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The utility of stakeholder involvement in the evaluation of community-based health promotion programmes

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Community-based health promotion programmes (CBHPPs) deal with cross cutting issues (social, economic, environmental) and utilise issue-based, population-based and setting-based approaches in programme planning, implementation and evaluation with the aim of empowering individuals and communities to gain control over the determinants of health. This multifaceted nature of CBHPPs has resulted in a number of questions particularly regarding the level of stakeholder involvement in evaluating such programmes. Evaluation is seen as one of the ways to provide evidence to inform health promotion decision-making and practice. Community programme implementers and lay people have lamented that evaluations are often imposed on them without recognition for the uniqueness of their community, its programmes, resources and skills. The aim of this paper is to critically examine the utility of stakeholder involvement in the evaluation of CBHPPs. We first explore the nature of CBHPPs and the methods of gathering evidence via evaluation. This is followed by a critical examination of the value of stakeholder involvement in evaluating CBHPPs. The Ottawa Charter for Health Promotion is used to conceptualise the paper with specific examples of stakeholder involvement in evaluation of CBHPPs used to support our arguments. The paper concludes that stakeholder involvement in evaluation of CBHPPs is of importance considering the empowerment and participation values of health promotion. As evaluation is done with people and not on people, stakeholder involvement should be central to the evaluation of CBHPPs rather than adopting an approach whereby the researcher is completely detached from the programme stakeholders particularly the community.

Keywords: community-based health promotion programmes; evaluation; stakeholder; epistemology

Introduction

The aim of this paper is to critically examine the utility of stakeholder involvement in the evaluation of community-based health promotion programmes. A number of arguments have been raised for and against the value of stakeholder involvement in evaluating community-based health promotion programmes (CBHPPs). One side of the argument is the need to build a strong form of evidence which is objective and reliable thus making programme evaluation a preserve of external evaluators or researchers (Green and South 2006). On the other side is the call for active involvement of internal evaluators (practitioners and community members) in the evaluation of CBHPPs thus keeping in tandem with the participation and empowerment values of health promotion (WHO 1998). Little attention has been paid to addressing these conflicting arguments in the literature on evaluation of health promotion programmes. More often than not, the most cited argument against

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stakeholder involvement is the purported difficulty associated with multiple perspectives in the evaluation process (Zani and Cicognani 2009). Health promotion practitioners, policy makers and commissioners are therefore in a dilemma as to what constitutes the true value of involving stakeholders in the evaluation of CBHPPs. It is for this reason that this paper aims to contribute to the literature on stakeholder involvement in evaluating CBHPPs.

In this paper, we first explore the nature of CBHPPs and the methods of gathering evidence via evaluation. This is followed by a critical examination of the value of stakeholder involvement in evaluating CBHPPs. To situate the value of stakeholder involvement in evaluation of CBHPPs, the Ottawa Charter for Health Promotion is used to conceptualise the paper. Specific examples of stakeholder involvement in evaluation of CBHPPs are used to support our arguments.

The Ottawa Charter and evidence-based health promotion

The Ottawa Charter has been a reference point for health promotion practice for the past 29 years (WHO 1986). The five strategies – build healthy public policy; create supportive environments for health; strengthen community actions; develop personal skills; and reorient health services outlined in the Charter – now, almost incidentally, routinely provide the framework for consideration of any major health promotion (Nutbeam 2008). The Charter has been criticised for providing a framework for the practice of health promotion without recourse to the role of evidence in health promotion practice. Evans et al. (2007) for instance, observe that due to their absence from the Ottawa Charter, evidence and effectiveness were not prioritised as important, and as a result, attracted less attention early on. However, in recent times, evidence-based health promotion has come high on the public health agenda and continues to inform health promotion decision-making and practice (Tones and Green 2010). Wiggers and Sanson-Fisher (1998, 126) define evidence-based health promotion as the ‘explicit application of quality research evidence when making decisions’. Evidence-based health promotion thus aims at ensuring that policy and practice are informed by reliable and strong evidence so as to address uncertainties in health promotion decision making and setting of priorities (MacIntyre and Pettigrew 2000; Raphael 2000; Tones and Green 2010). This need not be seen as a mere rhetoric as there exist a number of health priorities for which strong evidence is needed to underpin effective intervention.

