Intervention needed
Assumption
Program activities
Rationale
Indicator

Example assumptions A

A. Staff at a senior and strategic level in local authorities support implementation of the CGP, are willing to receive training and allocate existing resources and staff as necessary (even when there are pressures in core delivery of services.
B. Managers will release staff at partner agencies to attend DVA training.
C. Staff at partner organisations are willing to attend training and will refer women exposed to DVA to the "point of referral" organisation.
D. Trained facilitators will serve as organisational champions
E. Parent recognises the value of a child focussed intervention
F. Effective assessment process in place.
G. Women exposed to DVA are emotionally ready and willing to engage in parallel group work with their children.
H. Mothers will attend all group work sessions.
I. Children will attend all group work sessions.

Example program activities 1

1. Strategic and operational level meetings. Awareness raising and training re: impact of DV on children and how the CGP works and feasibility trial process.
2. AVA trains designated staff in running the CGP and an identified supervisor provides regular supervision and support to CGP facilitators.
3. Follow-up of women and children who can not be contacted/do not attend all CGP groups (including indirect contact through referring agency)
4. Motivational interviewing/engagement strategies
5. Weekly reminder about date, time and topic of session
6. Communication with parents about content covered in children's group and any difficulties experienced

Example rationale a

a. Evidence from a systematic review that parallel psycho-educational groups for women and children exposed to DVA can lead to
b. improvement in x, y, z (Howarth et al. 2014)
c. Evidence from HTA systematic review that providing health practitioners with training in DVA leads to increased awareness and detection of women affected by DVA (Feder et al. 2009).
d. Enhanced parenting and parental mental health lead to enhanced child functioning (ref)
e. Improved parental MH has an indirect effect on child functioning though enhanced parenting
f. Improved parental MH has an direct effect on child functioning though enhanced parenting
g. Reduced appraisals of threat, blame and enhanced coping efficacy have a direct effect on children's adjustment
h. Enhanced wellbeing is associated with improvements in school functioning

Example indicators (i)

i. Senior level management attend the training sessions and are aware of CGP programme.

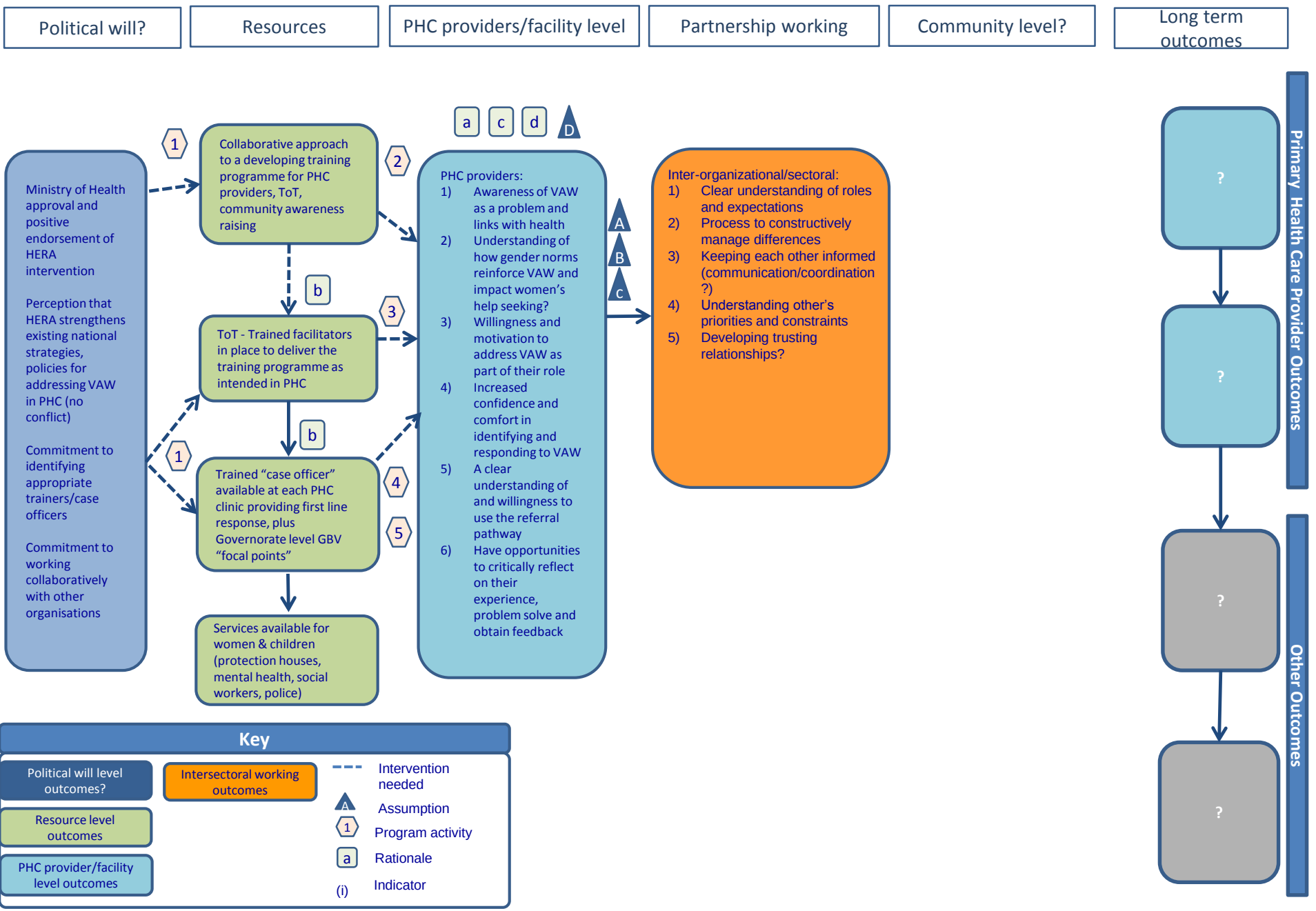
Portion of Palestine ToC pathway – *very tentative!*

