

DRAFT

**THEORY-BASED EVALUATION OF COMPLEX
COMMUNITY-BASED HEALTH INITIATIVES**

Avril Blamey, Ken Judge & Mhairi Mackenzie

Health Promotion Policy Unit

Department of Public Health

University of Glasgow

Introduction

It is useful to distinguish between two main strands of action that can be taken to tackle social inequalities in health: broadly based public policies and actions; and, more focused health promotion initiatives. The first relates to those policies with primary goals that are not directly health-related. Such policies might include anti-poverty strategies, welfare to work schemes, economic and physical regeneration of disadvantaged neighbourhoods. The challenge in these areas is to assess the health-related impact of policies and practices that may have a multiplicity of other objectives.

The second area of action is concerned with interventions, policies, practices and processes that have improvements in health, for either the population as a whole or sub-groups within it, among their primary objectives. The challenge here is to consider what evaluation methods are most appropriate to the generation of effective learning about how best to promote health for particular communities. In part the answer will be a very familiar one. Over many years the scientific community has developed reliable methods for evaluating the cost-effectiveness of interventions that lend themselves to processes of meta-analysis and systematic review. These approaches are particularly applicable to assessing the impact on the health of individuals of particular drugs or other kinds of therapeutic interventions. Carefully designed studies with well-defined interventions can generate very powerful learning about the health consequences of different course of actions. However, there are a host of other forms of health promoting interventions that combine a number of mechanisms within complex contexts. As a result, there is a growing body of opinion that broadly based approaches to health promotion require rather different methods of evaluation.

The aim of this paper is to outline one approach that lends itself particularly well to the evaluation of those kinds of complex community-based health promotion initiatives that are likely to be most suited to tackling inequalities in health. Such schemes vary considerably in their scope and detail but typically they tend to have a number of features in common. Connell & Kubisch (1998), for example, describe the aim of Comprehensive Community Initiatives (CCIs) as being: to promote positive

changes in individual, family and community institutions; to develop a variety of mechanisms to improve social, economic and physical circumstances, services and conditions in disadvantaged communities; and, to place a strong emphasis on community building and neighbourhood empowerment.

These characteristics pose a number of challenges for evaluation because:

- Such initiatives have multiple, broad goals;
- They are highly complex learning enterprises with multiple strands of activity operating at many different levels;
- Objectives are defined and strategies are chosen to achieve goals that often change over time - for example, interventions which aim to be locally driven require to respond to community needs and these cannot necessarily be defined at the outset;
- Many activities and intended outcomes are difficult to measure since
- units of action are complex, open systems in which it is virtually impossible to control all the variables that may influence the conduct and outcome of evaluation;
- The saturation of a given community with a particular intervention limits further the potential for traditional experimental designs;
- Improving health outcomes which are socially determined takes longer than the lifespan of an evaluation.

So, comprehensive interventions are both the most promising in terms of impact and the least likely to be understood using traditionally credible methods. This points to the pressing need to review more flexible evaluation frameworks since simply to ignore investments in highly complex programmes or initiatives would be to seriously reduce the potential for learning about how best to tackle many intractable social problems, including social inequalities in health (Judge & Bauld, 2001).

Theory-Based Evaluation

One of the most interesting approaches to evaluation, that seems especially applicable to learning about community-based initiatives that aim to reduce health inequalities, has been given the name “Theory of Change” by the Aspen Institute (Connell et al, 1995; Fulbright, Anderson et al, 1998).

The Theory of Change (ToC) approach to evaluation has been developed over a number of years through the work of the Aspen Institute's Roundtable on Comprehensive Community Initiatives. It was developed in an effort to find ways of evaluating processes and outcomes in community-based programmes that were not adequately addressed by existing approaches. The approach is defined as ‘a systematic and cumulative study of the links between activities, outcomes and contexts of the initiative’ (Connell & Kubisch, 1998). It aims to gain clarity around the overall vision or Theory of Change of the initiative, meaning the long-term outcomes and the strategies that are intended to produce them. In generating this theory, steps are taken to link the original problem or context in which the programme began with the activities planned to address the problem and the medium and longer-term outcomes intended. This framework has much in common with the development in the UK of ‘realistic evaluation’ (Pawson & Tilley, 1997).