Evaluation has been seen as one of the ways to provide primary evidence to inform health promotion decision-making (WHO 1998; McQueen and Anderson 2001). Some authors (Potvin, Haddad, and Frohlich 2001; Davies and Macdowall 2006) have argued that evaluation which involves stakeholders provides evidence on effectiveness from different perspectives which can help inform health promotion practice. Community programme implementers and lay people have, however, lamented that evaluations are often imposed on them without recognition for the uniqueness of their community, its programmes, resources and skills (Labonte and Robertson 1996). McQueen and Jones (2007) argue that though the Ottawa Charter provides a framework for the practice of health promotion without explicit mention of the use of evidence, it can be inferred that this same Charter and its guiding principles can be applied to assessing health promotion effectiveness from multiple perspectives to contribute to evidence-based practice.

The nature of community-based health promotion programmes

The Ottawa Charter has broadened the scope of health promotion beyond the biomedical model which primarily focused on disease prevention at individual levels (Nutbeam 2008;
Naidoo and Wills 2009). There is now emphasis on community-wide programmes which have wider scope and greater effect on health and its determinants than interventions focusing on individuals (Potvin and Richard 2001). CBHPPs can be defined as a set of multiple strategies with a number of activities which focus on a ‘community’ as an institution or community response to a particular situation (Bracht 1999). ‘Community’ here refers to a heterogeneous group of people with identified institutions, social norms and well defined structure for local governance (Green and Novick 2001; Russell-Mayhew 2006).

CBHPPs deal with cross cutting issues (social, economic, environmental) and utilise issue-based, population-based and setting-based approaches in programme planning, implementation and evaluation (Hubley and Copeman 2008; World Health Organisation 2008a) with the aim of empowering individuals and communities to gain control over the determinants of health (Wilkinson and Marmot 2003; Laverack 2004). For example, a community-wide programme on healthy eating may have a number of activities including health education, developing cooking skills, addressing the barriers to healthy foods, among others. CBHPPs are thus often implemented with the understanding of holistic health; they are also horizontal in nature, try to modify the social context that influences behaviours (Tones and Green 2010) and are also empowering, participatory, intersectoral and multi-strategic in nature (Bracht 1999; Rootman et al. 2001).

These characteristics of CBHPPs reflect the multidisciplinary nature of health promotion as well as the participation and empowerment philosophies of the Ottawa Charter and Alma Ata Declaration on primary health care (WHO 1986, 2008b). CBHPPs are also aligned with the settings approach to health promotion (Glouberman 2000; WHO 2002; Dooris 2009) as emphasised by the Ottawa Charter that ‘health is created and lived by people within the settings of their everyday life; where they learn, work, play and love’ (WHO 1986, v). To sum up, CBHPPs can be seen as people centred, socially constructed, involving multiple stakeholders and may adopt multiple strategies which could yield multiple outcomes (intended and unintended). All of these have implications for the methodologies that will be required to evaluate such interventions in building on evidence-based health promotion (Fawcett et al. 2001; Green and South 2006).

Methods of evaluating health promotion programmes

Finding out what the real ‘value’ of CBHPPs is of greatest importance considering the demand they place on resources (Katz, Peberdy, and Douglas 2000; Godfrey 2001). That is, are CBHPPs effective? Is it worth spending money on these interventions? Health promoters are faced with these kinds of evidence-based questions which need to be answered at least to win political or donor support for most community-based programmes (WHO 1998). Having access to evaluation results may help satisfy this call for evidence-based practice in health promotion (Wright 1999; Rychetnik et al. 2002).

‘Evaluation is concerned with assessing whether programmes are effective’ (Green and South 2006, 4). According to Rootman et al. (2001) programme evaluation is the process of systematically investigating the effectiveness of a programme. ‘Effectiveness’ here implies the degree to which programme goals are being met (Douglas et al. 2007). Programme evaluation could thus serve several purposes including for experiential learning, for accountability, impact of programmes on beneficiaries and evidence to inform policy making (Tones and Green 2004; Green and South 2006).

