# Evaluation Capacity Building in Primary Prevention: Learning Enquiry Final Report

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# EXECUTIVE SUMMARY

Monitoring, Evaluation and Learning (MEL) is vital in primary prevention work, providing practitioners with the evidence they need to understand what works, for whom, and why. Ultimately, MEL enables systemic improvement of primary prevention work, creating better outcomes for communities. MEL plays a key role in facilitating community voice, and ensuring that participant perspectives and experiences are more visible to decision makers. This report addresses the key question: **How can MEL capacity most effectively be strengthened within the primary prevention system in Melbourne's west?**

While many prevention organisations and practitioners have some capacity to conduct MEL, and in many cases are undertaking substantial activities, there is a need to increase the level of meaningful MEL work presently occurring within the primary prevention system. The Department of Health (DH), VicHealth, and evaluation capacity builders such as Primary Care Partnerships (PCPs) have important roles to play in this work alongside other sector partners.

This report presents the findings of an Evaluation Capacity Building Learning Enquiry commissioned by HealthWest Partnership to better understand blockages and opportunities for developing primary prevention evaluation capacity. The Learning Enquiry builds on HealthWest's one and a half years of evaluation capacity building (ECB) in the primary prevention sector in Melbourne's west and explores the broader context within which this work takes place. The findings identify key blockages and opportunities for consideration by DH and other key stakeholders in order to further develop primary prevention evaluation capacity.

Findings and recommendations are framed at the systems, organisational and evaluation capacity builder levels, and are contextualised with regard to the key actors, processes, structures and policies of the health system. The research draws on data collection and stakeholder consultation via the ECB project and Learning Enquiry, with a focus on lessons learned and opportunities for future efforts to strengthen evaluation capacity across the primary prevention system.

## Key findings

- **There is a particular need to strengthen the focus on evaluation and learning.**

The three components of MEL – monitoring, evaluation and learning – are often considered collectively. However, currently in primary prevention there is a particular need to strengthen the focus on evaluation and learning. The communities served by primary prevention activities are diverse. Effective responses to community needs rely on evidence of how well outcomes are being achieved in various community contexts, and an understanding of what enables or constrains these outcomes, as well as insights into relevance, appropriateness, and sustainability of program design and delivery. Gathering and sharing evidence and learning through evaluation can support greater collective effort and enhance the ability of the primary prevention system to achieve its intended impacts.

- **There are gaps in well designed and effectively coordinated MEL capacity building at the systems level, and agencies with stewardship roles have a key role to play in enabling systems change.**

MEL capacity building involves work at three main levels: system, organisation, and practitioner. Capacity built at each of these three levels supports increased activity and capacity at the other levels. While there

have been some successes within primary prevention in building MEL capacity at practitioner and organisational levels, there are gaps in well-designed and effectively coordinated MEL capacity building at the systems level. Addressing systemic barriers and taking up system-level opportunities will assist in enhancing MEL capacity at the organisational and practitioner levels, enabling substantial gains for effective, efficient primary prevention programming. Agencies with system stewardship and planning roles, including DH and VicHealth, have key roles to play in enabling system level changes that support effective MEL.

- **Specialist evaluation capacity builders can support other organisations to implement meaningful MEL process, and HealthWest and other PCPs have an existing track record in this area.**

There is a need to actively support organisations working in primary prevention to undertake fit-for-purpose MEL. Specialist evaluation capacity builders provide vital skills, knowledge and experience which support other organisations to implement meaningful MEL processes. Interagency collaboration is a foundation for strong prevention interventions; it is also an important enabler for MEL capacity building. Evaluation capacity builders can bring organisations and practitioners together to build skills, undertake collaborative learning and share their experiences to further evidence-based practice. System-level changes will support these processes to occur. HealthWest and other PCPs have expertise and an existing track record in evaluation capacity building roles, and it is important that this function is not lost in future structural changes to the primary prevention system.

## Systems level

The prevention system is complex. Capacity building at this level requires a holistic and integrated approach that encompasses multiple levels and actors, influential relationships and linkages, inter-organisational relations and institutional culture, values, norms and paradigms (VicHealth, 2008). There are a number of key actors, policies, processes and structures within the primary prevention system which have potential to influence MEL capacity. These provide leverage points for elevating evaluative capacity within the system.

DH and VicHealth are important systems actors with the power to make positive changes to MEL capacity which can ultimately improve primary prevention practice. This can be progressed through a variety of strategies including ensuring that MEL is properly supported and resourced, funding advisory roles, and more consistently building evaluation activities into funding contracts. In addition to this, there are opportunities to build on areas of current momentum, including working with other systems actors to further develop a stronger, shared understanding of the issues affecting evaluation capacity and culture within the primary prevention space, potentially utilising an Evaluation Needs Assessment approach. Current changes to the prevention system such as the revision of DH's *Community Health – Health Promotion guidelines* also presents an opportunity to actively strengthen the sector's focus on learning-focused outcomes evaluation and service improvement. This could contribute to building and encouraging a strong evaluative culture, and overcome some of the perceived blockages at a systems level.

There are also a broader range of actors within the system who could benefit from, and/or contribute to, evaluation capability building. These include peak bodies, specialist evaluation capacity builders (such as consultancies or other PCPS), educational institutions (such as universities) and other community and community health organisations working in Melbourne's west and more broadly.

## Organisational level

In addition to system-level work, there are substantial organisational-level opportunities to lead and support evaluative thinking and practice. The diversity of organisations working in primary prevention

means that there is no single 'catch-all' approach that will work for every organisation in the system. However, there are common issues and areas of opportunity which apply to many organisations.

Organisational commitment at the leadership level is crucial for developing organisational cultures that are supportive of MEL. This can be assisted though shifting perceptions away from MEL as a compliance reporting requirement, and focusing on its value in supporting organisations, project teams and individual practitioners to make more informed decisions, leading to better outcomes for communities. Financial and in-kind investment in MEL at an organisational level (money, staff and time) are also important enablers for building MEL capacity and undertaking effective evaluation. Negotiating dedicated resourcing allocations for undertaking evaluation and learning as part of project and service contracts can assist in dealing with this issue.

Organisations also need support to develop a range of other elements that support sustainable fit-for-purpose MEL. These include development and documentation of clear processes and guiding frameworks, provision of fit-for-purpose tools to collect, manage and report on data, broader organisational systems for knowledge management and learning, and supportive relationships with other MEL practitioners and providers, internally and externally.

## Evaluation Capacity Builders

Evaluation capacity builders have a specialist role in building MEL capacity at system, organisational and/or practitioner level. ECB is a field with a long history and there is now substantial academic research and practical experience available in this area. HealthWest's ECB project and Learning Enquiry have added further localised, prevention-focused learning to this body of knowledge.

Effective evaluation capacity building requires expert knowledge of relevant forms of MEL, a strong understanding of the sector context in which MEL efforts are occurring, and sound collaborative relationships between capacity builders and sector partner organisations. HealthWest and other PCPs have been well placed to lead this work in primary prevention. Peak bodies and evaluation providers such as consultancies and universities also play significant roles in organisational and sector MEL capacity building.

To be most useful, evaluation capacity building needs to be targeted to all levels of participating organisations, and activities tailored to address the diversity of issues faced by participants. The Evaluation Capacity Health Check tool (developed as part of HealthWest's ECB work) or other Evaluation Needs Assessment tools are helpful in identifying strengths and gaps in evaluation capacity, and focusing capacity building strategies. Building sustainable, effective MEL processes takes time, and works best when small-scale MEL approaches are successfully implemented, demonstrate their value, and can then be expanded and built on. ECB therefore needs to be seen as an investment over a minimum of a five-to-ten-year timeframe, rather than a brief intervention.

It is important to recognise and build on these learnings as the PCPs transition to the Local Public Health Units (LPHUs), and to leverage the unique MEL skillset and experience that PCPs bring to the Units. Continued investment is needed in the people and organisations who have the expertise to build primary prevention MEL capacity, in order to strengthen collective work towards meaningful evaluation and ensure that primary prevention practice and programming continue to improve.

# Recommendations

## Recommendations for systems level actors

1. ***DH to explore opportunities to resource the provision of tailored advice, guidance and support for primary prevention organisations, for example, through a MEL support team***
2. ***Consider allocating a percentage of primary prevention funding contracts (for example, minimum 10%) to be dedicated to monitoring, evaluation and learning activities.***
3. ***Work with other systems actors to further develop a stronger, shared understanding of the issues affecting evaluation capacity and culture within the primary prevention space. This could utilise a broader Evaluation Needs Assessment approach, including development of a systems level version of the Evaluation Capacity Health Check.***
4. ***Consider the development of a sector-wide evaluation agenda, identifying priority areas for further investigation.***
5. ***Consider funding and partnership models that generate and incentivise trust, collaboration and shared learning between organisations working in the primary prevention space.***
6. ***Continue to support and resource the work of evaluation capacity builders, such as HealthWest, to ensure their experience and expertise in primary prevention MEL is maintained and built upon as sector structures change.***
7. ***Further develop partnerships with community organisations to ensure future evaluation capacity building is co-designed, fit for purpose and builds on existing knowledge.***
8. ***Encourage and support primary prevention organisations to seek funding from and partnerships with philanthropic funders in order to provide space and resources to extend their MEL activities and further build capacity, or try new approaches.***
9. ***Explore and encourage further learning partnerships with educational bodies such as La Trobe and Victoria Universities, and the Australian Evaluation Society, to build evaluative capacity.***
10. ***Use the revision of DH's Community Health – Health Promotion guidelines as an opportunity to actively strengthen the sector's focus on outcomes evaluation, learning and improvement, whilst taking into account the diverse nature of prevention programming.***

## Recommendations for primary prevention organisations

1. ***Work with evaluation capacity builders such as HealthWest to co-design and participate in capacity building training specifically for organisational leaders (managers, executives and directors), that equips them to lead staff in the development of evaluation culture and systems within their organisations.***
2. ***Invest in the development of Theories of Change and MEL Frameworks at organisational and program/service levels to enable well-designed, coherent evaluation.***
3. ***Explore options for allocating a percentage of staff time to be dedicated to undertaking MEL work (for example, a set percentage or a portion of certain position/s). This can be included within position descriptions.***

4. ***Routinely use and integrate tools like the Evaluation Capacity Health Check (or similar Evaluation Needs Assessment tools) with organisational planning and development cycles, to assess capacity, track progress, and identify priority areas for development.***
5. ***Develop data collection systems that enable key MEL data to be efficiently collated and reported.***
6. ***Review team and organisational level processes (meetings, planning sessions) to identify opportunities to build in evaluative and reflective thinking.***
7. ***Map compliance reporting requirements and negotiate with funders to simplify and streamline these to enable more MEL resource to be focused on evaluation and learning.***
8. ***Where possible, work in partnership with peak bodies and other agencies to attract ECB funding targeted to sector needs.***

## Recommendations for Evaluation Capacity Builders

1. ***Continue to prioritise, invest in and deliver good practice evaluation capacity building initiatives, using fit for purpose suites of activities which respond to identified organisational needs and also promote partnership and collaboration.***
2. ***Leverage any opportunities presented by the revision of DH's Community Health – Health Promotion guidelines to further extend and embed MEL capability building opportunities.***
3. ***Work with the managers and leaders of primary prevention organisations to nurture engagement and participation in ECB at multiple levels of the organisation, support leaders to build their own MEL knowledge, and help transfer individual capacity gains to team or organisation level changes.***
4. ***Ensure that future capacity building initiatives undertake consultation with participants to understand needs and existing capacities and strengthen relevance of training.***
5. ***Continue to consult with partners and practitioners about the timing, length and practicalities of future ECB activities, to help minimise barriers to participation.***
6. ***Explore alternative models for facilitating, growing and strengthening engagement with MEL Communities of Practice, as a place to share success stories and peer learnings, collaboratively develop MEL resources for organisations, and advise on future ECB initiatives.***
7. ***Consider further refining training and learning modules developed through the ECB project to extend their reach - potentially including on demand delivery to organisations when needed, and/or flexible, short segments or recorded webinars.***
8. ***Consider the development of common, fit for purpose MEL tools and templates that can be shared with participants to support their MEL practice following training and learning, and/or a MEL handbook.***
9. ***Ensure future ECB projects include their own monitoring and evaluation processes, which will enable Evaluation Capacity Builders and partners to respond and improve projects in real time, and to learn and reflect about what needs to change in terms of evaluation culture.***

# CONTENTS

# 1 INTRODUCTION

MEL is vital in primary prevention work, providing practitioners with the evidence they need to understand what works, for whom, and why. Ultimately, MEL enables systemic improvement of primary prevention work, creating better outcomes for communities.

This report presents the findings of HealthWest Partnership's Evaluation Capacity Building Learning Enquiry, addressing the overarching question: **How can MEL capacity most effectively be strengthened within the primary prevention system in Melbourne's west?**

## 1.1 Focus of Learning Enquiry

The Learning Enquiry and this report have a dual focus. The first focus is the system level drivers which affect evaluative practice, together with a deeper dive into the challenges and opportunities for organisations and staff in embracing evaluative thinking and practice. These system and organisational level findings are presented and contextualised within the primary prevention system, along with opportunities and recommendations for consideration by the DH, VicHealth, and other key systems actors. The second focus is to evaluate and reflect on HealthWest's recent ECB project and identify future opportunities for evaluation capacity builders working in the primary prevention space.

Consistent with these areas of focus, the Learning Enquiry was guided by three key questions, which also shape this report:

1. What drivers are required, at a systems level, to elevate evaluative thinking and practice in the primary prevention space?
2. What is needed at the organisational level to lead and support evaluative thinking and practice within agencies, services and organisations?
3. What impacts have HealthWest's work towards evaluation capacity had for individuals, teams and organisations working in primary prevention in Melbourne's west?

Findings and recommendations are framed at the systems, organisational and evaluation capacity builder levels, and are contextualised with regard to the key actors, processes, structures and policies of the health system.

While the DH and VicHealth have been identified as prospective primary audiences of this report, many of the findings and recommendations are relevant for, and may be of interest to, organisations and other actors working in the primary prevention system.

## 1.2 Primary prevention sector context

The primary prevention sector in Victoria has been undergoing a period of change and reorientation. There is a recognised need for organisations funded by the Department of Health's Prevention and Population Health stream, as well as local government planners working on municipal public health and wellbeing plans, to better demonstrate the outcomes of their collective efforts and align monitoring and reporting with the *Victorian public health and wellbeing outcomes framework*. While many prevention organisations and practitioners have some capacity to conduct MEL, and in many cases are undertaking substantial activities, there is a need to increase the level of meaningful MEL work presently occurring within the primary prevention system.

At the same time as this emphasis on measuring the outcomes of prevention work increases, the primary prevention sector in Victoria has also been shifting away from traditional program models towards more collective action that creates systems change. These shifts push the prevention workforce into emerging and developmental territory. Increasingly organisations are required to move away from traditional evaluation approaches into navigating complex, emergent approaches to evaluation, and towards the challenges of implementing shared measurement. Organisations' evaluation capacity has therefore been stretched. There is a pressing need to provide supports that not only strengthen technical skills, but also create a space where agencies can feel comfortable navigating complexity together and recognise that no one agency has all the solutions.

The COVID-19 pandemic and associated impacts further add to the complex and changing nature of the primary prevention space, and serve to further highlight the need for organisations to act in agile and effective ways, with an ability to consistently evaluate and re-evaluate community health responses.

Over the past 21 years, PCPs have played an important role in improving sector coordination to meet community needs, strengthening the primary prevention evidence base and building capacity and capability. In 2022, PCPs will transition to the LPHUs and consideration is underway regarding how the functions performed by PCPs will be able to be fulfilled within the new structure.

Overall, the sector context is one of increasing complexity alongside increasing emphasis on well-designed, fit-for-purpose MEL.

## 1.3 HealthWest's Evaluation Capacity Building project

Recognising the need to support effective MEL within the primary prevention sector, during 2019-21 HealthWest led work to better understand and build the sector's capacity to monitor, evaluate and learn from primary prevention efforts in Melbourne's west.