Connell and Kubisch (1998) provide a number of convincing reasons why this approach to evaluating complex and evolving initiatives is an attractive one. Firstly, a Theory of Change can *sharpen the planning and implementation of an initiative*. An emphasis on programme logic or theory during the design phase can increase the probability that stakeholders will clearly specify the intended outcomes of an initiative, the activities that need to be implemented in order to achieve them, and the contextual factors that are likely to influence them. Secondly, with a Theory of Change approach, *the measurement and data collection elements of the evaluation process will be facilitated*. It requires stakeholders to be as clear as possible about not only the final outcomes and impacts they hope to achieve but also the means by which they expect to achieve them. This knowledge is used to focus scarce evaluation resources on what and how to measure these key elements. Finally, and most importantly, articulating a Theory of Change early in the life of an initiative and

gaining agreement about it by all the stakeholders *helps to reduce problems associated with causal attribution of impact.*

Problems associated with attribution, causation and generalisation are common to most health promotion initiatives. A Theory of Change approach explicitly addresses these issues. It involves the specification of how activities will lead to intermediate and long-term outcomes and an identification of the contextual conditions that may affect them. This helps strengthen the scientific case for attributing subsequent change in outcomes to the activities included in the initiative. Of course, it is important to acknowledge that using the Theory of Change approach to evaluation cannot eliminate all alternative explanations for a particular outcome. What it can do is to provide key stakeholders with evidence grounded in their own assumptions and experiences that will be convincing to them. Indeed, at the most general level, the Theory of Change approach assumes that the more the events predicted by theory actually occur over the lifetime of an initiative, the more confidence evaluators and other should have that the initiative's theory is right.

The aim of this paper is to share some preliminary thoughts about using the Theory of Change approach to evaluate a number of high-profile initiatives in Britain that form part of a concerted attempt to reduce inequalities in health. A brief description of each of the initiatives concerned – Health Action Zones and New Deal for Communities in England, and Health Demonstration Projects in Scotland – is set out in Box 1.

The paper addresses four main themes:

- the planning and commissioning of initiatives;
- experiences of independent evaluation in practice;
- links with local evaluation activities; and,
- the role of performance management systems and processes.

Box 1: Complex Community-based Initiatives

Health Action Zones

HAZs were established to act as ‘trailblazers in leading the way to tackle inequalities in health’. They were initially given a seven-year life and additional support and resources in order to form partnerships between local statutory agencies and communities to develop innovative ways of working to reduce health inequalities. There are 26 HAZs in England and these cover almost a third of the population. The National Evaluation of HAZs is being co-ordinated through the Health Promotion Policy Unit at the University of Glasgow in collaboration with colleagues at Queen Mary, University of London and the University of Birmingham.

Scottish Health Demonstration Projects

Following the publication of the Scottish public health white paper ‘Towards a Healthier Scotland’ four demonstration projects were established to address specific health issues – coronary heart disease (Paisley), child health (Glasgow), sexual health (Edinburgh) and colorectal cancer (North East of Scotland). The demonstration projects were requested to ‘identify, promote and facilitate the adoption of best practice throughout Scotland’ in their specific topic areas and to ‘stimulate collaborative multi-disciplinary working and thereby add value to existing activity’. The Health Promotion Policy Unit at the University of Glasgow has been awarded the contract for the evaluation of the first two projects – Have a Heart, Paisley (CHD) and Starting Well (Child Health).