Three main kinds of evaluation have been identified, namely formative, process and summative (outcome) evaluation (Tones and Tilford 2001). Formative evaluation collects
information during programme implementation and this information is often turned into action (Tones and Tilford 2001). The tracking of what happens in the course of programme implementation to document the strength and weaknesses, how and why the programme works is however termed as process evaluation whereas summative/outcome evaluation occurs at the end of the programme to assess the degree of programme success (Thorogood and Coombes 2004). The understanding and appreciation of these kinds of evaluation are crucial in determining the methodology which should be used to generate evidence via evaluation of health promotion programmes.

Although evaluation somewhat differs from research in that evaluation determines the ‘value’ of things while research is value free (Scriven 2003), evaluation still uses research methodologies (quantitative and qualitative) (Rossi, Lipsey, and Freeman 2004). Quantitative methodology belongs to the positivist tradition which holds the belief that there is a single truth which can be measured objectively (Bryman 2008) whereas qualitative methodology is more of an interpretivism approach focusing on ‘how the social world is interpreted, understood, experienced or produced’ (Mason 2002, 4).

The use of a particular methodology may have implications on the kind of evidence generated. There therefore exists some epistemological debates on the ‘appropriate’ methods required to determine evidence of the effectiveness of CBHPPs via evaluation (Thorogood and Coombes 2004; Springett 2001; South and Tilford 2000). Traditionally, experimental designs using random assignments and control groups (randomised controlled trials (RCTs) and rooted in the positivist tradition have often been used in evaluating programmes to determine their effectiveness (Broughton 1991). Proponents of RCTs argue that RCT provides the highest form of evidence by controlling intervening variables and thus increasing the validity of evaluation findings (Koelen, Vaandrager, and Colomer 2001). It has been argued, however, that the traditional methods (RCTs) focus more on outcome evaluation and the danger is that only things that are measurable are measured using such approach to the detriment of process evaluation (Thorogood and Coombes 2004). This narrow focus on health outcome is rooted in evidence-based medicine and often does not address issues important in health promotion (e.g. empowerment, participation and equity) (Judd, Frankish, and Moulton 2001; Russell-Mayhew 2006).

Similarly, CBHPPs focus on a wider population and as such they are not ‘neatly packed’ like clinical interventions that lend themselves to randomisation and quantification of results (Green and Tones 1999; Broughton 1991; Tones and Green 2010). Most importantly, health promotion values like autonomy and ethical principles such as ‘cause no harm’ limit the use of RCTs in health promotion evaluation (Armstrong, Waters, and Doyle 2008). That is, relying solely on experimental designs to evaluate the effectiveness of CBHPPs will result in missing out on other important issues such as how and why the programme works and what other health determinants the programme impacts on.

The limited applicability of experimental designs in health promotion has resulted in the call for qualitative methods and/or mixed methods in gathering evidence in the evaluation of health promotion programmes (Katz, Peberdy, and Douglas 2000). This is in line with Sackett and Wennberg (1997) and Glasziou et al.’s (2004) suggestion that the kind of questions and the type of evaluation will determine which method is appropriate.

In their Comprehensive Community-oriented Evaluation (CCOE) model, Walden and Baxter (2001) note that to achieve comprehensive results in evaluation, there is the need for the use of mixed methods (quantitative and qualitative) in evaluating community-based health promotion programmes. For instance, qualitative studies have great value as they can provide evidence on how well the programme fared in reaching its intended
outcomes as well as how equitable the programme was (Green 2000; Springett 2001; Macdowall, Bonell, and Davies 2006). Similarly, in a process evaluation where there is the need to learn from the programme’s successes and failures and the level of stakeholder satisfaction in order to ensure effective replication, qualitative studies combined with quantitative studies will be most appropriate (Perkins, Simnett, and Wright 1999; Daly et al. 2007).