HealthWest's ECB project was guided by the Western Region Primary Prevention Taskforce and delivered in collaboration with DH (Phases 1 & 2) and consultants Cultivating Change. Convened by HealthWest, the Taskforce is made up of 13 partner organisations working together to strengthen collaborative, cross-sector efforts to promote the health and wellbeing of communities and to prevent ill health before it occurs. The key aims of the Taskforce are to raise the profile of primary prevention in the region, to build capacity at a systems level, and support the alignment of resources and primary prevention efforts. The Taskforce played a key role in the design and delivery of the ECB project, as well as broader capacity building efforts.

The work involved three project phases over a period of 18 months:

1. The development and implementation of an Evaluation Capacity Health Check tool
2. Consideration of a regional Evaluation Capacity Building Plan
3. Piloting of Workforce Evaluation Capacity Building activities.

Appendix 1 provides a more detailed outline of the project phases.

## 1.4 Learning Enquiry process

The ECB Learning Enquiry builds on HealthWest's ECB project. HealthWest initiated the Learning Enquiry to gather and share insights on evaluation capacity building at the systems, organisational and practitioner levels. Lirata Consulting was commissioned to facilitate and report on the Learning Enquiry, and the process

was conducted in partnership between Lirata and HealthWest, with HealthWest providing crucial input into the design, planning and data collection phases.

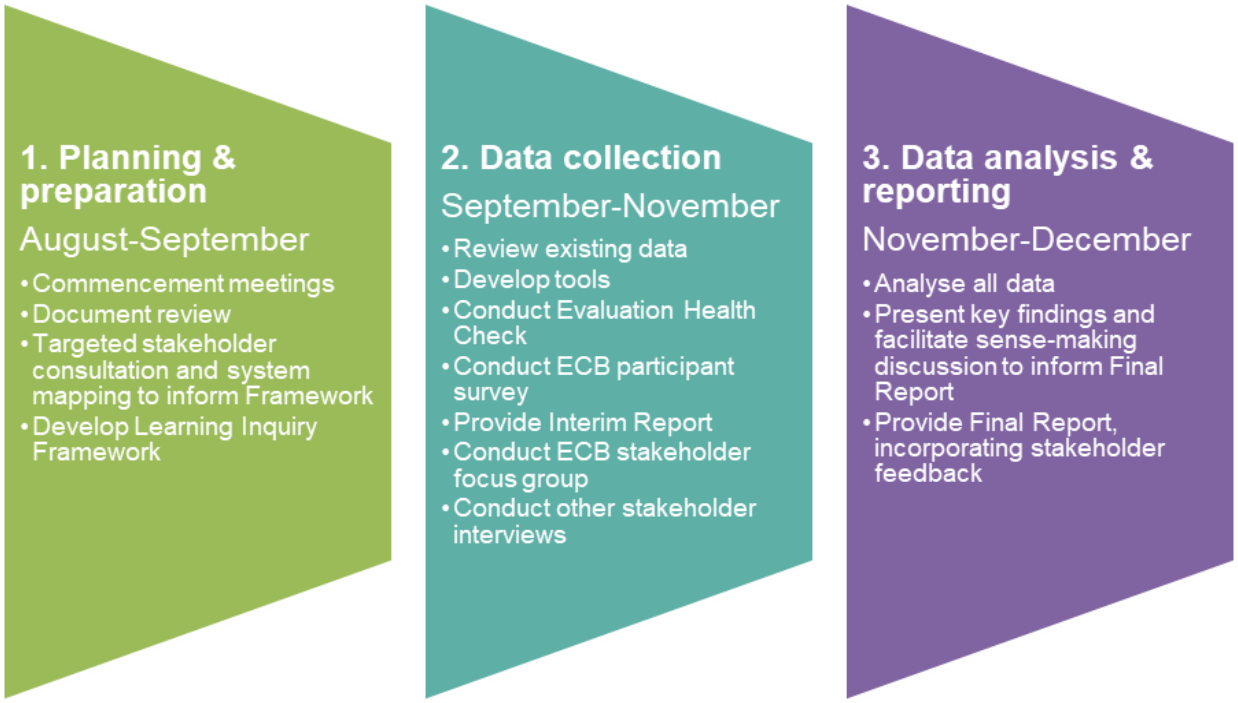
The key team members contributing to the Learning Enquiry for Lirata included: Alex Gruenewald (Project Lead), Kate Randall (Project Oversight), Mark Yin (Data analysis), Pam Kennedy and Mark Planigale (Project Advisors).

The Learning Enquiry design phase included a systems mapping exercise, which provided a strong base for understanding the primary prevention system, the actors involved and their relationships and influences. This exercise involved strong input from HealthWest staff.

Lirata's team then worked independently to gather data and feedback from stakeholders through focus groups (n = 9 participants), interviews (n = 11 participants) and a survey (n = 19 responses). Key stakeholders represented in data collection included staff of HealthWest and Cultivating Change, state and local governments, peak bodies, community health providers and women's health organisations. All ECB project participants were invited to participate in the online survey.

Data was analysed and integrated with evidence from ECB literature and Lirata's own ECB experience. Stakeholders provided feedback on Lirata's preliminary findings and recommendations, which, in addition to helping contextualise the findings, also closed the feedback loop for the Learning Enquiry and helped build broader ownership of the recommendations. Further information on these elements of the Learning Enquiry methodology can be found in Appendix 2.

FIGURE 1: LEARNING ENQUIRY PHASES




The Learning Enquiry report was prepared and finalised by Lirata with strong input from key HealthWest staff.

# 2 EVALUATION CAPACITY BUILDING MODEL

We know from decades of experience and research that evaluation capacity building works best if certain approaches and conditions are present. **Evaluation capacity** is the ability of an individual, organisation or collective to continuously ask questions about quality and value; to collect, analyse, interpret and report on evidence; and to use evidence to inform decision-making and action (HealthWest Partnership, 2020). In order to build evaluation capacity, people, organisations and society need to strengthen, create, adapt and maintain capacity to produce and use evaluation to effectively support accountability and learning. They do this through enhancing individual skills and knowledge, organisational systems and policies, and creating an enabling environment (OECD, 2021). Key literature describes a meta-theory of behaviour change, which includes equally increasing motivation, capacity (or capability), and opportunity, to create an enabling environment in which capacity can develop and practice can sustainably change (Michie et al, 2011).

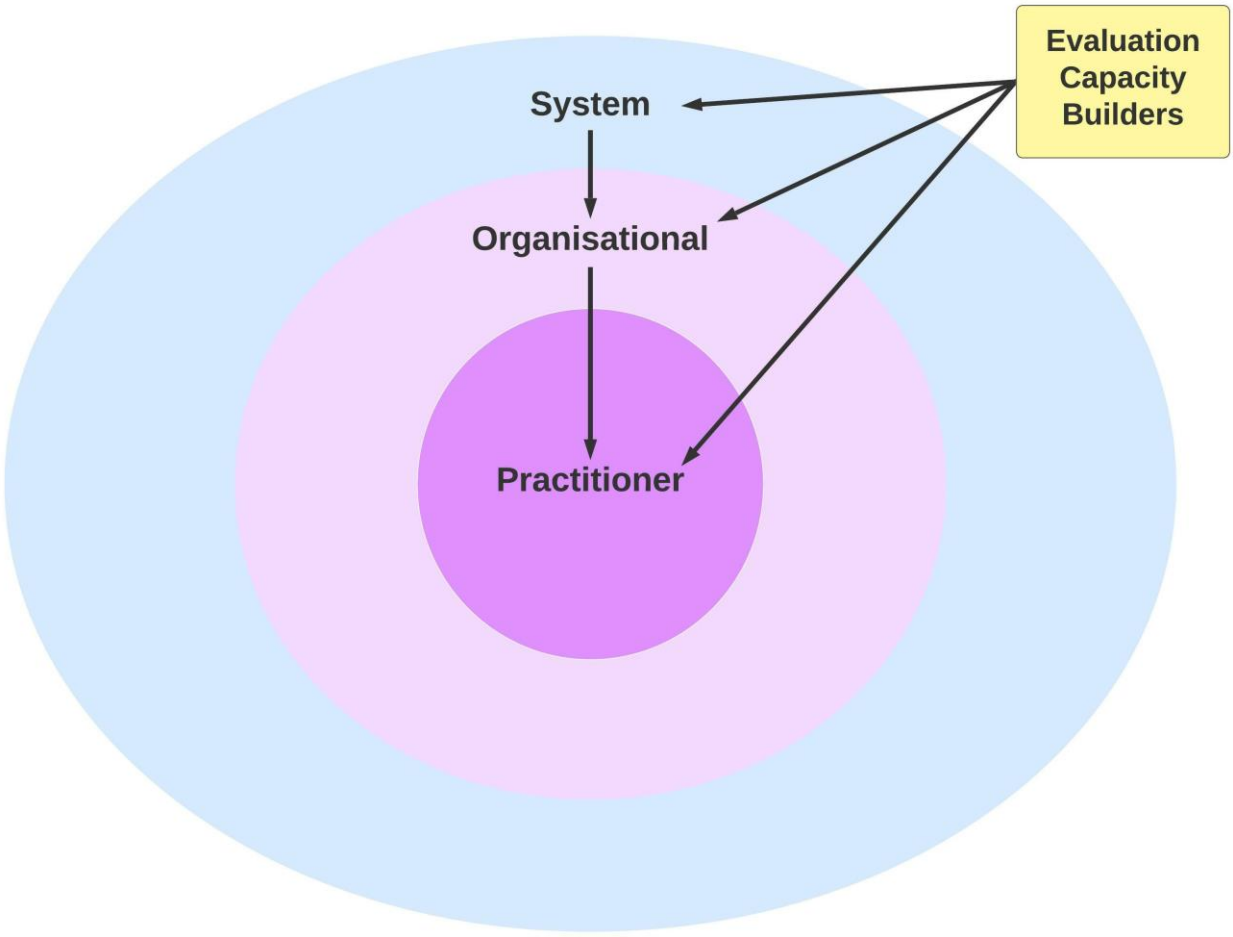
ECB takes place at different levels:

- **Systems level** – the overall primary prevention system, including actors, policies, processes and structures. ECB at this level involves incentivising and creating an enabling environment for actors at lower levels to undertake quality evaluation and learning, and leadership in building capacity and culture.
- **Organisational level** –particular agencies within the primary prevention system, including service providers, funders, policy and research bodies and others. ECB at this level involves ensuring organisations are properly resourced to conduct MEL work, with strong cultures of learning, and leadership which values this kind of work.
- **Practitioner level** – individual people with roles related to primary prevention, for example organisational staff, Board members, consumer representatives or others. ECB at this level involves building knowledge, skills, confidence, and attitudes toward MEL.

We know that leadership and coordinated action at the systems level, organisational level and individual practitioner level are all important in building sustainable, fit for purpose MEL. All layers need attention (Boyle and Preskill, 2008), and there are reinforcing dynamics between these levels. It is important to understand and address any systemic blockages, and act on existing momentum and relevant opportunities at the systems level, in order to realise cascading change at the lower levels. However, increased MEL capacity at practitioner level is also an enabler for increased MEL capacity at organisational and system levels; and organisational MEL capacity in its turn influences system approaches and supports the development of individual MEL skills and knowledge.

**Evaluation capacity builders** are individuals or organisations who play a leading role in strengthening evaluation capacity, through developing others' skills, knowledge, confidence, MEL processes, frameworks, tools, collaborative MEL relationships, and more. The most effective ECB approaches involve evaluation capacity builders working to strengthen capacity at each of the three key levels (system, organisation and practitioner), although different capacity builders may focus on different levels. The three ECB levels, and the roles of evaluation capacity builders across these levels, are represented conceptually in Figure 2 below.

FIGURE 2: EVALUATION CAPACITY BUILDING




ECB at systems level involves adjusting processes, structures and policies to enable and encourage MEL, and engaging a range of systems actors in collaborative work to strengthen their investment in meaningful MEL. Evaluation capacity building at this level can incentivise actors at lower levels to undertake quality evaluation and learning, through developing a stronger, shared understanding of the issues affecting evaluation capacity and culture within the system. It can also incentivise and provide space for other actors to conduct evaluation which is contextually relevant, through the provision of funding and support (including training) to enable this work. Evaluation capacity building at a systems level means increasing motivation and capacity (or capability). It involves strong leadership and encouraging coordinated and collective action.

Organisational evaluation capacity building is the improvement of organisational leadership and culture, systems and structures, and capability to undertake collective MEL efforts. Decisions made by leadership must seek to embrace learning, and ensure MEL activities are adequately resourced with time and staff. When organisational leaders build learning cultures, staff feel that they can be transparent about any project failures or mistakes made, and have space to reflect and learn from them. Improving systems and structures includes information systems, outcomes frameworks and indicators, and the ability to undertake systematised monitoring, evaluation, reporting and learning processes.

Building evaluation capacity at the practitioner level is closely related to the organisational level. Staff need opportunities to develop specific MEL skills, including proficiency in identifying key questions, determining what data is required to answer questions, collecting data using appropriate strategies, and analysing

collected data. Staff evaluation capacity building also focuses on building the confidence of staff to conduct MEL activities by providing time and space for reflection and learning, and ensuring responsibilities are included in roles. Staff need to see value in MEL, and, through experience, understand how utilising MEL can improve outcomes within their work. When findings are developed, practitioners then need to be able to understand, summarise, share and use the findings in their work (Baker et al, 2014).

**Evaluation Needs Assessment** is a process through which we can identify the MEL capacities and areas for development within a team, organisation or system. It involves looking at the ways that data collection, analysis, reporting, reflection and learning currently occur, and how they could be strengthened. It also considers the types of MEL that would be most useful for achieving organisational or system goals. This can lead to the development of an action plan to strengthen MEL capacity, which can then drive evaluation capacity building efforts (Planigale and Randall, 2021).

HealthWest's ECB project had a significant Evaluation Needs Assessment component. The Evaluation Capacity Health Check (ECHC) Tool was developed as the key baselining tool for organisations who participated in the project and allowed an evidence-based Evaluation Needs Assessment to be undertaken by each participating organisation. The tool provided a resource that enabled organisations, or departments and subsets within them, to assess their current evaluation systems and strategy. Data from the ECHC baseline assisted the development of shared capacity building priorities and informed the focus of capacity building training delivered through the ECB project. The Health Checks were also intended to be the starting point for a regional evaluation capacity strengthening plan, which would be based on aggregated results and agreed strategies, however, amidst the impacts of the COVID-19 pandemic, the plan was set aside in favour of more easy-to-action ECB activities (such as workforce capacity building).

Boyle and Preskill (2008) highlight the importance of employing multiple strategies when designing evaluation capacity building interventions. They suggest selecting from a suite of 10 different modes, including activities such as internships, participation in evaluations, training, CoPs, technical assistance and coaching, and more. It is crucial to not rely on one of single type of activity or one consistent blend of modes, but to ensure that the mix of activities is specifically designed around the needs, existing capacities, context and engagement levels of the participants.

The ECB project aimed its capacity building efforts primarily at the staff capacity level (see 2.1 and 2.2 in Figure 3 below).. Figure 3 outlines the components of MEL capacity identified within the ECHC Tool.

FIGURE 3: EVALUATION CAPACITY HEALTH CHECK CAPABILITIES (HEALTHWEST, 2021)

| | |
|---|---|
| **1 Leadership and Culture**  | 1.1. Organisational leadership |
| | 1.2. Attitude to investigation, learning, risk taking and change within the organisation/team |
| | 1.3. Decision making by leaders within the organisation/team |
| **2 Staff Capacity**  | 2.1. Time for strategic thinking and reflection |
| | 2.2. Experience and skills for MEL |
| | 2.3. MEL responsibilities within staff roles |
| **3 Systems and structures**  | 3.1. Outcomes framework and associated indicators |
| | 3.2. Information systems |
| | 3.3. Stakeholder engagement (including co-design) within MEL activities |
| | 3.4. Systematised monitoring, evaluation and reporting |
| | 3.5. Systematised learning and outcome sharing processes |
| | 3.6. Funding to support the implementation of MEL activities |
| **4 Collective MEL efforts**  | 4.1. Alignment of outcomes and indicators with the collective MEL effort |
| | 4.2. Alignment of data collection tools with the collective MEL effort |
| | 4.3. Sharing relevant data with the collective MEL effort |
| | 4.4. Participation in the design, implementation and learning of collective MEL systems |
| | 4.5. Support from the collective MEL effort to enable participation |

# 3 FINDINGS: ECB AT SYSTEM LEVEL

This section of the report addresses the question ***'What drivers are required, at a systems level, to elevate evaluative thinking and practice in the primary prevention space?'***

There are a range of approaches to systems analysis. The approach adopted in this Learning Enquiry examined four key aspects of the primary prevention system in Victoria: **actors** (and their relationships to MEL capacity within the system), **processes**, **structures**, and **policies**. Each of these aspects potentially offers leverage points for strengthening MEL capacity.