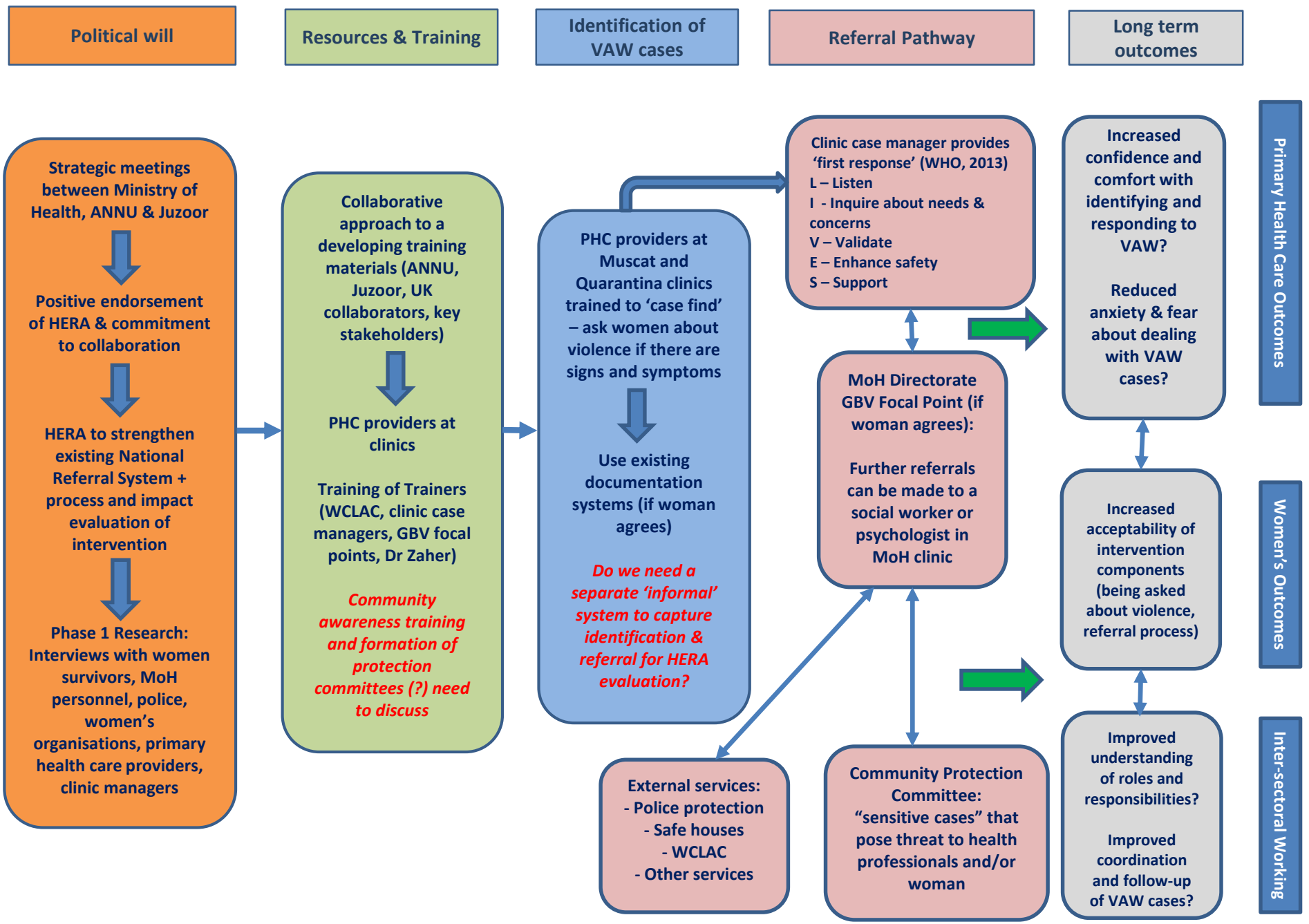
Informed by…

- Phase 1 data & field work visits
- Monthly project & training meeting discussions