The use of mixed methods in evaluating programmes gives room for triangulation, stakeholder involvement, and validating quantitative findings via qualitative data (Denscombe 2007) which enriches the depth of analysis (Parry-Langdon et al. 2003). This is directly in line with Tones and Green’s (2004, 2010) call for the use of ‘judicial principle’ where evidence is sought from different sources. Mixed methods fit the ‘realistic evaluation’ approach (context + mechanism = outcome) proposed by Pawson and Tilley (1997 cited in Beattie 2003, 244) which enhance in-depth analysis of the programme context and enrich the findings of evaluation (Parry-Langdon et al. 2003). For instance, the use of mixed methods to evaluate a community-based HIV/AIDS programme was greatly embraced by the project staff and the management team as for them ‘it opened their eyes’ and enriched the evaluation process (Walden and Baxter 2001). A major challenge that occurs when a mixed method is employed in evaluation is getting a seasoned facilitator to facilitate qualitative data collection methods such as group interviews and focus groups in assessing programme’s effectiveness (Bowling 2009). Following the discussions on the nature of CBHPPs and the debates on evaluation methodologies, the next section discusses the utility of involving stakeholders in evaluating community-based health promotion programmes.

The value of health stakeholder involvement in evaluating CBHPPs

The key principles espoused by the Ottawa Charter for promoting health include empowerment, participation and intersectoral collaboration (Nutbeam 2008). CBHPPs involve a number of stakeholders and in line with the participation, empowerment and intersectoral principles of health promotion, stakeholder involvement cannot be undermined in evaluating such programmes. Green and South (2006, 33) outline ten principles of evaluating public health interventions of which stakeholder involvement features prominently. Stakeholders refer to individuals, groups or organisations with vested interest in a programme evaluation in that they may affect or be affected by it (Brugha and Varvasovszky 2000; Robson 2000; Buse, Mays, and Walt 2005). Stakeholders can be classified into primary (beneficiaries of programmes), key (those with high power to influence the programme) and tertiary stakeholders (those with intermediate interest in a programme) (Department for International Development 2003). In the evaluation of CBHPPs, the stakeholders may include policy-makers, programme managers/staff, community members and the researcher (external evaluator) (see Figure 1). Stakeholder involvement may vary depending on the evaluation stage and those commissioning, managing or undertaking the evaluation need to decide on who is to be involved and at what stage of the evaluation process (Green and South 2006). Robson (2000) maintains that there is the need for active involvement of stakeholders at each stage of the evaluation in order to achieve a high quality evaluation which will be useful.

Collaboration is at the centre of CBHPPs and this requires the involvement of all stakeholders in the programme evaluation (Springett 2001). In this case, an external evaluator becomes a collaborator rather than an expert who imposes a personal agenda (Fawcett et al. 2001). ‘The bringing together of stakeholders can have benefits over and
above those connected with the current evaluation’ (Robson 2000, 19). This can happen because stakeholder involvement in evaluation may result in empowerment and also create linkages that can be used in the future (Huberman 1990; Boots and Midford 2007).

Empowerment is a core value of health promotion and the involvement of stakeholders, particularly the community in programme evaluation, helps to realise this goal (Thorogood and Coombes 2004; Tones and Green 2010). Involving the community in programme evaluation helps to develop their capacity which empowers them to be able to carry out self-help community-programmes and also creates a sense of awareness of their problems (Springett 2001). That is, involving the community and other stakeholders in the evaluation process can help develop key skills (problem solving, communication, critical thinking and research) which are crucial for increasing their control over and improve their health. For instance, in a community-based environmental management programme in Bangkok, the involvement of the community in the evaluation played an educational role (Fraser 2002). Again, stakeholder involvement in evaluating community-based health promotion interventions can increase the legitimacy of health promotion interventions (Rootman et al. 2001).