In this section, each of the four aspects is discussed in turn, with findings regarding challenges and opportunities they offer for system-level evaluation capacity building. The systems analysis was informed by data collection and analysis including:

- A systems mapping exercise using an adapted actor mapping approach (FSG, n.d.) undertaken through a workshop facilitated by Lirata with three key staff members from HealthWest. The process identified evaluation of primary prevention activities as the central issue, and investigated the strength of the relationships between the different groups of stakeholders and this central issue.
- Interviews and focus groups with Learning Enquiry participants.
- Further analysis conducted by Lirata and HealthWest.

## 3.1 Actors

This section discusses the actors present within the primary prevention system, and their roles in relation to evaluation capacity building.

The primary prevention system involves a diverse range of actors with different roles. These can be grouped into **six main types of actors**: community health and community organisations, government, funding bodies, educational institutions, peak bodies and evaluation capacity builders.

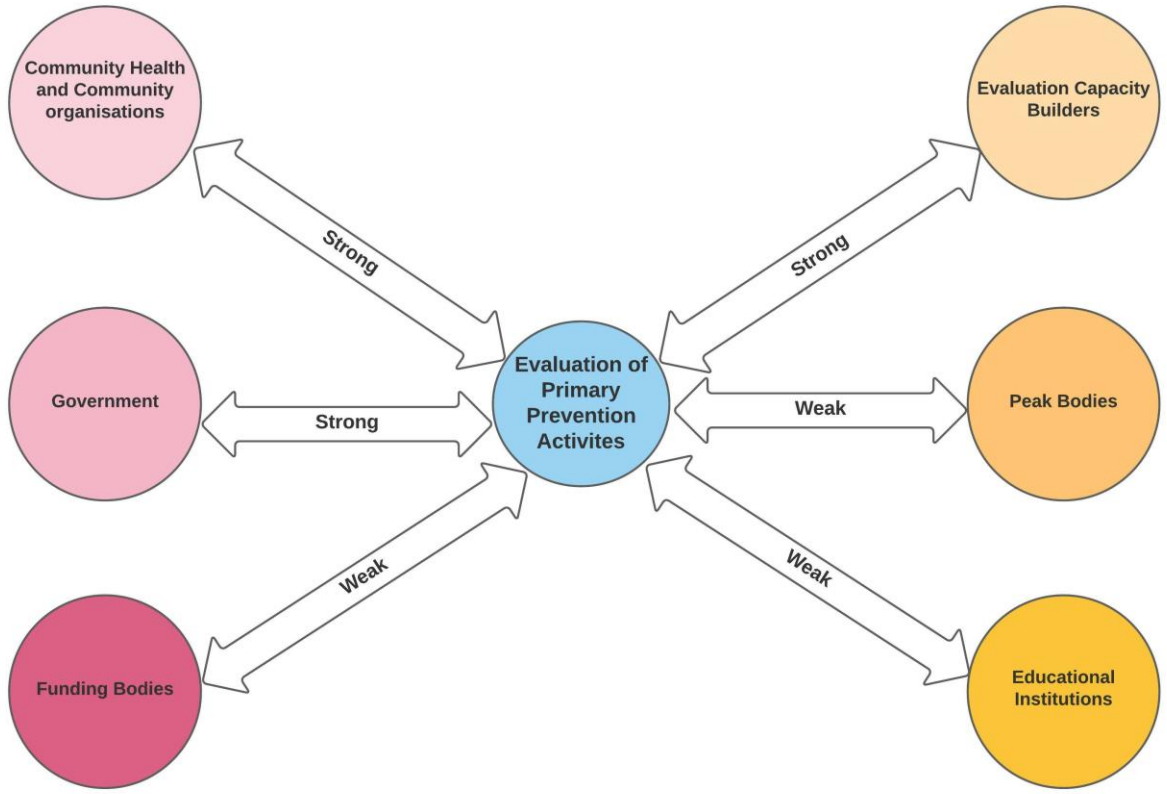
The actor mapping process identified some of the key actors within each of those types (arranged into 'quadrants'), and discussed and ranked the relationship that each of the quadrants had as a whole with the central issue – the evaluation of primary prevention activities. The list of actors is not exhaustive, and a much larger process would be required to have a complete representation of all actors within the system. Table 1 summarises the quadrants and provides examples of key actors within them, while Figure 4 summarises the strength of relationship between each quadrant and the central issue. Some organisations have more than one role and sit in multiple quadrants. The focus is on HealthWest's catchment in Melbourne's west, however a similar analysis could easily be extended to cover other regions.

TABLE 1: KEY ACTOR QUADRANTS WITHIN PRIMARY PREVENTION SYSTEM IN MELBOURNE'S WEST

| QUADRANT | KEY ACTORS IDENTIFIED |
|---|---|
| Community Health and Community organisations | • cohealth<br>• Djerriwarrh (Western Health)<br>• IPC Health<br>• Other HealthWest member organisations<br>• Western Bulldogs Community Foundation |

| QUADRANT | KEY ACTORS IDENTIFIED |
|---|---|
| Government | • State government (Department of Health, and Department of Families, Fairness and Housing - local and central)<br>• Local governments - Melton, Wyndham, Hobsons Bay, Brimbank and Maribyrnong<br>• Primary Health Networks (PHNs) |
| Funding Bodies | • Department of Health<br>• Philanthropic funders<br>• VicHealth<br>• Western Melbourne Partnership/Metropolitan Partnership |
| Educational Institutions | • Australian Evaluation Society<br>• La Trobe University<br>• Victoria University |
| Peak Bodies | • Victorian Healthcare Association (VHA)<br>• Our Watch<br>• Domestic Violence Resource Centre Victoria (now known as Safe & Equal)<br>• Victorian Primary Care Partnerships (VicPCP)<br>• Centre for Multicultural Women's Health<br>• Victorian Council of Social Services |
| Evaluation Capacity Builders | • Primary Care Partnerships<br>• Consultants including such as Lirata, Cultivating Change, Rooftop Social, and others<br>• Australian Prevention Partnership Centre<br>• Primary Health Networks (PHNs) |

FIGURE 4: STRENGTH OF RELATIONSHIP BETWEEN KEY ACTOR QUADRANTS AND ECB



## Findings and opportunities

The actor mapping process provided insight into system-level challenges and enablers, which help to identify where efforts to influence evaluation capacity building may be best focused.

Strong influential relationships have been developed through building bridges between diverse partners within the system - particularly amongst members of the Western Region Primary Prevention Taskforce ('the Taskforce') - including community and community health organisations, members of government and evaluation capacity builders. Participants in the actor mapping exercise highlighted this "bridge building" as an important aspect of their work during the ECB project. Similarly, HealthWest's work with consultants led to the development of capacity building tools and processes that were informed by engagement with primary prevention practitioners and applied learning.

Greater challenges were identified in influencing state government departments in relation to raising evaluation capacity in and across the system, and in strengthening the participation of organisational leaders in evaluation capacity building initiatives.

These relationships of influence resonate with some of the key findings from the Learning Enquiry. **Buy-in from organisational leadership is crucial** to building evaluation capacity amongst staff. Systems leaders who already have influential relationships with organisational leaders therefore have an important role to play in continuing to ensure that organisational leaders are engaged in, and understand the importance of, MEL activities

Another key challenge in nurturing collective MEL efforts and shared learning is that **the current primary prevention funding environment essentially places organisations in competition with each other for funding, which limits organisations' confidence or willingness to share lessons learned through MEL**. As the primary prevention space has many service providers and a limited amount of funding, there is a reluctance to share project or service learnings that may be perceived as failures - either with funders or with potential collaborators working within the space. A number of Learning Enquiry participants reported that involving multiple organisations in capacity building activities together led to a reluctance to share information around failings.

> *"Competition and fears about sharing performance on broader platforms are a barrier. People afraid to say that things didn't work out. The nature of work does set us against each other at times. It's a barrier to collectively sharing data." - Program staff interview*

> *"Sometimes it seems like there is a reluctance to share information that could be perceived as unsuccessful"- Senior Stakeholder Focus Group participant*

Similarly, there can be a hesitance to share the details of innovative new models with the sector until agencies initiating these models have received funding commitments for them.

A challenge for HealthWest's ECB project was to create the pathways needed to **generate trust between partners, in order to move towards processes like shared measurement**. While the ECB project brought together practitioners from a number of Taskforce organisations, this has not yet directly translated into the development of new partnerships or collaboration between participating organisations. This challenge remains, and comes with tangible opportunities for system level actors to influence positive change. Trust could potentially be built through increasing the enabling environment, and systems leadership which highlights that all primary prevention players are working towards a common goal. There is momentum

through the open and trusting culture within the Taskforce, which could be built upon to further enhance evaluation capacity and encourage shared measurement.

> *"We do come together as health planners to network in this space, to have some common understanding of areas where they can work together." - Senior Stakeholders Focus Group participant*

One potential lever that system level actors could use is **encouraging an evaluative culture, where lessons and challenges from prevention programs can be shared among organisations to inform project planning and improve outcomes** for communities.

Actor mapping also identified **a broader range of stakeholders within the system who could benefit from, and/or contribute to, evaluation capability building**. There are opportunities to draw upon the expertise of different types of stakeholders to build evaluation capacity, including several evaluation capacity builders who may not be subject to the same funding constraints which are in some ways limiting the capacity of frontline actors. These opportunities are summarised below according to the quadrants of the actor mapping, together with further consideration and analysis of potential opportunities:

### *Community/Community Health organisations*

Given the strong relationship between these organisations and MEL capacity, these actors are well placed to provide further feedback on evaluation capacity building efforts within the system. They have a strong knowledge of their local contexts, and can provide useful advice on what relevant indicators, frameworks and learning methodologies should look like. There is significant benefit to be gained from further engaging these organisations in any future evaluation capacity building work at a systems level. Using collaborative and collective methods of engagement also offers the potential for additional gains in nurturing collective MEL efforts.

### *Government bodies*

Government agencies have multiple opportunities to continue to support evaluation capacity building across the system. A promising strategy could be exploring the possibility of allocating funding for a team of MEL advisor roles, who would have an overview of the system and the challenges within it, to provide on demand support for organisations in developing their evaluation capacity. This is not without precedent in the primary prevention space. Between 2008 and 2011, VicHealth's Mental Wellbeing program employed a Research Practice Leader for Preventing Violence against Women (PVAW), a role dedicated to driving and supporting participatory, learning oriented evaluations. This Practice Leader supported five partner organisations to design and implement fit-for-purpose evaluations of their primary PVAW projects. VicHealth documented some lessons learned and good practice identified from this initiative (VicHealth, 2016), which offers some useful guidance for evaluating and building evaluation capacity in the context of broader primary prevention initiatives.

Roles like this could also include the development of log frames and evaluation frameworks, development of indicators, or facilitating learning activities such as reflections. They could also be responsible for aggregating findings and sharing common learnings from the evaluations of multiple partners, presenting a stronger overall picture. Ideally, multiple such roles could come together in a broader team of MEL specialists. For example, the Department of Education and Training in NSW has a team focused on evaluation and research. The Centre for Education Statistics and Evaluation (CESE) undertakes in-depth analysis of education programs and outcomes across early childhood, school, training, and higher education to inform whole-of-government, evidence-based decision making. The team has capacities in quantitative

and qualitative analysis, data collection, analysis of policies and capacity building. Government bodies have the opportunity and resources to actively encourage and require an evaluative and learning focus for implementing partners and are well placed to provide overarching support and resources to this end.

### *Funding bodies*

There is scope for funders, including those within and outside of government, to play a larger role in building the evaluation capacity of the system. DH, as well championing innovative funding streams, could also encourage and support sector partners to build stronger partnerships with external funding bodies, and create incentives for partners to develop these relationships. DH could develop and facilitate broader networks and partnerships which could be useful for their partners in the primary prevention space. Securing new sources of funding can provide space and resources for organisations to extend their MEL activities and further build capacity, or try new approaches. Additionally, partners could seek funding for specific activities related to learning, including funding internal MEL roles, undertaking specific program or project evaluations, or research on effective primary prevention. This approach also has significant benefits for funding bodes, as supporting evaluation capacity building work will allow their partners to better demonstrate results.

### *Educational institutions*

Although this quadrant of the system is not heavily involved in evaluation capacity building activities in the primary prevention sector, some organisations have developed formalised relationships with the education sector to further build MEL capacity. For example, cohealth currently has a partnership with La Trobe University, focused on ways to better demonstrate collective health and wellbeing improvements. There are opportunities for many other prevention system actors to expand on and build similar relationships to further strengthen evaluation capacity. Opportunities may also exist through the Australian Evaluation Society (AES) which undertakes a wide range of evaluation capacity building activities. Potential opportunities may include taking up organisational or individual practitioner memberships to access a range of MEL resources and training workshops at reduced cost, establishing a prevention focused Special Interest Group with other relevant AES members, participating in the evaluator mentoring program, and more.

### *Peak bodies*

Peak bodies were identified in the actor mapping activity as currently having a weak relationship to sector evaluation capacity building efforts. However, they are a potentially important source of information and oversight in relation to practice standards, addressing member organisations' needs and challenges, and play a key influencing role within the system. Peak bodies are a useful vehicle for providing subsidised ECB activities through their purchasing power, in partnership with ECB providers. They could also play a greater role in informing or advising on the design of evaluations and learning activities by providing a 'bird's eye view' of contextual understanding and knowledge. They could also potentially be engaged to help lead and encourage collaborative MEL efforts amongst their memberships, and in advocating at the system level to strengthen primary prevention evaluation capacity. In particular, opportunities may exist with Safe & Equal (the peak body for specialist family violence services in Victoria), given their recent merger and organisational restructure has enshrined a dedicated Primary Prevention Unit which is undertaking substantial MEL capacity building work.

### *Evaluation capacity builders*

Evaluation capacity builders - such as HealthWest and various consultants - have played a major role in building evaluation capacity amongst primary prevention organisations. A number of Learning Enquiry

participants saw value in the ECB project activities and expressed appreciation of the important role these capacity builders play. It is important to note that while evaluation capacity builders play a crucial role, they cannot be successful without changes at the system and organisational levels.

Evaluation capacity builders need continued support and resourcing from other system-level actors to help maintain and build on the substantial existing momentum and learnings that have been achieved. It is also important to ensure that capacity builders use a sound, evidence-based approach to their activities, as well as having the ability to tailor capacity building to organisational context. This includes targeting efforts to engage and build MEL capacity at different levels – including organisational leaders – drawing on the literature, and 'walking the talk' by applying MEL to their own capacity building initiatives, to further strengthen understanding of how MEL capacity can most effectively be built in the prevention space. Another opportunity, building on the positive response to the Evaluation Health Check Tool, is for further development and co-design of practical tools and processes which can be shared with and owned by partner organisations. These opportunities are further explored in Section 4 of this report.

## 3.2 Processes and structures

Within the primary prevention system (and other social service systems), actors work together to achieve results for communities through a set of processes and structures. MEL processes are most sustainable when they are embedded within these existing processes and structures, rather than being constructed as 'add-ons' that need to be implemented over and above the everyday work of the sector. System processes and structures therefore present further challenges and opportunities for MEL capacity building.

Key processes that shape the work of the primary prevention system include:

- Overall policy development and implementation, including processes of dialogue and advocacy that surround these
- Needs analysis and service and system planning, including identification of intended outcomes and structures of health care portfolios
- Funding and commissioning of services
- Data collection, information management and sharing
- Regular reporting to funders on delivery of programs, services and projects
- Other accountability, regulation and quality improvement mechanisms, including audit, standards and accreditation, etc.
- Sector coordination and integration processes including networking, referral, joint service delivery, continuity of care mechanisms, etc.
- Research and evidence building, including sharing the results of research.

In a sector which relies extensively on collaboration and collective effort, it is not surprising that many of the structures that shape the primary prevention sector's work are based on partnerships of different types. Key structures include:

- Contractual relationships between funders and service providers
- Cross-government relationships which assist in policy development and implementation of reforms
- Consultative structures such as Ministerial Advisory Councils or Consumer Advisory Committees which gather input and perspectives from the community and sector experts

- Regional and local planning and service coordination structures such as Regional Partnerships and Local Area Service Networks
- Formal sector partnership structures such as PCPs, and more informal sector networks.