New Deal for Communities

The New Deal for Communities is the government’s pathfinder programmes for the National Strategy for neighbourhood renewal. The specific outcome areas for each NDC will be unique but should focus on reducing the gap between the most deprived areas and the rest of the country particularly in relation to worklessness, crime, health, housing and the environment, and education. NDC Partnerships have been established in 39 neighbourhoods across England. The schemes are led by local partnerships formed between local people, community and voluntary organisations, public agencies, local authorities and business in neighbourhoods comprising between 1,000-4,000 households. The programme is administered through Government Offices for the Regions (GO's). Over the ten-year duration of the programme they will receive funding totalling £1.9billion. Partnerships bring local communities together with mainstream service providers and other local stakeholders to tackle the problems in their neighbourhoods in an intensive and co-ordinated way. The national evaluation of NDCs being undertaken by a large consortium of partners lead by Sheffield Hallam University will make a major contribution to the learning that is generated.

Planning and Commissioning of Complex Community Initiatives

All of the complex community initiatives (CCIs) where we have adopted a Theory of Change perspective have been subject to some form of performance management by their sponsors. The starting point is usually the need to produce an initial plan that details problems, proposed actions and goals in order to obtain resources to fund the initiative. Many organisations (e.g. DOH, SE and NOF) have utilised competitive bidding processes whereby project plans are specified and judged by commissioners and steering groups prior to awards being made. In the case of Health Action Zones, for example, bids were invited from local partnerships associated with health authorities on the basis of guidance produced by the Department of Health. The precise details vary from one programme to another but at least in principle there is a common rhetoric that finance will not be made available until satisfactory plans are produced. In some cases such as New Deal for Communities there has been an explicit recognition that local partnerships need some earmarked resources even to engage in the process of producing a plan. Nevertheless, even in the case of NDCs, final approval for an initiative is supposed to be on the basis of having produced a satisfactory plan.

In short, a key starting point for the funding of CCIs is that a satisfactory plan that links problems, interventions and goals – preferably with a clear indication of intermediate milestones or indicators – has been completed. In practice, this rarely happens. Once resources have been set aside to support a programme then the governmental agency concerned seems committed to allocating finance almost regardless of the quality of the plans that have been produced. It may be that commissioners provide awards on the basis of need and political imperative, rather than quality of plans, despite the rhetoric of a competitive process. In the case of at least one Health Action Zone, for example, Ministers decided to proceed despite being advised quite explicitly that the plan that had been submitted was substandard. More generally, where we have examined in some detail the plans for achieving population health change produced by HAZs and NDCs the conclusion that the plans on average have been poor has been unavoidable. Box 2 summarises some of the concerns that we encountered when reviewing early plans produced by HAZs in 1999.

More recently, we have examined the health-related plans produced by NDCs and found that many of the problems associated with HAZs were still very evident despite the fact that NDCs received specific resources to help them produce their plans (Mackenzie et al, 2001). On the basis of what we regarded as a relatively generous assessment of the plans we concluded that at best only about 35% of them could be regarded as “reasonably satisfactory” and none of them were “good”.

Box 2: HAZ Plans

To varying degrees all of the plans are strong on identifying problems and articulating long-term objectives, and to some extent on specifying routinely available statistical indicators that might be used for monitoring progress. On the other hand, they are much less good at filling in the gap between problems and goals. Only in very rare cases is it possible to identify a clear and logical pathway that links problems, strategies for intervention, milestones or targets with associated time scales and longer-term outcomes or goals ... There appears to be a significant gap between problems and goals. Interventions and their associated consequences (which we prefer to think of as targets) are not usually clearly linked to problems and goals.

Many of the 1st wave health action zones, in particular, found it difficult to specify precisely how they would intervene to address problems, and what consequences they expected to flow from such interventions and how precisely these related to their strategic goals. As a result, the ‘targets’ that they included in their plans were not convincing, for a number of reasons.