To be incorporated as we go along…

- Systematic review
- Stakeholder intervention planning workshops
- Phase 2 data from pilot


Political will?
Resources
PHC providers/facility level
Partnership working
Community level?
Long term outcomes
Ministry of Health approval and positive endorsement of HERA intervention
Perception that HERA strengthens existing national strategies, policies for addressing VAW in PHC (no conflict)
Commitment to identifying appropriate trainers/case officers
Commitment to working collaboratively with other organisations
1
Collaborative approach to a developing training programme for PHC providers, ToT, community awareness raising
2
b
ToT - Trained facilitators in place to deliver the training programme as intended in PHC
3
b
1
Trained "case officer" available at each PHC clinic providing first line response, plus Governorate level GBV "focal points"
4
5
Services available for women & children (protection houses, mental health, social workers, police)
a c d D
PHC providers:
1) Awareness of VAW as a problem and links with health
2) Understanding of how gender norms reinforce VAW and impact women's help seeking?
3) Willingness and motivation to address VAW as part of their role
4) Increased confidence and comfort in identifying and responding to VAW
5) A clear understanding of and willingness to use the referral pathway
6) Have opportunities to critically reflect on their experience, problem solve and obtain feedback
A
B
C
Inter-organizational/sectoral:
1) Clear understanding of roles and expectations
2) Process to constructively manage differences
3) Keeping each other informed (communication/coordination ?)
4) Understanding other's priorities and constraints
5) Developing trusting relationships?
?
?
?
?
Primary Health Care Provider Outcomes
Other Outcomes
Key
Political will level outcomes?
Resource level outcomes
PHC provider/facility level outcomes
Intersectoral working outcomes
Intervention needed
A Assumption
1 Program activity
a Rationale
(i) Indicator


Political will
Resources & Training
Identification of VAW cases
Referral Pathway
Long term outcomes
Strategic meetings between Ministry of Health, ANNU & Juzoor
Positive endorsement of HERA & commitment to collaboration
HERA to strengthen existing National Referral System + process and impact evaluation of intervention
Phase 1 Research: Interviews with women survivors, MoH personnel, police, women's organisations, primary health care providers, clinic managers
Collaborative approach to a developing training materials (ANNU, Juzoor, UK collaborators, key stakeholders)
PHC providers at clinics
Training of Trainers (WCLAC, clinic case managers, GBV focal points, Dr Zaher)
Community awareness training and formation of protection committees (?) need to discuss
PHC providers at Muscat and Quarantina clinics trained to 'case find' – ask women about violence if there are signs and symptoms
Use existing documentation systems (if woman agrees)
Do we need a separate 'informal' system to capture identification & referral for HERA evaluation?
Clinic case manager provides 'first response' (WHO, 2013)
L – Listen
I - Inquire about needs & concerns
V – Validate
E – Enhance safety
S – Support
MoH Directorate GBV Focal Point (if woman agrees):
Further referrals can be made to a social worker or psychologist in MoH clinic
External services:
- Police protection
- Safe houses
- WCLAC
- Other services
Community Protection Committee:
"sensitive cases" that pose threat to health professionals and/or woman
Increased confidence and comfort with identifying and responding to VAW?
Reduced anxiety & fear about dealing with VAW cases?
Increased acceptability of intervention components (being asked about violence, referral process)
Improved understanding of roles and responsibilities?
Improved coordination and follow-up of VAW cases?
Primary Health Care Outcomes
Women's Outcomes
Inter-sectoral Working

Example assumptions A

A. PHC providers will feel safe addressing VAW
B. There is confidential space available in PHC clinics to talk to women safely about violence
C. Clinic has resources & capacity to absorb the intervention (e.g. time, staff etc..)
D. Women who disclose violence to a PHC provider want to be referred to services outside the clinic
E. Women who want to be referred are able to access services safely
F. Services are available for women and children exposed to violence
G. Women are comfortable having the violence documented

Example program activities 1

1. Strategic and operational level meetings with relevant clinic and MoH personnel
2. Community based awareness raising on VAW, formation of "special protection committees"
3. Develop awareness raising and training programme for PHC providers
4. Develop training of trainers programme, plus ongoing supervision and support of trainers
5. Training of Identified GBV "case officer" at each clinic, plus ongoing supervision and support of them

Example rationale (evidence) a

a. Evidence from HTA systematic review that providing health practitioners with training in DVA leads to increased awareness and detection of women affected by DVA (Feder et al 2009)
b. Evidence from IRIS that having an advocate-educator increases PHC provider's comfort with DVA interventions (Feder et al 2011)
c. Experiential learning is needed to enhance acquisition of knowledge and skills (Kolb, 1984)
d. Theories from organizational sociology that to explain internal structure of organisational working and connections with external structures, allegiances etc..

Example indicators (i)

i. ???

Discussion

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- ✓ *What approach to use to surface program theory*
- ✓ *Implications for P2 process evaluation*
- ✓ *Practicalities of running the workshops*
- ✓ *When? Which stakeholders?*
- ✓ *What do we think the long-term outcome(s) of the intervention are?*