Each of these processes and structures potentially have a role to play in strengthening MEL capacity. It is important to note that sector processes and structures are linked through complex relationships affected by a range of power dynamics and differing agendas. Care is needed to design evaluation capacity building interventions that are fit for purpose within this environment. When done well, inclusion of MEL elements within these system elements can help shape an enabling environment for meaningful evaluation and learning.

## Findings and opportunities

The Western Region Primary Prevention Taskforce provides a clear example of the value of **collaborative local structures** in building evaluation capacity.

The Taskforce and its participant organisations represent a key area of momentum for further building the prevention system's evaluation capacity in Melbourne's west, and beyond. Specifically, despite various constraints, there is **appetite and interest among these stakeholders to improve systemic and collaborative evaluative thinking**, including focusing more on collective planning, monitoring, evaluation and measurement.

> *"All want to do it, but given limitations with resources [it] often gets dropped. Often reduced to monitoring. Intent and desire is there" - Senior stakeholders focus group participant*

Similar structures could be supported in other regions, or consideration could be given to a collaborative state-wide structure bringing together key sector players to discuss issues of MEL in the prevention sector.

Currently there is a perception among some organisations that the focus of reporting needs to be on meeting Key Performance Indicators (KPIs) and sharing success stories, rather than learning, improvement and building the prevention evidence base. The Learning Enquiry found that system stakeholders see a pressing need to show results, which prioritises demonstrating success over learning and acts as a system level constraint to evaluative thinking. Some stakeholders also reported that this is further exacerbated by a lack of feedback loops from funders to partners - when organisations do not receive sufficient feedback on their reports to funders, it is difficult for them to understand what they need to change or how they could improve. Funders have the opportunity to provide feedback on reports, and to **broaden reporting requirements to seek evidence of outcomes and lessons learned, which can complement the required KPIs and results focus**, and thereby further encourage and reinforce evaluative culture. Additionally, encouraging and reinforcing an evaluative culture can lead to improvements in organisational systems, further enhancing evaluation capacity.

HealthWest's work on the ECB project has also demonstrated the value of regional partnerships in building sector capacity. The ECB project has created momentum which, with further investment, could be leveraged and built upon. Learning Enquiry respondents praised HealthWest's work in this area, and particularly its focus and expertise on the social determinants of health, its ability to create collaborative action, capacity building work and its innovation. **HealthWest has demonstrated effective leadership in raising evaluation capacity within the sector in Melbourne's west**, and bringing issues around evaluation capacity and planning to be discussed at systemic and cross-sectoral levels. The existence and commitment

of the Taskforce, and HealthWest's willingness to coordinate this kind of collaborative work, are both useful processes and structures to have in place.

An important upcoming change in the structures of the primary prevention system is the transition of PCPs into the Local Public Health Units. In this transition, **it is vital to ensure that PCPs' role as evaluation capacity builders is maintained and supported** within the LPHUs. Primary prevention organisations have unique knowledge and skillsets – particularly relating to the social determinants of health, and in building processes, systems and engagement that encourages learning – that can powerfully complement the clinical and technical expertise of the Units. They also have a strong understanding of the local service system and experience in building partnerships and relationships. This transition presents an opportunity to integrate and leverage these complementary skills for better health outcomes.

Government can also ensure the organisations that they fund **have space and resources to complete effective evaluation work. As funders, there are opportunities to provide specific funds or a percentage of contracts which must be used for evaluation activities.** For example, a minimum of 10% of project contracts, or a fixed amount depending on project size and complexity, could be reserved for MEL activities.

There are further opportunities for systems level actors to **enable stronger evaluative capacity through reducing the burden on organisations within the system**. This could be through reviewing, streamlining and harmonising reporting processes across funding streams to reduce reporting burden and allow more focus on the evaluation and learning aspects of MEL. Additionally, data collection capacity could be improved by increasing support for commonly used database systems.

Given the oversight that DH has over the primary prevention space, significant opportunity exists to **increase the enabling environment by ensuring that MEL is considered within all policy development processes within the sector, both as an element supported within new policy frameworks, and to provide mechanisms for review and improvement of policy directions themselves**. Additionally, key systems level actors could consider ways in which MEL can be given increased emphasis in any accountability and quality improvement processes.

Systems level leadership can also support the **development of sector-level frameworks and processes that support the evaluation of outcomes, service relevance, and collaborative service delivery**, while minimising imposition of widespread compliance data collection regimes. This can be extrapolated by senior systems-level actors leading **the development of a sector evaluation priority agenda, identifying key areas where further evaluation is required**, and offering collaborative funding opportunities to service providers, evaluators and other sector partners who can work together to meet these priorities.

There are clear opportunities to build upon existing structures and processes to further advocate for, extend and strengthen evaluation capacity within the system in the future. In harnessing these opportunities, system actors should seek to use and build on the findings from the Learning Enquiry, and the tools, knowledge and resources which have been developed as a result of HealthWest's substantial capacity building work.

This Learning Enquiry has started the process of developing a shared understanding of key system drivers, blockages and opportunities. However, the system is complex and currently undergoing major change - therefore further work could help deepen understanding and better inform future evaluation capacity building efforts. It is **recommended that an Evaluation Needs Assessment approach be used to continue**

**identifying areas of strength and areas for improvement in MEL capacity at system, organisation and practitioner levels, as well as identifying the key stakeholder requirements which effective MEL processes need to serve**. This approach can build on the actors mapping commenced in the Learning Enquiry, to further develop and strengthen a shared understanding amongst all actors as to where systems change efforts can best be directed.

## 3.3 Policies

This section briefly discusses key policies, guiding strategies and plans which shape the primary prevention space and inform any evaluation capacity building efforts. Incorporation of MEL elements within these key sector frameworks potentially provides a strong leverage point for evaluation capacity building, because it enables MEL to be reinforced over the medium to long term as policies and strategies are implemented.

### National level

The *National Preventative Health Strategy 2021-2030* (Federal Department of Health, 2021) aims to create a stronger and more effective prevention system, and recognises that a whole-of-government response is required at all levels. This strategy focuses on involving other sectors and industries that have a direct impact on the health and wellbeing of Australians.

A key focus of the strategy is that effective preventive health interventions must be underpinned by evidence and incorporate evaluation to inform the knowledge base and ensure continuous quality improvement. The strategy highlights the importance of embedding and mainstreaming evaluation at every point of any project cycle. This includes building evaluation into program design, utilising and building internal and external MEL resources, and ensuring that evaluation is timely and focused on learning. The strategy highlights that:

> *"Prevention research and evaluation should be underpinned by strong partnerships between multiple stakeholders to generate the most valuable research for informing the health of Australians." (Federal Department of Health, 2021)*

The strategy also identifies linkages at the regional level as being crucial in meeting the local health needs of communities and responding rapidly - and appropriately - to public health issues and threats. These linkages can be used to create sustained, coordinated action, and lead to the development of enabling environments for change. In turn, they enable co-design with community, collection and effective use of data, development of capacity, tools and networks, and building the research and evidence base, to inform improvements and direct future efforts.

In addition to this focus on multi-sector collaboration, the National Strategy also reinforces the need for strong leadership, governance and funding of prevention work and workforce development, to enable effective workforce participation in prevention activities.

The capacity, tools and networks developed as part of HealthWest's ECB project are strong examples of evaluation capacity building that supports greater evaluative reflection and learning, and evidence-based practice, in line with the National Strategy.

### State level

At the Victorian level, primary prevention evaluation practice is largely shaped by the *Victorian Public Health and Wellbeing Plan 2019-2023* (Department of Health and Human Services, 2019) and the

associated *Outcomes Framework* (Department of Health and Human Services, 2016). These documents set out a number of key policy areas which influence evaluation capacity building efforts. Specifically, the process for selecting public health and wellbeing priorities identifies some key principles which speak to the need for strong evaluation capacity within the system, including:

> *"Data to indicate a significant contribution to the modifiable burden of disease and health inequalities in Victoria, strong evidence for what works to improve outcomes, co-benefits for improved outcomes in another area and system stewardship required to ensure a comprehensive public health approach can be taken." (Department of Health and Human Services, 2016).*

The ECB project has helped build the prevention sector's MEL capacity to deliver on these principles in Melbourne's west, and the Learning Enquiry highlights what needs to be done to continue towards fulfilling them. Specifically, the ECB project's focus on the evaluation and learning elements of MEL supports organisations and the system to gather and analyse evidence about what works (and where, for whom, and why) to improve outcomes. It is a strong example of system stewardship in relation to building evaluation capacity which takes organisations beyond monitoring and reporting on population level data or KPIs, to help them focus on continually improving primary prevention outcomes.

Additionally, VicHealth sees the PCPs as key stakeholders and is actively seeking to strengthen and extend its collaboration and partnerships with primary prevention and public health organisations. This is reflected in a number of VicHealth's engagement objectives which align with evaluation capacity building, including:

> *"Develop and enhance our relationships with a diverse range of stakeholders, create and strengthen effective partnerships, foster a culture of collaboration and innovation with stakeholders and support the health promotion activity, capacity and direction of stakeholders." (VicHealth, 2018).*

This provides clear impetus for collaboration and partnership in the primary prevention space, which aligns well with HealthWest's efforts to strengthen collective evaluation capacity.

## Findings and opportunities

While these various national and Victorian strategies provide some elements of useful guidance to focus and motivate MEL activity and capacity in the primary prevention system**, there are further opportunities in the revision and/or implementation of these strategies to strengthen the evaluative and learning lens and create a more enabling system environment.** HealthWest's ECB project aligns with and contributes strongly towards some of the key principles and enablers set out in national and state primary prevention strategies, particularly in building the capacity of the workforce and responding to the emerging threats. By working together, system-level actors can address key blockages identified through this Learning Enquiry, and enable stronger, more widespread primary prevention evaluation and learning.

The Learning Enquiry identified a key theme emerging at the systems level around **the perceived lack of an overarching primary prevention strategy**, which a number of respondents reflected upon as a potential blockage to evaluative thinking and practice. The absence of an overarching strategy for the primary prevention sector and system means that organisations may be hesitant to make decisions around outcomes measurement - including how they would attempt to undertake measurement, or which outcomes they should attempt to measure - to gain a better understanding of their own contribution within a broader complex system.

> *"People are unable to see their broader contribution to the big picture. What's our contribution - how does this tie to a bigger contribution? This makes it a bit overwhelming for people." - Project participant interview*

Sophisticated and more drilled down outcomes models linked to the *Public Health and Wellbeing Plan* and its Outcomes Framework may assist with these concerns, if they are developed in a way which enables services and programs to be associated with relevant outcomes and indicators. Recent work by Council to Homeless Persons has explored **outcomes architectures that provide a balance between commonality and diversity** across complex sectors (Planigale & Read, 2020). In developing these models, it is important to avoid approaches that narrowly define intended outcomes that may be of little relevance to many service users, or which mandate the collection of substantial sets of data that may provide little value in terms of learning and improvement.

The **current revision and release of DH's new *Community Health – Health Promotion guidelines* presents a major opportunity for developing a stronger evaluation culture within the primary prevention space**, by elevating the importance of evaluation and learning (as opposed to routine monitoring and KPIs), and formalising some appropriate Departmental requirements around outcomes evaluation which take into account the diverse community contexts and nature of prevention programs. In light of this opportunity, HealthWest's recent focus on MEL capability building is timely, providing strong foundational capacity that would help organisations hit the ground running in implementing revised guidelines with a stronger evaluative focus (which will operate for the next 4-year funding cycle).

> *"This work has primed some agencies about what might be coming – also given [the] Department an understanding of what is doable on the ground" - System stakeholder interview*

The **time required for change** is also important to consider. Even with a clear guiding strategy, it will take time to effectively align program funding cycles and organisational plans. Support for organisations to build their MEL capacity and plans in the necessary areas will be valuable throughout this process.

## 3.4 Recommendations for systems actors

1. ***DH to explore opportunities to resource the provision of tailored advice, guidance and support for primary prevention organisations, for example, through a MEL support team.***
2. ***Consider allocating a percentage of primary prevention funding contracts (for example, minimum 10%) to be dedicated to monitoring, evaluation and learning activities.***
3. ***Work with other systems actors to further develop a stronger, shared understanding of the issues affecting evaluation capacity and culture within the primary prevention space. This could utilise a broader Evaluation Needs Assessment approach, including development of a systems level version of the Evaluation Capacity Health Check.***
4. ***Consider the development of a sector-wide evaluation agenda, identifying priority areas for further investigation.***
5. ***Consider funding and partnership models that generate and incentivise trust, collaboration and shared learning between organisations working in the primary prevention space.***
6. ***Continue to support and resource the work of evaluation capacity builders, such as HealthWest, to ensure their experience and expertise in primary prevention MEL is maintained and built upon as sector structures change.***

7. ***Further develop partnerships with community organisations to ensure future evaluation capacity building is co-designed, fit for purpose and builds on existing knowledge.***
8. ***Encourage and support primary prevention organisations to seek funding from and partnerships with philanthropic funders in order to provide space and resources to extend their MEL activities and further build capacity, or try new approaches.***
9. ***Explore and encourage further learning partnerships with educational bodies such as La Trobe and Victoria Universities, and the Australian Evaluation Society, to build evaluative capacity.***
10. ***Use the revision of DH's Community Health – Health Promotion guidelines as an opportunity to actively strengthen the sector's focus on outcomes evaluation, learning and improvement, whilst taking into account the diverse nature of prevention programming.***

# 4 FINDINGS: ECB AT ORGANISATIONAL LEVEL

This section addresses the question ***'What is needed at the organisational level to lead and support evaluative thinking and practice within agencies, services and organisations?'*** It sets out some of the key levers that organisations can use to help further strengthen their evaluative thinking and practice, and identifies some of the key organisation-level barriers to evaluation capacity building and how these might be overcome. It draws upon data collected during the Learning Enquiry – including interviews and focus groups with key stakeholders and a survey of HealthWest's ECB project participants – as well as Lirata and HealthWest's analysis and experience, to provide considerations and recommendations for future evaluation capacity building.

## 4.1 Findings and opportunities

### Committed and capable organisational leaders

Organisational leaders play a crucial role in developing a culture of monitoring, evaluation and learning within their organisations. In this section, organisational leaders largely refers to managers of teams, although there are other recommendations and learnings which have been targeted at boards and executives. This has been highlighted where necessary.

Leadership is one of the strongest themes that emerged from the Learning Enquiry, reported by both senior stakeholders and operational staff. Senior systems stakeholders noted this includes **not just ensuring a focus on monitoring and evaluation, but also allowing time and space for reflection and learning**. There was a general sense that leaders could lift their view to see monitoring and evaluation more as a way of supporting their organisations, project teams and staff to make better informed decisions that can lead to better outcomes for communities, rather than just gathering and synthesising data to complete a report for funders. In the words of one senior stakeholder:

> *"This is the most important piece of the puzzle. There are super big benefits to being able to make better decisions, not just fill in your funders report." - Interview with key system stakeholder*

Not all organisational leaders have extensive MEL knowledge or capacity; some therefore find it difficult to understand project MEL approaches and challenges, or to effectively lead organisational MEL strategies. Examples shared by respondents included leaders lacking the capacity to properly and clearly communicate the evaluation aims of the organisation, at times misunderstanding day-to-day roles and responsibilities in relation to monitoring and evaluation, and a possible lack of confidence in MEL which permeated throughout the organisation.

**Organisational leaders could benefit from targeted capacity building in how to lead the development of effective MEL systems**. The nature of the capacity building approaches used are likely to vary with the level of leadership being supported. For middle managers, a solid understanding of the steps involved in undertaking effective MEL is important; this can be built through targeted training workshops. In addition to the many and varied MEL training and capacity building offerings available in the market, a number of resources developed through the HealthWest ECB project – and through other ECB initiatives – could be adapted to support training workshops for managers in the primary prevention space. For senior executives, focused mentoring and advice on MEL strategy development may be more feasible.

Boards also have a key role to play in championing cultures of evaluation, innovation and improvement. At Board level, MEL capacity might be strengthened through a subcommittee with a focus on Quality and Learning, which provides the Board with access to information from key staff with MEL roles, and expert advisors. Discussion of MEL and its level of importance within the organisation could also be incorporated within governance review processes and strategic planning discussions.