For example, many specific ‘targets’ were not clearly linked with strategic goals or objectives set out elsewhere in the plans. Other ‘targets’ were not located within a specific time scale. Most importantly, and most frequently, specific ‘targets’ were highlighted without any accompanying explanation of the mechanisms intended to achieve them. This omission is key. It breaks the critical link between the problems that HAZs are there to address and the ambitious goals that they rightly wish to set for themselves. It also limits the extent to which the intended outcomes in each HAZ can be perceived as part of a process of broader change, the type of change that is required to make significant improvements in health over time.

Source: Judge et al, 1999

Our overall impression is that substantially more time, technical support and focus on measurement and evaluation is required than is currently being provided and that this can only properly be achieved if there is a move away from competitive bidding processes. Such a move would allow awards to be made on the basis of greatest need. It would allow scarce resources in terms of performance management and evaluation skills to be directed to support prioritised areas that will receive funding, rather than

diluted across a range of competing projects that may not succeed beyond the bidding process.

Two main lessons emerge from our experience to date. The first is that sponsors have been relatively slow to recognise and respond to the difficulties that all local initiatives appear to have in setting out their plans in a logical fashion that links problems, interventions and outcomes so that developments can be evaluated and lessons learned. The second is that logical planning does not seem to be part of the natural culture of practice in the partner agencies that have committed themselves to improving population health. This poses a major problem of evaluability. An important part of the rationale for sponsoring CCIs is that they will contribute to future policy and practice development; that valuable learning for other agencies can be generated from them. But unless the basis on which they are designed and implemented is very substantially improved then their learning potential will be very substantially reduced. Our experience has been that CCIs will not make speedy progress when they have to rely primarily on their own internal resources. They need greater understanding from their commissioners and practical assistance from skilled professionals.

Evaluation in Practice

The Aspen Institute papers provide a strong theoretical case for the need to prospectively articulate a Theory of Change. The papers propose *in broad terms* the ways that this might be achieved such as through “working together with stakeholders” or through “a collective and collaborative process”. In addition a six-step approach to uncovering a Theory of Change is presented.

Our experience across a range of CCIs suggests that although the broad approaches described above are valid, the process is somewhat more complex than this simple model implies and the articulated theories that result are substantially more detailed (even for single site interventions) than many of the high level examples provided in the Aspen papers. Capturing this degree of complexity and specificity is necessary if the resulting framework is to be used to uncover, not only the rationale and theories underpinning the initiatives, but particularly the do-ability and testability of the

programme. Even if learning only arises in terms of reasons for deviation from the programme, rather than attribution, then a well-specified theory is necessary.

A key issue that has arisen in the CCIs where we have been involved is the scale of the effort required to elicit and build consensus about local theories of change. Large numbers of stakeholders need to be consulted. Trust and credibility have to be established. Group discussions need to be facilitated. Multiple versions of embryonic ToC statements have to be produced for review and discussion. These investments of time are not without value but they are resource intensive. Such a developmental process can be very valuable to CCI stakeholders and to commissioners, and from an independent evaluation perspective it helps to reduce the problems of evaluability that appear to be common to most CCIs. But when this process works best it brings in its train another problem.

CCIs are usually established because the problems they face are very considerable ones. As a result local stakeholders often generate many ideas about possible ways of intervening to achieve the ambitious goals that they set for themselves. But we would question whether they are realistic in certain important respects. First, there is a real danger of chasing too many hares and so dissipating scarce resources. Our belief is that to achieve real change when resource constraints are ever present requires real discipline about setting and sticking to priorities. The same applies to issues related to the generation of management information to monitor the impact of interventions. In practice it is impossible to evaluate everything and scarce research resources should focus on those areas where change is most likely. Local stakeholders have been reluctant to make these judgements for a variety of reasons. This will hamper the learning potential of the ToC approach, which critically depends on a flow of good management information about the degree to which prospectively specified milestones and targets are being achieved.