Existing tools such as the Evaluation Capacity Health Check can be integrated into organisational or project planning and reporting cycles, to help organisations and their leaders better understand their evaluation capacity needs, inform action plans to prioritise and address their needs, and track progress over time.

Operational staff also noted that their **leaders' time was often consumed by other demands or priorities**, and rarely focused on MEL. This meant that the respondents in turn had little incentive to prioritise MEL in their own work.

> *"If there is no appetite from management then there's no real drive to do it, apart from personal interest." - Operational staff*

> *"Lack of senior support and time given to looking into it and trying different things." - Operational staff*

Organisational leaders can signal the importance of MEL to their teams by ensuring that MEL activities are included in operational plans, and requesting regular progress reports on MEL activities. Organisational leaders can also ensure that reflection and learning is given space regularly within a range of organisational meetings. During planning and decision-making processes, asking questions which seek to draw on evidence and evaluative findings can also increase staff perceptions of the importance of MEL.

One of the most powerful methods available to leaders to build staff buy-in to MEL processes is sharing emerging findings with teams, asking them to make sense of them, and engaging staff in action planning based on the results. MEL can also provide a valuable avenue for shining a light on the voice of the community and program participants. When staff see that data is being actively used for decision making and service improvement, as well as reflecting the voices of communities and participants, practitioner investment in collecting quality data quickly increases. All organisational leaders have the capacity to model this with their staff.

When organisational leaders can commit to developing and sustaining an organisational culture of monitoring, evaluation and learning, then they will be better able to develop the internal capabilities and systems that will sustain effective evaluative practice. This includes creating the time and space for staff to reflect on what works and what does not, and to properly understand their contribution to improving outcomes for the communities they serve.

## Resourcing

Commitment can only translate into action through resourcing, and so it is vital that MEL initiatives are properly resourced at the organisational level. The Learning Enquiry identified the need to increase organisational MEL resourcing in terms of **money, staffing and time**.

In common with organisations across all social service sectors, primary prevention agencies typically operate with high levels of community demand and many competing priorities. Organisations are very focused on delivering services and projects, and find it difficult to prioritise the time to conduct proper MEL

work, especially in relation to learning. In response to the question "Do you have the time and space to conduct MEL?", one senior stakeholder observed:

> *"Probably not. Half the time it's very reactive services (e.g. COVID). [There is] some chance to do planning now, but has been very reactive for the past year." - Senior stakeholders focus group participant*

A range of options are available within organisations to resource MEL work. Organisations could seek to negotiate and allocate a dedicated portion of project or program funding for evaluation and learning. Organisations could also benefit from employing a suitably skilled staff member – or, alternatively, enshrining in position descriptions a percentage of key staff time – dedicated to conducting or supporting MEL. Developing and maintaining staff skills in MEL also requires resourcing, with options including external and internal training and support, or a blend of both.

> *"This could look like mandating 10% of staff resources or time towards evaluation work." - Senior Stakeholder interview*

While the quantum of resourcing that can be allocated will depend on sector and organisational type, the principle of setting a dedicated budget or time allocation for MEL is sound. In addition to appropriate staffing, some respondents acknowledged the time it takes to do effective MEL work, and highlighted that, among the many organisations that do not mandate staff spending time on MEL, it is the reflection and learning aspect that is specifically lacking.

Some organisations may be able to **explore ways to re-structure their budgets to dedicate funding and/or staffing to MEL**. Others may **pursue new or more flexible funding opportunities** that could support enhanced MEL activities and capacity (as noted and recommended at the systems level, in section 3). **Organisational resources, however, are largely dependent upon the system level settings noted earlier, including limited funding and lack of consistent MEL requirements** across prevention programs. When MEL is actively encouraged, mandated or incentivised at the systems level, then organisations will be better able to allocate resources and prioritise time and effort towards MEL, and further improve their capacity.

There is potential for service provider organisations to work together with peak bodies and partnership structures, to identify shared MEL priorities within sectors and regions, and to attract ECB funding targeted to these needs.

### Improved internal systems

Internal systems play a key role in the ability of organisations to implement sustainable and effective approaches to MEL. Few primary prevention organisations have mature, well embedded MEL systems. There is scope to **strengthen multiple aspects of internal organisational systems** to support data collection, evaluation and learning; and indeed, developing the understanding that effective MEL requires an organisational systems approach is itself an important aspect of evaluation capacity building.

IT and data gathering structures, tools and processes are often duplicated, poorly understood or not utilised to their full extent, and strengthening these tools and processes is an obvious area for further capacity building. One suggested improvement is to **move towards centralised data management systems that are flexible, relevant to the needs of organisations and enable more efficient retrieval** of datasets and reports for MEL purposes. An example raised in the Learning Enquiry illustrates this need:

> *"All the systems don't talk to each other and we need to be able to gain insights. We need the right info collected at the right time and being made available to be used. No time to stop and reflect on what you've done because you're focused on service delivery." - Senior stakeholder interview*

Operational staff also suggested **opportunities to streamline and strengthen data collection tools and processes**. Participants shared examples of their organisation using Excel spreadsheets and other multiple tools or platforms which were not fit for purpose, and not linked to or consistent with other data collection tools, which makes it challenging to draw substantive conclusions, learn and improve, or demonstrate contributions to outcomes.

Custom developed CRM systems, data warehousing and business intelligence systems can all play a useful role in establishing these connected data platforms for MEL, and there are examples of primary prevention sector organisations who have successfully implemented these approaches. However, they tend to be complex and costly, and require specialist technical expertise to design and implement, making them challenging for smaller organisations to sustain. Simpler approaches to data collation and reporting can also be effective at project and service level, provided that tools are developed based on best practice principles and with MEL requirements in mind.

A challenge for many primary prevention organisations is multiple funding streams with conflicting and inconsistent reporting requirements. As well as exacerbating reporting burden, these messy requirements make it very difficult to implement streamlined and integrated data collection systems. Some organisations have experienced success in mapping compliance reporting requirements, and **negotiating with funders to simplify and harmonise these reporting requirements** to enable a greater proportion of MEL resources to be focused on meaningful evaluation and learning.

Other important elements of internal systems capacity focus on the guiding documents needed to develop and support MEL practice. One aspect of this is the development of a **MEL strategy or ECB plan**, to guide the process through which an organisation will build its MEL practice and systems over time. Although many organisations undertake various forms of MEL, few have a coherent strategy for strengthening their work in this area. An Evaluation Needs Assessment approach, using tools such as the Evaluation Capacity Health Check and related resources, provides a sound basis for ECB planning. Another aspect concerns the establishment of the **underpinning frameworks that enable consistent and well-designed MEL** to occur: i.e. program logics, Theories of Change, and MEL Frameworks. These can be developed at a range of levels including organisation, program, service and project. While gradually becoming more common, there is still scope for these foundational frameworks to be implemented more consistently. Their absence makes it difficult for organisations to undertake insightful MEL.

Making substantial improvements to data collection, monitoring, evaluation and reporting systems and tools requires resourcing – including financial resources and internal skills and capabilities. Therefore, the potential opportunities available to organisations in this area will vary depending on their size, resources and the health of their existing systems, tools and processes. Nonetheless, when resources are available and used wisely, organisations have much to gain from improved, simplified and more consistent internal systems which support more effective monitoring, evaluation, learning and reporting. Other **systems stakeholders could play a vital role in supporting organisations to understand, develop and implement enhanced tools and systems**, by providing funding, facilitating collective efforts to identify or develop fit for purpose tools and platforms, or other initiatives in partnership with organisations.

### Continuing to build staff capacity in monitoring, evaluation and learning

Operational staff see a need for organisations to **continually build the MEL capabilities of their staff**, and not just rely on one-off training activities or ECB projects. The diversity of projects in the primary prevention space and the complex and cyclical nature of MEL requires a level of ongoing support in order to effectively apply new knowledge and develop competency through practice. This is particularly true when it comes to undertaking reflection and learning activities, which require specific capabilities beyond simply monitoring and reporting – such as complex data analysis, evaluative thinking and reasoning, communicating findings in engaging and accessible ways to various audiences, and collective measurement or planning. One participant observed that operational staff often have either primary prevention and health skills, or skills in MEL – and that, given the technical nature of both, it is rare that a staff member will have high level skills in both areas. There is a valuable opportunity for primary prevention organisations to build this dual capacity amongst its workforce, through a blend of targeted capability building activities and ongoing support and guidance in MEL practice.

While MEL training is valuable, many practitioners find that the most effective learning occurs through the practical application of knowledge and skills with flexible mentoring. The opportunity to problem solve and share experience with peers, for example though Communities of Practice or with others in like roles across an organisation, also supports learning.

## 4.2 Recommendations for organisations

1. ***Work with evaluation capacity builders such as HealthWest to co-design and participate in capacity building training specifically for organisational leaders (managers, executives and directors) that equips them to lead staff in the development of evaluation culture and systems within their organisations.***
2. ***Invest in the development of Theories of Change and MEL Frameworks at organisational and program/service levels to enable well-designed, coherent evaluation.***
3. ***Explore options for allocating a percentage of staff time to be dedicated to undertaking MEL work (for example, a set percentage or a portion of certain position/s). This can be included within position descriptions.***
4. ***Routinely use and integrate tools like the Evaluation Capacity Health Check (or similar Evaluation Needs Assessment tools) with organisational planning and development cycles, to assess capacity, track progress, and identify priority areas for development.***
5. ***Develop data tools that enable key MEL data to be efficiently collated and reported.***
6. ***Review team and organisational level processes (meetings, planning sessions) to identify opportunities to build in evaluative and reflective thinking.***
7. ***Map compliance reporting requirements and negotiate with funders to simplify and streamline these to enable more MEL resource to be focused on evaluation and learning.***
8. ***Where possible, work in partnership with peak bodies and other agencies to attract ECB funding targeted to sector needs.***

# 5 FINDINGS: ROLE OF EVALUATION CAPACITY BUILDERS

This section has a dual focus. First, it recognises the contribution of evaluation capacity builders within the primary prevention system, and in particular, summarises the impact that HealthWest's ECB project had for participants. Secondly, it identifies some opportunities and recommendations for leveraging the contributions of HealthWest and other evaluation capacity builders to further strengthen evaluative practice and shared learning within the primary prevention system.

Evaluation capacity builders are actors within the system who have a leading role in building the evaluation capacity of individuals, organisations and the system. Some, like HealthWest and other PCPs, have identified a need to improve evaluation capacity and have taken initiative in developing and delivering responses. Others, such as consultants and certain peak bodies, may have the required expertise and a level of motivation to deliver evaluation capacity building activities or supports.

Learning Enquiry findings relating to the delivery and impact of the ECB project offer useful lessons for other evaluation capacity builders working in the primary prevention space. The findings are focused on the following four key areas:

- The extent to which the activities and approach used by the project were appropriate and relevant in building evaluation capacity within and across partner organisations.
- The enablers and barriers which affected participation in the activities of the project.
- The influence the project had on the way participating organisations operate or plan to operate in the evaluation space.
- The outcomes (both expected and unexpected) that the project had in building evaluation capacity for individuals, teams and organisations working in primary prevention in Melbourne's west.

## 5.1 Insights from the ECB Project

HealthWest's ECB project set out to better understand and strengthen the sector's capacity to monitor, evaluate and learn from primary prevention efforts in Melbourne's west. The project used a range of ECB strategies, with varying levels of engagement and reported effectiveness. Throughout the process, HealthWest consulted with organisations and individuals responsible for evaluation within the primary prevention space in Melbourne's West. This involved:

- Pre-project consultation with stakeholders including group discussion with the Taskforce, followed by one on one consultations between HealthWest and members of this group. This led to the drafting of a Workforce Evaluation Capacity Development Plan which was specifically designed based on feedback from the consultations, and endorsed by the Taskforce.
- Various informal review and evaluation throughout, including:
    - Project team reflections following all workshops
    - Polls taken at beginning and end of each formal workshop
    - Mid project review and planning session undertaken by the project team
    - Ongoing discussions with the Taskforce.

It is clear that the project was successful in strengthening MEL capacity among representatives of participating organisations. However, the project also faced a number of challenges.

## Appropriateness and relevance of the project's activities

The ECB project designed and delivered a range of activities in collaboration with sector partners over 18 months. Key elements included:

- Development of the Evaluation Capacity Health Check tool (ECHC)
- Implementation of the ECHC by individual organisations
- Development of the Regional ECB MEL plan (not completed as originally planned – in light of the COVID-19 context, the Taskforce agreed to prioritise more immediate, actionable initiatives)
- A western region Monitoring and Evaluation Community of Practice was developed
- A number of professional development activities trialled in late 2020 and early 2021, including a Lunch and Learn Session ('Creative Community Consultations'), a MEL Clinic ('Theory of Change') and provision of formal training ('Data Collection Methods')
- Provision of formal MEL Training –covering the following topics:
    - Planning an Evaluation
    - Data Collection Deep Dive: Visual and Story Telling
    - Data Sense-Making and Communication
    - The L of MEL
- Informal Training (Learning Circles).

Feedback indicates that the project's activities were mostly appropriate and relevant in building capacity within participating organisations. Development and implementation of the ECHC tool was highlighted as a particularly useful process by both participants and program delivery staff and consultants. The formal training sessions were also highlighted as being relevant and had much stronger participation than informal learning activities. While the data doesn't point to clear reasons for this, participants noted a hesitancy to share internal evaluation frameworks or lessons learned in group discussions, which may have reduced enthusiasm for the learning circles.

Overall, there was a generally shared perception that the diversity of backgrounds of the participants made it very challenging to design fit for purpose, relevant activities.

### *Participants responses on the most useful and influential ECB activities were varied*

When asked how appropriate the activities were in starting to build evaluation capacity, one respondent specifically identified the training presenters as a strength. Another described the Basecamp CoP as a very useful community to have access to. During the operational staff focus group, participants agreed that the formal training activities, such as the "Planning an Evaluation" and "Data collection deep dive" sessions were the most useful and influential activities for them, because they were more structured and similar to university-level or formal courses on MEL.

### *Health Check was appropriate and relevant*

Learning Enquiry feedback has demonstrated that the ECHC tool was a highly appropriate and relevant tool for assessing organisations' evaluation capacity. Participants were involved in this process when the project was just starting, which meant they were fresh and eager to take part. The partnership approach, in which HealthWest was able to conduct the Health Check in collaboration with participating organisations, meant

that the process was perceived as very valuable by participants. This view was shared by program staff. While similar tools have been used elsewhere in various contexts, they had not previously been applied in the primary prevention sector in this region.

> *"This was a very useful process – it was collaboratively shaped and developed by the participants." - Program staff interview*

> *"It was revolutionary for the sector – no one had ever done this before" - Program staff interview*

The Health Check was seen by participating organisations as a highly relevant and appropriate way to commence the process of evaluation capacity building, as it contextualised evaluation capacity for their experience. It also enabled people to better understand their own organisations' strengths, gaps and needs, as well as enabling capacity building activities to be targeted towards common gaps and needs.

### *Formal training was more relevant than informal activities*

The program staff and consultants who designed and led the ECB project reflected that participation was stronger during formal learning opportunities than with some of the informal learning activities – for example, the learning circles. They had initially expected that participants would share successes, challenges and insights from their projects, but in fact many participants were very reluctant to do this.

> *"We thought we'd be doing a lot more sharing, but instead we ended up doing MEL 101" - Program staff interview*

A number of reasons were suggested, which varied somewhat between respondents. One participant shared that evaluation can be a challenging topic, especially in the prevention sector. As the language and practice of evaluation is very complex, some participants felt they did not have the right level of skill or ability to engage with the subject matter easily. As noted in the System-level analysis (section 3), there was also some reluctance amongst organisations to share their work with one another.

> *"Unspoken competition between the organisations – they don't want to show their evaluation frameworks" - Program staff interview*

### *Basecamp Community of Practice*

The Basecamp CoP was intended to be a centralised place for the ECB project to strengthen MEL capacity for primary prevention work in Melbourne's west. The CoP was open to member organisations of the Taskforce, and aimed to support participants to improve their individual and collective capacity to monitor, evaluate and learn from primary prevention activities. The CoP was coordinated by HealthWest as part of the ECB project, and was intended to iteratively develop in response to members' needs. It included things like a schedule of informal and formal learning opportunities, access to MEL resources such as templates, guides and case studies and external learning opportunities. It was also intended as place for cooperation and peer learning, with opportunities for peer revision of projects and connection with primary prevention colleagues.

Feedback from project stakeholders and participants was that there was minimal engagement in the Basecamp CoP. While one respondent noted the CoP was a useful community to have access to, both participants in the operational staff focus group provided feedback that they were unsure of the value of the CoP, and that it did not seem relevant to their work.

*"Didn't use the Basecamp at all – wasn't sure if anything on there was useful for me"- Operational staff focus group participant*

### *Diversity of participants meant it was hard to build relevant activities for all*

Many Learning Enquiry participants observed that attendance at training sessions declined markedly after a strong first session. In addition to the length of workshops making them difficult to fit in with time pressures, operational staff cited the diversity of participants' needs as a key reason for this drop-off. Participants in the operational staff focus group shared that while the training workshops were quite long and broad, they still didn't necessarily meet all participants' learning needs.

*"Everyone's specific needs were so different that it meant it was very difficult to build a community." - Operational staff*

## Enablers and barriers to participation in the ECB project

Representatives from 9 organisations (in addition to HealthWest) participated in ECB training activities. Organisational representation at the four training sessions ranged between 5 and 8 organisations, with many organisations sending multiple staff. At the individual level, attendance at the four training sessions ranged between 8 and 19 individuals, with the strongest attendance at session 1. The number of registrations was generally not indicative of the number of attendees at training sessions. Registration and attendance at Learning Circle discussions was substantially lower than the training workshops, ranging between 0 and 2. (More detailed attendance data is presented in Appendix 3.)

Feedback indicates that HealthWest staff and project consultants took a flexible approach which supported participants to engage and contribute throughout the different activities and trainings. However, a number of barriers limited the active participation of operational staff during the project, as discussed below.

### *HealthWest staff and project consultants' flexibility in delivery of training and initiatives*

Participants were very appreciative of HealthWest staff's efforts to engage and build participation through being flexible and approachable during the delivery of project activities. Feedback was received that the HealthWest team coordinating the project were very responsive to all requests from participants to adjust and change content, provide resources, or answer any questions. While the Learning Enquiry sought to identify a range of key enablers to participation, this was the only clear theme emerging from the data collected.

*"Kate was very prompt with her communication, resources were available if you wanted them" - Operational Focus Group participant.*

### *Finding time to commit was a major barrier to participation*

Time pressures were repeatedly cited as one of the major reasons for lower participation in training and capacity building activities. Many Learning Enquiry participants provided feedback that the sessions were quite long, and demanded a lot of time from their very busy schedules. The training sessions each ran for three hours. As a number of project activities took place during the COVID-19 pandemic, many of the participating organisations were heavily involved in COVID-19 public health response activities, which further limited their availability to take part in training or development activities. (Similar patterns of attendance have been observed across a number of other capacity building activities during the pandemic, in other health and community services sectors.)

### *Mixed views about the participatory method of delivering training*

Some participants found that the participatory method of delivering training was a challenge, while others praised the approach. Feedback shows that the challenges related to some perceived pressure to share internal learnings with other organisations. Conversely, other participants appreciated this approach and found it valuable for their learning.

## The project's influence on the way in which participating organisations operate or plan to operate in the evaluation space

The ECB project had a moderately positive influence on the evaluation activities of the individual participants, but this was not always transferred to changes at an organisational level. It was hoped that participation in project activities would lead to the development or operationalisation of evaluation plans within participating organisations, however this did not eventuate within the project period – potentially due to competing priorities and lack of time, the drop-off in engagement over the course of the project, and/or a lack of organisational motivation or need to prioritise MEL.

### *The project had a positive influence on the evaluation activities of the participants, but this was not always reflected at the organisational level*

The survey asked whether the project activities led to a greater awareness of the role and value of evaluation, as well as whether activities inspired plans for future evaluation. A little over half (7 of 12 responses) were positive (Agree or Strongly Agree), but did not provide further comment as to why.

Four respondents provided a rating for whether the ECB project activities improved awareness of evaluation. Three of four agreed it had improved their own awareness of evaluation, compared to two of four who agreed it has improved the awareness of their team or organisation. The lower rating for change in organisational awareness was potentially because activities only involved some staff members:

> *"I developed greater skills and understanding as an individual … but this has not impacted the broader team or organisation. The broader organisation were (sic) not involved in the Health Check work" - Survey respondent*

A similar theme emerged when considering how the project influenced plans for future evaluation. While most respondents agreed that they were personally planning to do more evaluation in the future, they were hesitant to say the same of their organisations. This resonates with the organisational-level finding (discussed in section 4) that, in many organisations, meaningful evaluation is not currently being prioritised.

> *"Evaluation needs to be prioritised across the organisation … hard to build capacity if there is no appetite to evaluate work" - Survey respondent*

### *Organisations participating in the ECB project have not yet developed MEL plans*

The Learning Enquiry did not find evidence that participating organisations had developed evaluation plans, at either a project or organisational level, as a result of the ECB project. This potentially further illustrates the challenges in translating individual capacity building into organisational level capacity or changes, and feedback suggests a number of likely reasons for this. The drop-off in engagement over the course of the project means some participants were not engaged over the longer term – had this occurred, it could have helped participants further build their evaluation skills and confidence, and provided support as they started to develop and operationalise plans. Participants having competing priorities and limited time to engage with evaluation capacity building activities also means they are unlikely to have the time to develop a comprehensive MEL plan, and some participants may not yet have developed enough knowledge to

develop plans with confidence. This would be even more challenging in organisations that are not currently prioritising MEL.

## The outcomes of the project's work in building evaluation capacity

Survey data showed that a small proportion of respondents reported an increase in their ability to use evaluation techniques as a result of the project, however, as with most of the survey findings, low response numbers mean this may not be generalised across all ECB participants. The project influenced a number of outcomes at an individual level, but these were largely not reflected at the team or organisational level. Notably, some participants reported utilising aspects of the training in their work, and some examples are described below. A key success for the project was raising the awareness of key systems actors about the realities of conducting MEL on the ground, and the need for greater understanding of the complexities of the system.

### *Survey findings do not indicate broadly increased understanding of evaluation methods*

Respondents were ambivalent about whether the project improved their understanding and ability to use evaluation methods. Just two the of survey responses agreed there had been an improvement, and as many disagreed. Most of the 10 respondents felt unsure.

This might suggest that although the activities were generally positively regarded, there have not yet been opportunities for participants to apply new knowledge, test out their training, and see outcomes. However, the low numbers of response to this question means that the finding is not necessarily a strong indication of the outcomes for participants.

> *"Opportunities to use [evaluation methods, specifically theory of change] have not yet arisen." - Survey respondent*

### *Participants have used some techniques learned in training*

The Learning Enquiry found that some participants have utilised learning from the ECB project in their work, and that this has led to some outcomes in terms of improved evaluation and reporting. For example, one participant shared that the ECB work that they undertook supported them to better approach evaluation within their organisation. Another reported that they utilised specific techniques from training in MEL and reporting on their projects – in particular, the photo voice approach to community health reporting. This process, drawn from action research, allows participants to represent their experience in research through images and photos (Buris and Wang, 1997). The participant used this technique in a community health report, which was seen as innovative by the donor. One participant also reported using the Most Significant Change (MSC) technique within their programming.

### *Evidence of cross organisational partnerships enabling shared measurement was not found*

One of the intended outcomes of the ECB project was strengthening of cross-organisational relationships enabling greater capacity for shared measurement. Although evidence of cross organisational partnerships was identified during the Learning Enquiry, these examples were not necessarily new or stronger as a result of participating in the ECB project. The key examples of cross organisational partnerships identified are the ongoing work of the Taskforce, and the ECB project itself – and as noted earlier (in section 3), these were generally seen to be valuable collaborations. No evidence was found at agency level of shared cross-organisational measurement in the primary prevention space. However, the level of sophistication required to implement shared measurement systems is high, placing this as a more advanced step on an ECB pathway with a longer timeframe than was available through the ECB project to date.

*Systems-level actors gained stronger insight into the realities of MEL for organisations*

Two funders/key systems actors interviewed during the Learning Enquiry provided feedback that the project had provided them with a stronger understanding of the realities of conducting MEL on the ground in primary prevention. One reflected that it had given them an insight into the realities of undertaking MEL at a community and organisational level.

*Recognition of the work and innovation of HealthWest*

Feedback from system stakeholders indicates that they recognise the importance of HealthWest's work – in particular, its focus on the social determinants of health, its ability to create collaborative action, effective management of capacity building initiatives, and innovation. There was also recognition that HealthWest, and other members of the Taskforce, had adapted as well as could be expected to the pandemic and resultant pressures.

*Recognition of the need to build further shared understanding of the primary prevention system*

System stakeholders reflected that there is a greater need for key actors, at all levels of the system, to better understand the health and context of the primary prevention system, and the incentives and pressures that influence it. One stakeholder noted that a systems mapping approach, similar to that used in the design phase of this Learning Enquiry, would be an important step to be undertaken with a wider group, potentially involving senior stakeholders and other Taskforce members.

## 5.2 Opportunities for Evaluation Capacity Builders

While the COVID-19 context of the ECB project limited participants' ability to fully engage with the project, there are still a number of tangible outcomes and useful lessons which can inform future ECB efforts. These are presented below, including opportunities and recommendations for Evaluation Capacity Builders such as HealthWest.

### Sharing success stories and peer learning

Although the Community of Practice may not have seen consistently high levels of engagement, if well-facilitated, the CoP could be an excellent place to share some of the success stories from the ECB project. For example, the participants who were able to successfully utilise the photo voice technique could share their approach and the results with their peers. These success stories could also be turned into case studies and shared with participants, and the wider prevention work force.

The CoP could also be trialled, with a small amount of facilitation or moderation, as an ongoing forum or series of regular meetings where ECB participants can continue to ask MEL-related questions and share information, resources and experiences with each other. A CoP model of structured meetings of a core group of members is used extensively in other health and community services sectors, traditionally face to face and more recently online. The involvement of an Evaluation Capacity Builder as an informal MEL mentor could also be useful, and may help ECB participants to develop and operationalise MEL plans over the coming months and years. A forum with regular and structured meetings could be used in place of, or in conjunction with, platforms like Basecamp.

## Tailoring activities and resources to suit participants' needs and norms

The feedback from the Learning Enquiry provides some helpful guidance that can enable greater participation and engagement with future ECB activities in the primary prevention sector. Suggestions include:

- Carefully consider the length and timing of training sessions, and structure these in a way that minimises barriers to participation by time-poor cohorts. Partners and potential participants will be well placed to advise on these considerations.
- Use the Evaluation Capacity Health Check tool as the basis for developing a 'pre survey' of training participants to understand their individual capacity in key MEL topics, prior to finalising training material or activities. This information will support more effective pitching of content to diverse cohorts.
- Draw on partners' expertise when planning activities and content – the Taskforce was a useful advisor in the design and delivery of the ECB project, and, if continued, the CoP could also provide valuable feedback to inform future content, approaches and logistics.
- Co-develop and provide practical MEL templates and tools – such as evaluation planning and/or program logic templates, and reflection and learning discussion guides – that can be used during training activities and support participants' ongoing MEL practice.
- Take care to establish a safe and respectful environment for informal learning circles, CoPs and other peer learning group discussions, where trust can develop so that challenges can be shared. This includes careful facilitation, inviting participants who have some common ground or shared experience, and communicating the expectations, benefits and any ground rules around confidentiality to participants at the time of invitation. This can help participants approach these discussions with a sense that they are going to learn something of value by attending, and understand that they also have a role in contributing ideas to the discussion.
- Conduct planned and systematic monitoring and evaluation on future ECB projects, and use participant feedback to inform project decision-making or improvements in a timely way.

## Engage with and provide opportunities for participants at multiple levels within organisations

As discussed in earlier sections, there are a number of important organisational level influences on MEL capacity – including organisational leaders' knowledge and confidence with MEL, organisational commitment or incentive to prioritise MEL, and the time available to staff to conduct meaningful MEL. These influences all affect the level of opportunity that individual staff have to apply their learning and practice new MEL skills, and we know that opportunity is a key component of successful capacity building (Michie et al, 2011). There is a major opportunity for Evaluation Capacity Builders to engage with organisational managers and senior leaders when planning ECB initiatives, however, ECB activities should be tailored for this audience. For instance, a "MEL thought leadership" session showcasing how other organisations have used MEL strategically to achieve their goals is likely to attract an executive audience, whereas a 6-hour training session on evaluation planning will not.

Benefits include greater organisational engagement and support, which can help maximise attendance and participation and the transference of individual capacity gains to team or organisation level changes; as well as helping to build managers' MEL knowledge and skills in order to support more active MEL leadership.

### Leverage the resources and materials developed through the ECB project for future benefit

A range of useful training content, materials and resources have been developed through the ECB project (and other previous ECB initiatives), which could be further used and extended with other primary prevention stakeholders. Opportunities to leverage the ECB project investment may include:

- Promoting and delivering training workshops to organisations on demand (potentially on a fee for service basis) when needed.
- Refining training modules into shorter sessions that can be delivered flexibly, potentially online or as recorded webinars.
- Sharing common, useful, fit for purpose tools or templates through sector newsletters and networks, and the CoP if continued.

Many MEL tools, templates, glossaries and other information resources are already available online from various sources. In assembling resources for the sector, it is worth drawing on existing materials where possible to avoid re-inventing the wheel.

## 5.3 Recommendations for Evaluation Capacity Builders

1. ***Continue to prioritise, invest in and deliver good practice evaluation capacity building initiatives, using fit for purpose suites of activities which respond to identified organisational needs and also promote partnership and collaboration.***
2. ***Leverage any opportunities presented by the revision of DH's Community Health – Health Promotion guidelines to further extend and embed MEL capability building opportunities.***
3. ***Work with the managers and leaders of primary prevention organisations to nurture engagement and participation in ECB at multiple levels of the organisation, support leaders to build their own MEL knowledge, and help transfer individual capacity gains to team or organisation level changes.***
4. ***Ensure that future capacity building initiatives undertake consultation with participants to understand needs and existing capacities and strengthen relevance of training.***
5. ***Continue to consult with partners and practitioners about the timing, length and practicalities of future ECB activities, to help minimise barriers to participation.***
6. ***Explore alternative models for facilitating, growing and strengthening engagement with MEL Communities of Practice, as a place to share success stories and peer learnings, collaboratively develop MEL resources for organisations, and advise on future ECB initiatives.***
7. ***Consider further refining training and learning modules developed through the ECB project to extend their reach – potentially including on demand delivery to organisations when needed, and/or flexible, short segments or recorded webinars.***
8. ***Consider the development of common, fit for purpose MEL tools and templates that can be shared with participants to support their MEL practice following training and learning, and/or a MEL handbook.***
9. ***Ensure future ECB projects include their own monitoring and evaluation processes, which will enable Evaluation Capacity Builders and partners to respond and improve projects in real time, and to learn and reflect about what needs to change in terms of evaluation culture.***

# 6 CONCLUSION

Key stakeholders across the primary prevention system recognise MEL capacity as an important enabler for the work of the sector. The evaluation capacity building work undertaken by HealthWest and other evaluation capacity builders is valued by participants and stakeholders. This work has enhanced the level of MEL capability and evaluative practice within the western region's primary prevention system.

Primary prevention is a complex space in which to conduct evaluation, with a rich diversity of partners, programs, issues and capacities throughout the system. Continuing to work together to better understand these interrelated complexities will support all key players working within the system to plan and conduct more meaningful and relevant evaluation. It will also help to inform collective advocacy to improve the systemic conditions for, and drivers of, effective, outcomes-focused MEL.

Many opportunities remain to further strengthen MEL capacity at the system, organisational and practitioner levels. In particular, strategic action at the system level will provide high leverage to reinforce MEL capacity at organisational and practitioner levels. Agencies with system stewardship and planning roles, including DH and VicHealth, have key roles to play in enabling system level changes that support effective MEL.

Specialist evaluation capacity builders provide vital skills, knowledge and experience which support other organisations to implement meaningful MEL processes. HealthWest and other PCPs have expertise and an existing track record in evaluation capacity building roles, and have demonstrated their success in enabling capacity building collaboration across a sometimes challenging sector environment. It is important to recognise and build on this expertise as PCPs transition to the Local Public Health Units.