We have not yet completed an evaluation of any CCI based on the ToC approach but some lessons about its utility and limitations are emerging. Given time, and in practice reasonably close proximity to a CCI, skilled researchers with “street level” skills can help to clarify what initiatives are trying to do and why in ways that facilitate evaluation opportunities. In relation to current UK evaluations a variety of methods

and tools have been used. These methods include documentary review, one-to-one and group interviews, focus groups and tools borrowed from performance management. One of the strengths of CCIs has been their commitment to inclusiveness and participation but paradoxically this may also prove to be a Achilles heel. Action that is focused and therefore potentially more effective may be constrained by the need to keep a thousand flowers/projects blooming so as to ensure that all partners stay on board. At the end of the day there is some sort of relationship between the number of actions being undertaken and the amount of research that is necessary. If real learning is to be generated from CCIs and if research resources are to be kept within realistic bounds then local initiatives have to be more tightly managed.

Local evaluation

Our experience suggests that the use of a theory-based approach can bring benefits to the process of local evaluation and here we draw attention to two particular aspects of this process: the focusing of local evaluation resources; and, building local capacity for evaluation. We conclude this section by discussing the implications for the interface between internal and external evaluators and their funders.

Identifying local evaluation priorities

Connell and Kubisch have argued that a Theory of Change approach, through the articulation of an initiative's rationale and a surfacing of conflicting views, helps to direct scarce resources at the key evaluation issues raised by the initiative. They argue that this happens by identifying the aspects of a programme of activity that have less of an existing evidence base or where the context within which the interventions will be operating is thought to be very different from previous studies of the intervention.

We can cite examples where the development of a programme's Theory of Change has indeed helped this process. For example, within the Starting Well project, early work with key stakeholders identified the need for the external evaluators to place an increased focus on the process learning from the implementation of a new model of home visiting for the families of new babies. The same process encouraged the internal team to focus on monitoring the types of health problems, solutions and

changes in referral patterns emerging through the therapeutic alliance that is anticipated between families and their home visitors.

On the other hand, whilst the articulation of a Theory of Change can facilitate this type of prioritisation, we believe that it is neither necessary nor sufficient. Other types of technical assistance and means of identifying inherent conflicts within programmes might be equally useful and, even with the production of a well developed programme, project implementers continue to struggle with competing criteria around the identification of evaluation priorities. Have a Heart, Paisley, for example, struggled initially with determining whether the key demonstration element of their initiative was to identify whether specific activities such as promoting physical activity within socially disadvantaged areas could impact on health or to assess whether a combination of activities could work *synergistically* to change health outcomes associated with coronary heart disease.

Theory based approaches, we believe, can help structure local evaluation decisions for initiatives but require to be used in such a way that they highlight the *impetus* for collective decisions to be made. When used in this way the Theory of Change serves not only as a map for the implementation of a programme but also as a map of its evaluation, both external and internal.

Building capacity for evaluation

In common with many of the policy initiatives unleashed by New Labour, the initiatives that we refer to in this paper aim to bring about whole system change. One way of conceptualising change is as a cycle that starts with joint strategic planning to address an agreed problem and then moves through stages of implementation, learning and strategy refinement. Evaluation, in this model, is not simply a means of capturing endpoints but is a dynamic part of the change cycle.

For this reason, embedding evaluation skills and methods within service delivery and community organisations is an important part of ensuring sustainability for both projects and ways of working. Our experience with the HAZ initiative in particular suggests that theory-based approaches help to provide an overall evaluation framework that allows the smallest project cogs within the overall wheel of

programme planning to identify their role in bringing about change and to develop relatively simple means of assessing whether this change has taken place.

For this approach to be effective there seems to be a need for at least two separate investments of time. The first of these is to provide evaluation training and support to projects that provides skills in linking project plans to performance monitoring and evaluation. Within the HAZ initiative this has been supported through the development of local tool-kits for evaluation, through dedicated evaluation lead officer time and through both national and local fellowship schemes where local staff are given small-scale resources to evaluate an element of their practice.