Building sustainable, effective MEL processes at organisational and system levels takes time. It is easy for systems actors to underestimate the complexity and length of time involved in establishing a high-functioning MEL approach. Evaluation capacity building often works best when small-scale MEL approaches are successfully implemented and demonstrate their value to those who have invested in them. These initial successes can then be expanded and built on. ECB therefore needs to be seen as an investment over a minimum of a five-to-ten-year timeframe, rather than a brief intervention.

The recommendations provided in this Learning Enquiry report offer tangible options that can be used in the ongoing process of evaluation capacity building in the primary prevention space. By implementing these steps, system actors can support greater shared understanding of MEL benefits, needs and context. Strategic consideration will be needed to select the options that are most feasible and relevant to the evolving sector context, and the opportunities and recommendations will benefit from further discussion, development and reflection by all actors within the system.

Despite the challenging context, the primary prevention sector has many strengths, including a commitment to evidence-based practice and a robust collaborative spirit that provide a great starting point for effective MEL. Consistent evaluation capacity building will enable ongoing improvement of primary prevention work, which will ultimately support better outcomes for communities across Victoria.

# GLOSSARY

The following acronyms are used throughout this report.

| ACRONYM/ABBREVIATION | DEFINITION |
|---|---|
| CESE | Centre for Education Statistics and Evaluation (NSW) |
| CoP | Community of Practice |
| DH | Department of Health |
| ECB | Evaluation Capacity Building |
| ECHC | Evaluation Capacity Health Check |
| KPI | Key Performance Indicator |
| LPHUs | Local Public Health Units |
| PCPs | Primary Care Partnerships |
| MEL | Monitoring, Evaluation and Learning |

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# APPENDIX 1: HEALTHWEST ECB PROJECT OUTLINE

## Phase 1: The development of an Evaluation Capacity Health Check tool

In 2019 HealthWest engaged consultant Judy Gold (Cultivating Change) to work with the Western Region Primary Prevention Taskforce to develop a shared understanding of evaluation capacity and to learn how organisations were placed to monitor, evaluate and learn from their work. With input from partner organisations, a tool to assess evaluation capacity was adapted and implemented with seven organisations across Melbourne's west.

The Evaluation Capacity Health Check tool assesses evaluation capacity across the domains of leadership and culture, staff capacity, systems and structures, and collective MEL efforts. Findings from the implementation of the tool showed that while competence is emerging in a limited number of areas, many organisations' capacity to apply MEL to their work is guided by their compliance requirements.

In April 2020 a workshop was held for participating organisations to discuss results from the Health Check and priorities for future evaluation capacity building at a regional level. Some priorities were identified in the areas of organisational leadership, as well as in the area of workforce skills and confidence for monitoring, evaluation and learning (MEL). There was interest from the group in continuing conversations on the results and further workshopping of priorities, particularly in increasing capacity for collective MEL efforts and in creating a MEL culture across the west.

Initially these conversations involved the 7 organisations who participated in the Health Check process, however then expanded to the broader Taskforce membership in the latter half of 2020.

## Phase 2: Consideration of a regional Evaluation Capacity Building Plan

Following the development and implementation of the Health Check tool, and in recognition of an appetite amongst partners to continue MEL capacity building in Melbourne's west, consideration was given to the development of a four-year Western Region MEL Capacity Strengthening Plan for the 2021-25 planning period. However, as significant impacts of COVID-19 continued through to late 2020, the Taskforce made a decision to delay further development of a four-year Plan, and instead, focus on more immediate and actionable capacity building initiatives within the domain of workforce skills and confidence.

A western region Monitoring and Evaluation Community of Practice was developed and a number of professional development activities trialled in late 2020 and early 2021, including a Lunch and Learn Session ('Creative Community Consultations'), a MEL Clinic ('Theory of Change') and provision of formal training ('Data Collection Methods').

## Phase 3: Workforce evaluation capacity building activities

To build upon initial professional development activities, HealthWest appointed an Evaluation Project Manager in January 2021 to consult on, develop and implement a 6-month evaluation capacity professional development plan.

Alongside continuation of the MEL Community of Practice, a tailored program of more in-depth formal training workshops and less formal learning circle opportunities were delivered in partnership with Cultivating Change.

## Program logic

A program logic for the ECB project was developed collaboratively between Lirata and HealthWest during the Learning Enquiry and is presented on the following page.

| | |
|---|---|
| **PROBLEM/NEED:** | There is an increasing need for Primary Prevention Partnership organisations to better demonstrate outcomes and build capacity in complex, emergent approaches to evaluation, and towards the challenges of implementing shared measurement. |
| **STATEMENT OF PURPOSE:** | The ECB project will bring together agencies across five local government areas to collectively identify, develop and deliver capacity building activities required to effectively evaluate primary prevention work, so that agencies have increased abilities in monitoring, evaluation and learning. This will ensure that there is an increased understanding of the collective efforts of primary prevention work in Melbourne's West, and organisations can more effectively deliver this work. |

| INPUTS | ACTIVITIES | OUTPUTS | OUTCOMES | IMPACT |
|---|---|---|---|---|
| **People**<br>*Lead:*<br>1.1 HealthWest<br>*Participants*<br>1.2 Primary Prevention workforce participants<br>1.3 Western Region Primary prevention taskforce<br>**Resources**<br>1.4 Funding from DHHS<br>1.5 Knowledge from ECB services (Cultivating Change, Lirata)<br>1.6 Participants MEL knowledge and experience<br>1.7 HealthWest MEL thought leadership | **Identification and Assessment**<br>2.1 Identification and assessment of key evaluation enablers required to demonstrate the outcomes of primary prevention efforts<br>2.2 Assessing system readiness to adopt rigorous evaluation techniques<br>2.3 Identification of workforce development needs<br>**Implementation and Delivery**<br>2.4 Implementing workforce monitoring, evaluation and learning capacity strengthening activities<br>2.5 Facilitation of the monitoring, evaluation and learning Community of Practice<br>**Communication**<br>2.6 Engagement with key systems actors about the activities and outcomes of the project | 3.1 Evaluation Health Check tool<br>3.2 Workshop for participating organisations to discuss results from the Health Check and priorities for capacity building<br>3.3 Workforce Evaluation Capacity Building Plan<br>3.4 Evaluation Practice Learning Circles<br>3.5 Lunch and Learn Session (Creative Community Consultations)<br>3.6 A MEL Clinic (Theory of Change)<br>3.7 Provision of formal MEL training sessions<br>3.8 Establishment of a Monitoring and Evaluation Community of Practice (CoP) | 4.1 Organisations have identified and understand the key evaluation skills required to demonstrate the outcomes of primary prevention efforts<br>4.2 Organisations have the required skills to demonstrate the outcomes of primary prevention initiatives<br>4.3 Increased evaluation knowledge, skills and confidence of primary prevention staff.<br>4.4 Increased capacity of members to undertake evaluation in a rapidly changing context.<br>4.5 Cross organisational relationships are strengthened enabling greater capacity for shared measurement<br>4.6 Funders and key system actors have a stronger understanding of capacities and realities of monitoring, evaluation and learning processes for the western region<br>4.7 Systems and structures are in place that support a cohesive evaluation space within the primary prevention context | 5.1 Organisations have an increased understanding of the effects of their work<br>5.2 There is an increased understanding of the collective efforts of primary prevention work in Melbourne's west<br>5.3 Organisations can more effectively deliver Primary Prevention activities. |

| | |
|---|---|
| **CONTEXT & EVIDENCE:** | The Primary Prevention sector has been undergoing shifts away from more traditional program models towards more collective action that creates systems change. These shifts push the prevention workforce into emerging and developmental territory. During the implementation of the project, the effects of COVID placed additional pressures on organisations and staff to participate in project activities. |

# APPENDIX 2: LEARNING ENQUIRY METHODOLOGY

## Methods

The Learning Enquiry used a variety of methods to design the project, capture data, and shape the findings and recommendations. These methods are summarised in Table 2.

TABLE 2: METHODS USED DURING LEARNING ENQUIRY

### *Learning Enquiry design stage*

| METHOD | DATE | DETAILS |
|---|---|---|
| Actors mapping workshop | 26/08/2021 | The Actor Mapping was co-facilitated by two consultants from Lirata and utilised an Actor Mapping approach. Three key staff members from HealthWest participated.<br>The key output from the session was an active System Map, which guided the development of the data collection phase, including:<br>• Informing the stakeholder interviews,<br>• Shaping the Learning Enquiry Framework and<br>• Providing an overview of the system within which the evaluation capacity building initiative operated.<br>The Actor mapping exercise also provided some early information into the needs, blockages, opportunities and areas of momentum within the system. |
| Program Logic workshop | 31/08/2021 | The program logic workshop was structured around the following objectives:<br>• To build a shared understanding of program theory and program logics, and how they relate to the ECB project<br>• To share the next steps of the Learning Enquiry and how our program logic fits<br>• To review, discuss and agree on the draft ECB program logic<br>• To review and discuss some potential guiding questions<br>A draft program logic and six evaluation questions, based on a document review, were developed by Lirata prior to the session. Following the session, feedback was incorporated into the draft program logic, before being circulated for final feedback and agreed. |
| Development of the learning enquiry framework | 06/09/2021 | Using the evaluation questions developed during the program logic workshop, a draft Learning Enquiry framework was developed and shared with the HealthWest team. The Learning Enquiry framework was finalised on the 6th of September, 2021. |

### *Data collection stage*

| METHOD | DATE | DETAILS |
|---|---|---|
| Survey for project participants | 11/10/2021 | The survey for project participants was codesigned by Lirata and HealthWest, and focused on gathering information for the relevance, effectiveness and sustainability domains. The survey received 19 responses. |

| METHOD | DATE | DETAILS |
|---|---|---|
| Evaluation Capacity Health Check Tool | 14/10/2021 | An invitation to complete a second round of the Health Check tool was sent to six organisations who participated in the first round. Two organisations were unable to participate, and three did not respond. |
| Interviews with Project Staff/ Consultants | 07/10/2021 | Four semi structured interviews were conducted with project staff and consultants, three with HealthWest staff and one with a consultant from Cultivating Change. |
| Interviews with Sector Stakeholders | 03/11/2021 | A total of six semi structured interviews were conducted with sector stakeholders from peak bodies, state governments, local councils and other primary health care partnerships. |
| Focus Group with Operational Staff | 26/10/2021 | The focus group was adjusted to be a small group interview, in response to scheduling conflicts and a number of participants being unavailable. Two participants, both from local councils, took part. |
| Focus Group with Senior Stakeholders | 28/10/2021 | The focus group was attended by eight participants. Discussion focused on organisational culture, practice and capacity in evaluation, and the drivers, blockages and areas of momentum for evaluative thinking and practice within the prevention system. |

*Data analysis and synthesis stage*

| METHOD | DATE | DETAILS |
|---|---|---|
| Data analysis | 03/11/2021 | Data analysis was conducted by the lead consultant for the project, in conjunction with a Research Officer from Lirata. Qualitative analysis was conducted through a thematic analysis approach. Interviews, focus groups and survey data were reviewed to draw out key themes, and organised under the key evaluation questions of the Learning Enquiry Framework. Quantitative analysis was conducted using the ratings and numerical data which came out of the survey. Additional quantitative analysis was conducted on some participant attendance data which was provided by HealthWest. |
| Data synthesis | 15/11/2021 | Building on the data analysis, data synthesis was conducted by a secondary review of the analysis, and identifying common themes emerging from the data analysis phase. Key findings and subsequent recommendations were identified during a collaborative internal process involving the Lirata team. |
| Presentation of preliminary findings and recommendations to key HealthWest staff | 06/12/2021 | Lirata presented the preliminary findings and recommendations to HealthWest, and received initial feedback and contextual advice at the organisational and systems level. Lirata and HealthWest also used this meeting to plan the presentation of findings to a broader group of stakeholders. A decision was made to focus on discussing and agreeing the organisational and systems level recommendations. |
| Presentation of preliminary findings and recommendations to key stakeholders | 14/12/2021 | Lirata presented the preliminary findings and recommendations to a broader group of stakeholders who had been involved in the data collection phase of the project, and other interested parties. The discussion focused on the systems and organisational level findings and recommendations. |

## Limitations

There were some limitations during the data collection phases of the project, mostly due to organisations and individuals having limited time or ability to take part in data collection. Despite Lirata and HealthWest's best efforts with scheduling and recruitment, the operational staff focus group only had two participants. Similarly, interviews with three organisations who identified as evaluation capacity builders who may have been able to feed into the Learning Enquiry, were unable to proceed. The Learning Enquiry took place during a period of COVID-19 lockdowns and public health crisis response, severely limiting the time and capacity of organisations and individuals to participate.

Additionally, the initial proposed methodology included six organisations undertaking the ECB Health Check a second time, in order to compare any progress against baseline evaluation capacity. The organisations were invited by HealthWest, but were unable to find the time to participate. HealthWest (as the seventh organisation completing a baseline Health Check) declined to participate as it would not have been useful for the Learning Enquiry.

The survey was sent to 89 recipients, however, only 19 responses were received (approximately 21% response rate), limiting the overall usefulness of the results. The survey was designed to enable participants to only answer questions on sections which were relevant to them, for example, ECB activities which they took part in. This means that many respondents only answered four or five of the survey questions and left many questions blank. As a result of these substantial gaps in survey data, the data analysed for this Learning Enquiry has been mainly qualitative, drawn from the interviews and focus groups.

# APPENDIX 3: TRAINING SESSION DATA

The following graphs show the breakdown of participating organisations and individuals across the four ECB project training sessions held in 2021.

FIGURE 5: ORGANISATIONS IN ATTENDANCE AT 'PLANNING AN EVALUATION' SESSION

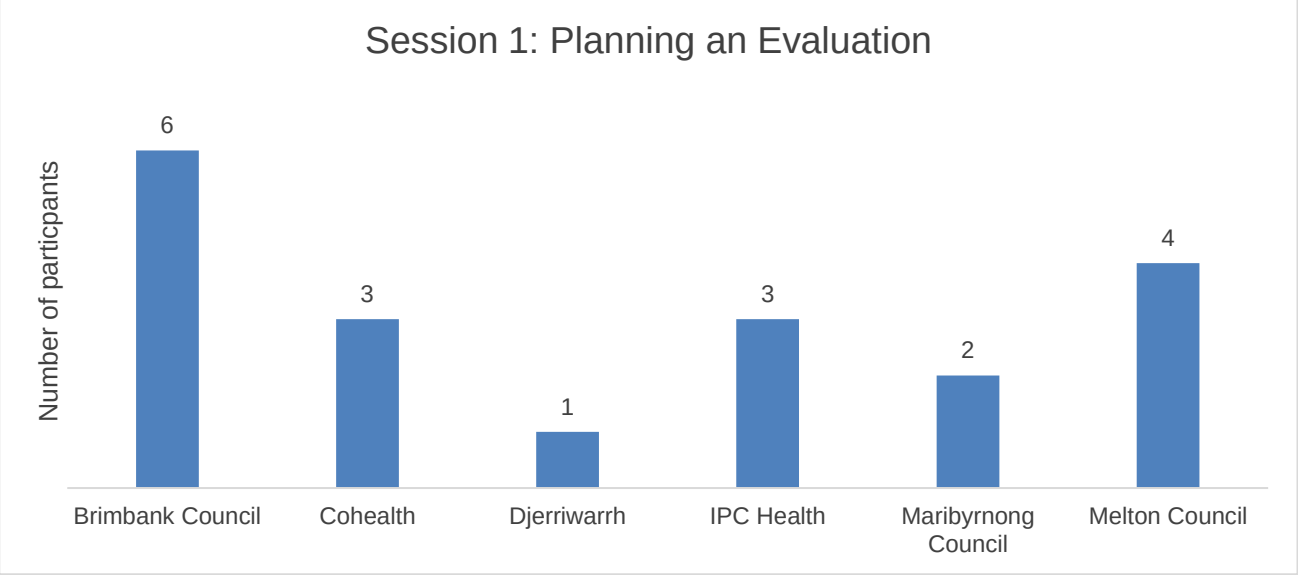



FIGURE 6: ORGANISATIONS IN ATTENDANCE AT 'DATA COLLECTION DEEP DIVE' SESSION

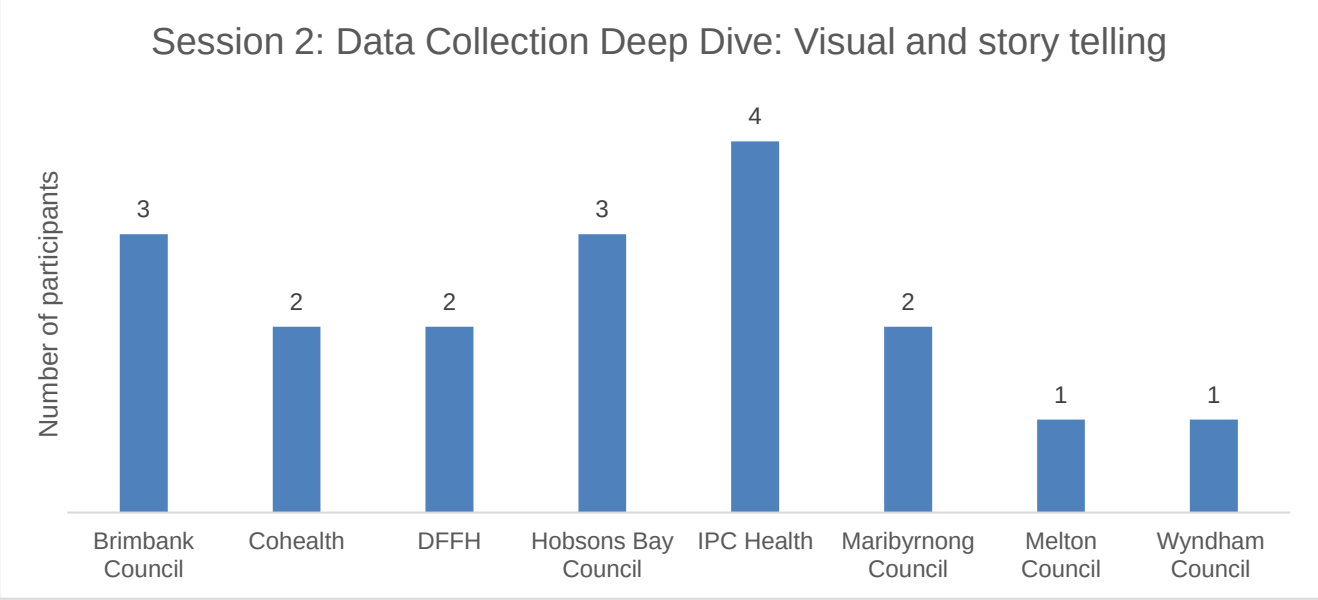


FIGURE 7: ORGANISATIONS IN ATTENDANCE AT 'DATA SENSE-MAKING AND COMMUNICATION' SESSION

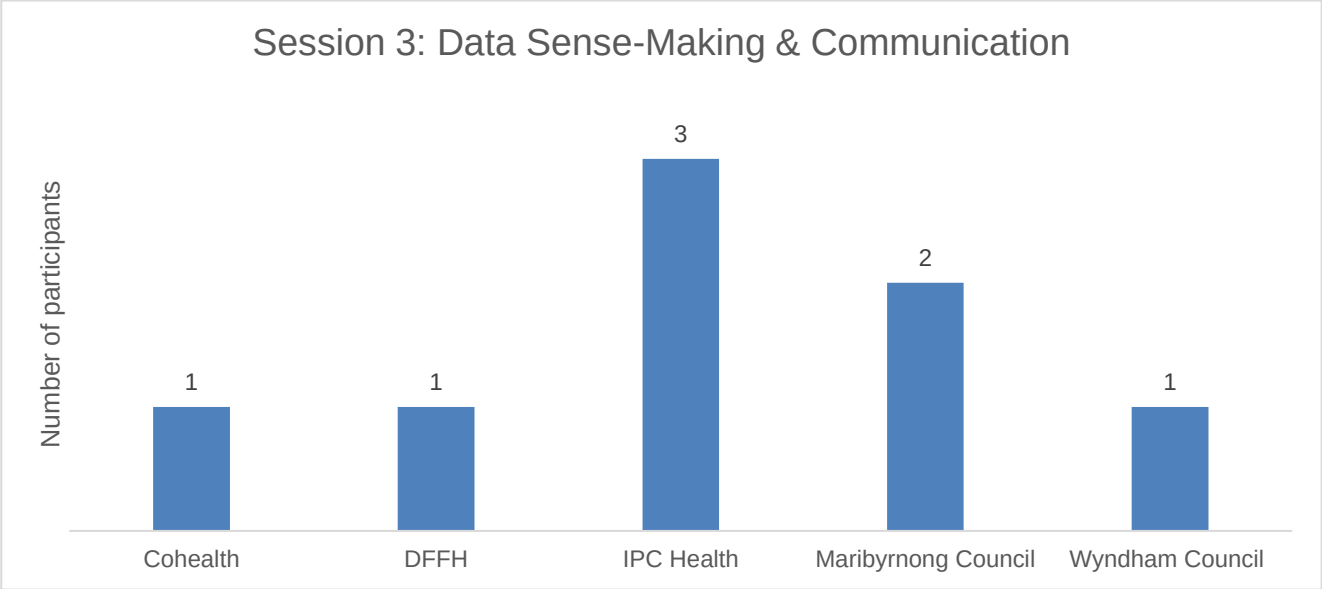
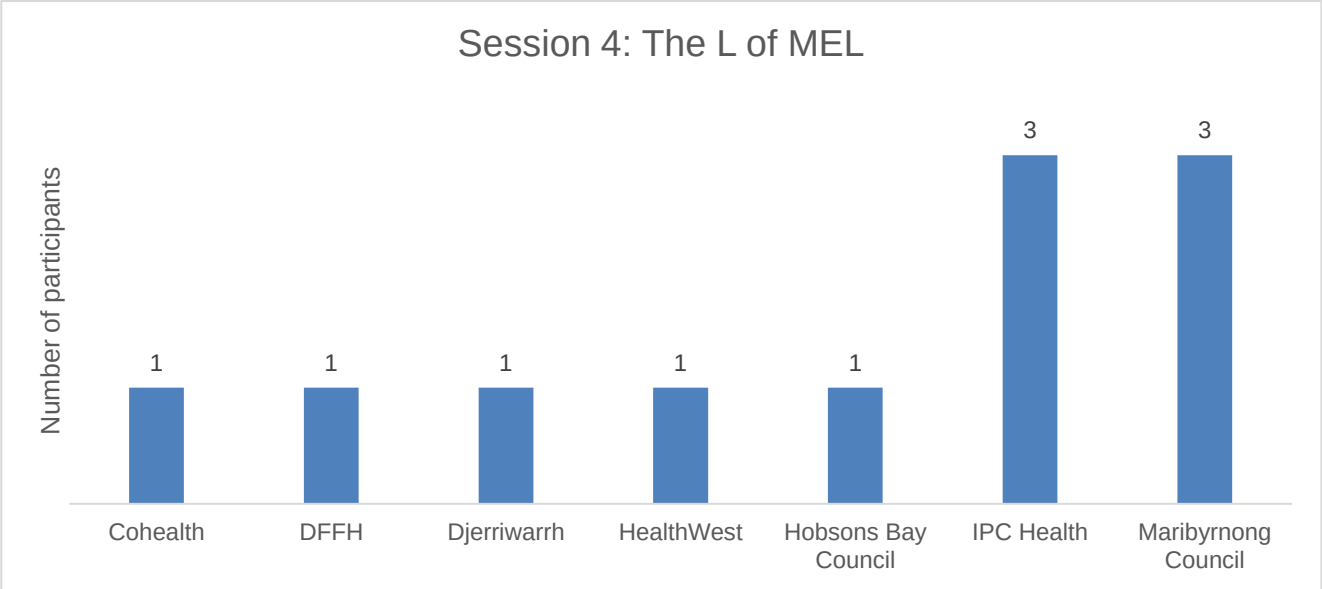
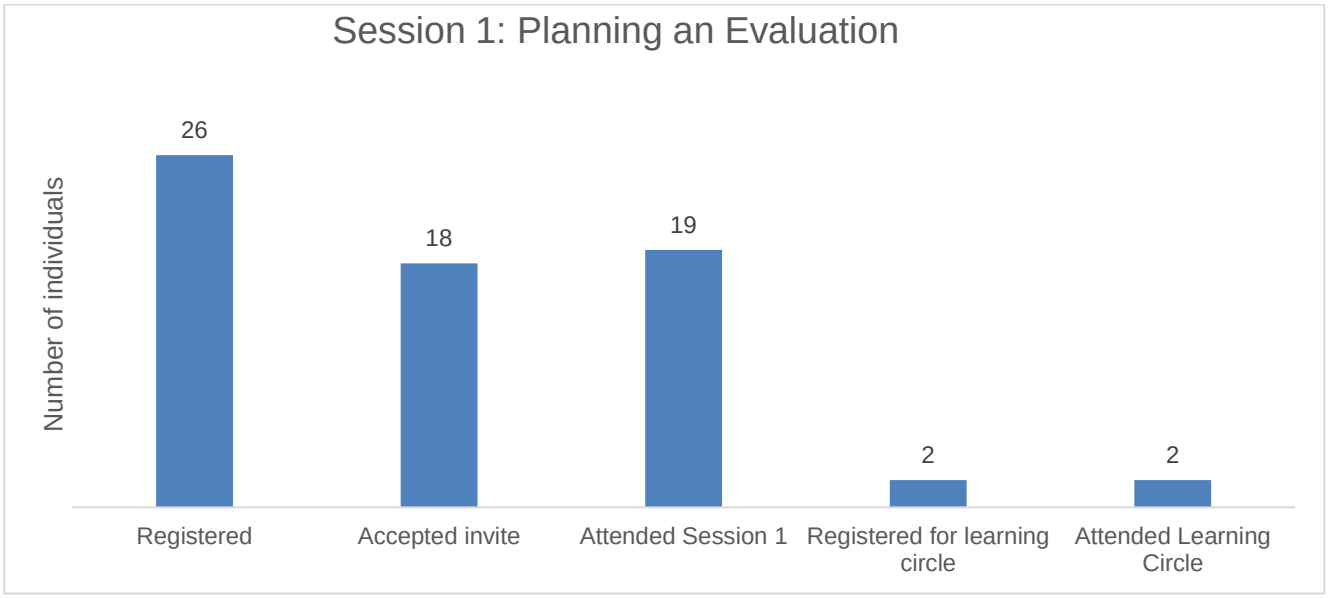



FIGURE 8 ORGANISATIONS IN ATTENDANCE AT 'THE L OF MEL' SESSION




The following graphs are drawn from individual registration and attendance records across the four training sessions held in 2021.

FIGURE 9: INDIVIDUAL ATTENDANCE AT 'PLANNING AN EVALUATION' SESSION




Detailed individual attendance data for Session 2 is not presented as there were some slight data discrepancies. However there were 18 attendees as laid out in Figure 6 above.

FIGURE 10: INDIVIDUAL ATTENDANCE AT 'DATA SENSE-MAKING AND COMMUNICATION' SESSION

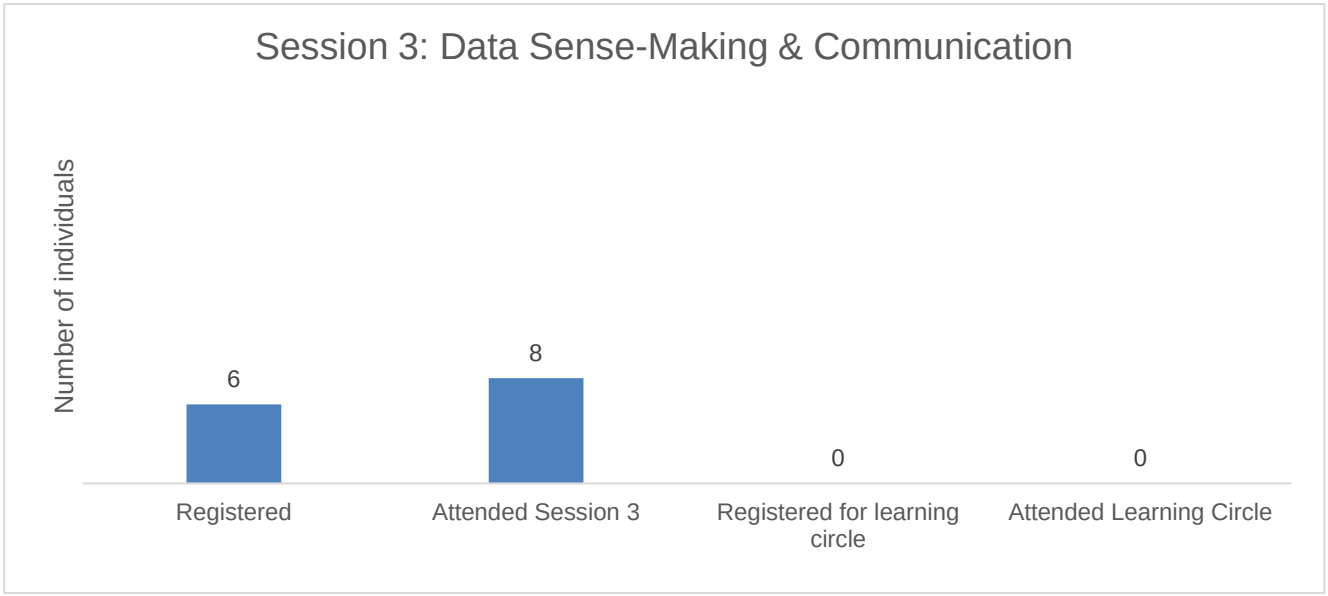
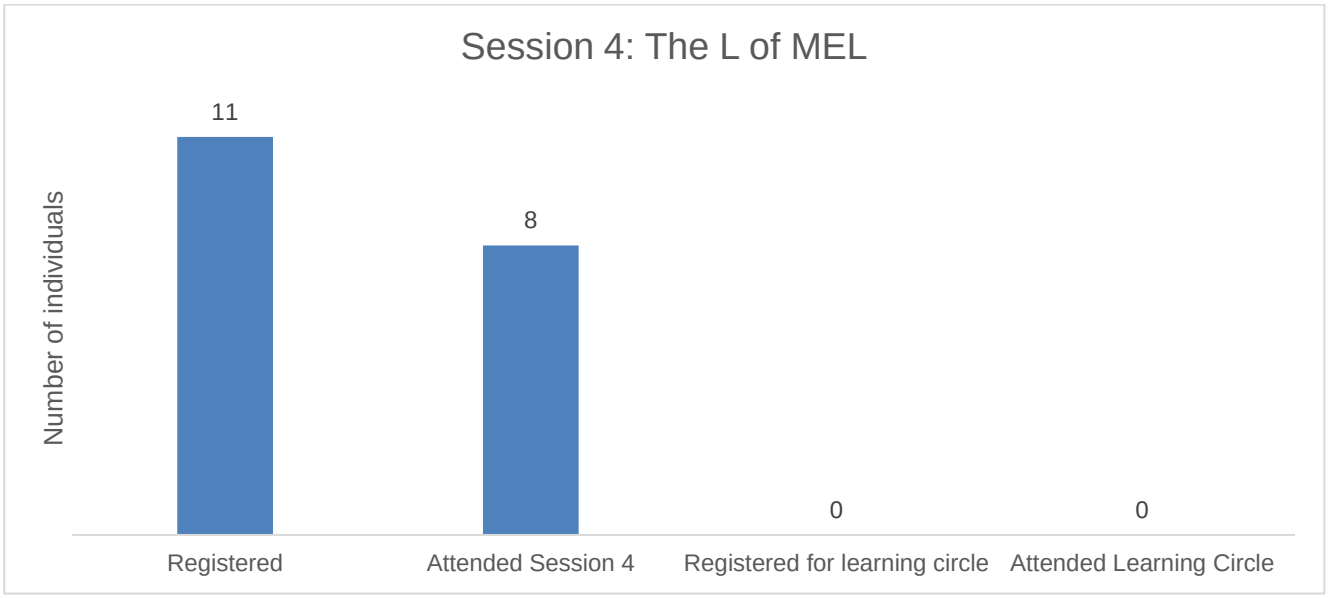


FIGURE 11: INDIVIDUAL ATTENDANCE AT 'THE L OF MEL' SESSION

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