The second process by which projects and work streams can contribute to an assessment of change and overall programme success is where a Theory of Change is undertaken at a strategic programme level and where there is a clear strategic overview of how the activities of single projects and work streams aggregate to the overall HAZ goal. In practice, of course, this is rarely done in a systematic manner but some HAZs have made serious attempts to use evaluation in general and Theory of Change in particular as a tool in bringing about whole system change.

Implications for the interface between internal and external evaluators

If a Theory of Change approach is to aid in supporting local evaluators to identify their own evaluation priorities, and to build local capacity in the arena of measuring change and developing strategy, then there is a need for external evaluators to have close involvement with an initiative. Researchers ought to be involved from the stage of drawing up programme plans and this involvement should remain throughout the project. In this way both formative and summative learning can emerge and is encompassed by a Theory of Change approach. The approach also encourages the use of a common framework and language; this in turn helps to prevent the sense of overlap between internal and external evaluation.

The close liaison of external evaluators and the internal team with project commissioners is also vital and our experience, particularly with the Scottish Health Demonstration Projects, is that a project's Theory of Change is a useful focus around which these players can coalesce. Such close working can ensure that the *type* of

findings that will emerge during the lifespan of a project match with the expectations of funders.

Performance Management

Sponsor agencies - such as the Scottish Executive, the Department of Health and the Department of Transport, Local Government and Regions – have responded to the perceived inadequacies of the plans produced by CCIs in a number of ways. They have tried various forms of stick and carrot approaches to strengthening the planning process and over time there has been a growing recognition of the need to provide substantial practical assistance to local initiatives. But a common feature of the performance management process has been to demand planning and review documentation that tries to help local initiatives make much more explicit the underlying logic of the change pathways that they are trying to introduce. In the case of HAZs, the DH provided training about log frames and required their use in the production of regular “high level statements” about the development of local programmes. To support NDCs, the DTLR has repeatedly emphasised the importance of project cycle management that has a strong reliance on the use of logic models. The Scottish Executive for its part has been trying to use a template or grid of its own manufacture to extract more meaningful indications from Scottish Health demonstration projects about the theories of change that are being adopted in different places.

More specificity and clearer roles and responsibilities have been identified when these tools have been used at *both* a strategic and operational level and where a wide range of stakeholder have been involved in completing them.

A very clear message arising from our experience is that, irrespective of the precise tools used, *a substantial amount of technical assistance is required*. Skills in using such tools often vary according to the existing planning methods and accountability procedures of the various stakeholders and agencies. In all cases it appears that implementation teams need support and or training to be able to successfully complete the log frames or logic models and that even when this has been given it is difficult to get stakeholders to address project areas where the theory is poorly specified, or where outputs and outcomes are difficult to measure (e.g. no base lines or data

available). Additional encouragement, prompting and support is required in particular to ensure that the strategic stakeholders actually utilise these findings from the ToC process to *prioritise and focus* on key areas for delivery and measurement.

Important issues for consideration include: Who is best placed to provide the type of technical assistance that is required in such complex initiatives? Does it require both evaluation and performance management knowledge and skills? Would input from one or other of these professional groups improve the process of planning as it currently stands? To what degree is domain knowledge important in improving planning and evaluation? If domain knowledge is important then what are the implications for regeneration projects that tackle wider social determinants (education, housing, crime, worklessness and health)? If all of these factors are required then this has quite major implications for the nature and multi-disciplinary mix of future evaluation teams that work on such complex initiatives. All of these matters require further thought and testing in practice, and should be considered along with issues about the role and influence of evaluators, how this impacts on objectivity of the whole evaluation process and what this means in terms of replication and transferability of learning.

In addition to the above issues our experience suggests that ToC processes have highlighted divergence in the expectations and views of commissioners that add to the difficulties experienced by the implementation teams. If further clarity and consensus could be achieved in terms of commissioning then it might be feasible to establish more realistic timeframes and more streamlined accountability processes. In turn this might improve opportunities for the use of formative feedback from the ToC process to identify where remedial action is needed and how best to implement it. There is, therefore, a strong case to be made for using ToC both with commissioners prior to funding and with implementation stakeholders throughout the project delivery process.

Key Points

When considering local action to reduce health inequalities we believe that comprehensive community-based interventions are both the most promising in terms of impact and the least likely to be understood using traditionally credible methods. This points to the pressing need to review more flexible evaluation frameworks since simply to ignore investments in highly complex programmes or initiatives would be to seriously reduce the potential for learning about how best to tackle many intractable social problems

The aim of this paper is to share some preliminary thoughts about using the Theory of Change approach to evaluate a number of high-profile initiatives in Britain that form part of a concerted attempt to reduce inequalities in health. Some of our main conclusions are summarised below.

- Our overall impression is that substantially more time, technical support and focus on measurement and evaluation is required than is currently being provided and that this would be aided if there is a move away from competitive bidding processes when launching pathfinder initiatives.
- Sponsors have been relatively slow to recognise and respond to the difficulties that all local initiatives appear to have in setting out their plans in a logical fashion that links problems, interventions and outcomes so that developments can be evaluated and lessons learned.
- Logical planning does not seem to be part of the natural culture of practice in the partner agencies that have committed themselves to improving population health. This poses a major problem of evaluability for many complex initiatives.
- A key issue is the scale of the effort required to elicit and build consensus about local theories of change. Large numbers of stakeholders need to be consulted. Trust and credibility have to be established. Group discussions need

to be facilitated. Multiple versions of embryonic ToC statements have to be produced for review and discussion.

- If real learning is to be generated from CCIs and if research resources are to be kept within realistic bounds then local initiatives have to be more tightly managed.
- For the ToC approach to be effective it is essential to provide evaluation training and support to projects that provides skills in linking project plans to performance monitoring and evaluation.
- Our experience suggests that ToC processes tend to highlight divergence in the expectations and views of commissioners that add to the difficulties experienced by implementation teams. If further clarity and consensus could be achieved in terms of commissioning then it might be feasible to establish more realistic timeframes and more streamlined accountability processes to help initiatives to perform more effectively. In turn this might improve opportunities for the use of formative feedback from the ToC process to identify where remedial action is needed and how best to implement it. There is, therefore, a strong case to be made for using ToC with both commissioners prior to funding and with implementation stakeholders throughout the life of an initiative.

References

Connell J.P. and Kubisch A.C., (1998) Applying a theory of change approach to the evaluation of comprehensive community initiatives: progress, prospects, and problems. in Fulbright-Anderson et al (eds) *New Approaches to Evaluating Community Initiatives. Volume 2 Theory, Measurement, and Analysis*. Washington DC: The Aspen Institute.

Connell J.P., Kubisch A.C., Schorr L.B., Weiss C.H. eds. (1995) *New Approaches to Evaluating Community Initiatives: Concepts, Methods & Contexts*. Washington DC: The Aspen Institute.

Fulbright-Anderson K., Kubisch A.C., Connell J.P. eds. (1998) *New Approaches to Evaluating Community Initiatives. Volume 2 Theory, Measurement, and Analysis*. Washington DC: The Aspen Institute.

Judge K. and Bauld L. (2001) Strong theory, flexible methods: evaluating complex community-based initiatives, *Critical Public Health*, 11:1, 19-38.

Judge K. et al (1999) *Health Action Zones: learning to make a difference*. www.haznet.org.uk.

Mackenzie M., Lawson L., Blamey A. and Judge K. (2001) *Analysis of NDC Delivery Plans within the Health Domain*, Glasgow: University of Glasgow.

Pawson R. and Tilley N. (1997) *Realistic Evaluation*. London: Sage Publications.