As indicators are required to measure programmes’ effectiveness, it is important to involve the stakeholders (Smith et al. 2008). This is because involving the stakeholders (e.g. programme managers and communities) will help develop appropriate indicators that are socially constructed and which will not only measure outcomes (e.g. reduction in smoking rate) but also measure other determinants of health (e.g. extent of workplace policy on smoking) (McQueen and Anderson 2001; Fraser et al. 2006). Involving the stakeholders will also ensure that the indicators evolve over time as the local circumstances change (Fraser et al. 2006). For instance, in developing community indicators in a Healthy Community Initiative in Canada in a participatory manner, the stakeholders were very particular about developing indicators that would help measure changes occurring in the community due to the project aside the specific project outcomes (Smith et al. 2008). Similarly, Fraser et al. (2006) in their study on stakeholder involvement in developing indicators for programme evaluation found that the involvement of the stakeholders

![Diagram of Stakeholders in Evaluating Community-Based Health Promotion Programmes](image)
resulted in the development of a comprehensive list of indicators which had local relevance and the community was also empowered in the process.

It has been argued that in less participatory evaluation whereby the evaluator treats stakeholders as research ‘subjects’ and only focuses on finding the so called ‘truth’ in a manner of reliable and valid data from the stakeholders, the values of the researcher features prominently (Robson 2000). On the contrary, actively involving the stakeholders in a collaborative manner has the potential to ensure that stakeholder’s values particularly that of the community drive the evaluation agenda (Springett 2001). Tones and Green (2004), however, warn that active participation of communities, for example, may not happen due to power dynamics among the stakeholders as the values of the more powerful (e.g. funders and policymakers) may drive the evaluation as opposed to the values of the community. Notwithstanding these power dynamics, Green and South (2006) maintain that as a principle of evaluation, power structures should be recognised but evaluators need not be limited by them so as to incorporate lay views and contribute to empowerment. Active participation of stakeholders in the evaluation of six programmes in the USA was found to have contributed to development of user friendly evaluation reports and guidelines and practical lessons for programme improvement (Gilliam et al. 2002).

Stakeholder involvement in evaluation is particularly important in ensuring the implementation of recommendations. Springett et al. (1995, cited in Rootman et al. 2001, 32) argue that ‘if people have been involved in the process, they will already be committed to acting on the findings and be receptive to the results.’ Involving programme managers, practitioners and the community in the evaluation has greater significance for implementation of the recommendations as there will be a sense of ownership and the development of relevant and credible findings (WHO 1998). Again, involving policymakers and funders in the evaluation will ensure that the findings are not ignored but acted on (Rossi, Lipsey, and Freeman 2004). Research particularly on diffusion of innovation and theory of change indicates that ‘people are more likely to accept and use information, and make changes based on information, when they are personally involved in and have a personal stake in the decision-making processes aimed at bringing about change’ (Patton 1982, 61 cited in Robson 2000, 18).

Another significance of stakeholder involvement in evaluation is the creation of social capital through social networks (Parry, Gnich, and Platt 2001). When stakeholders are involved in evaluation, alliances and partnerships are created among individuals, between professionals and lay people, and across sectors which have the potential for addressing the determinants of health after the programme evaluation (Gillies 1998). Involving the stakeholders who have varied interest will thus to some extent ensure that the evaluation is carried out in an ethical manner due to the recognition of stakeholder interests which may foster bonding and bridging (Rootman et al. 2001) via unpicking of contextual issues like the way of working and networks among stakeholders (Poland, Frohlich, and Cargo 2008). Taylor (2007), for instance, notes that engaging with the stakeholders in the design, planning and implementation of the evaluation has the potential for sharing professional and lay resources. In a study on stakeholder involvement in evaluation, the authors reviewed eight studies on stakeholder involvement in evaluating community-based health promotion programmes and found that the involvement of stakeholders facilitated resource mobilisation, sharing of ideas and also enhanced the quality of evaluation data and outcomes (Boots and Midford 2007). Stakeholder involvement in the evaluation of community projects was similarly found to have fostered long-term relationship between evaluators and community members, and created an open dialogue in addressing the use of evaluation findings for programme improvement and capacity building (Gilliam et al. 2002).
Notwithstanding the strengths of stakeholder involvement in programme evaluation, there exist some weaknesses in the processes. Power imbalance remains a greater challenge (Eakin et al. 1996). For instance, the subjective views of stakeholders such as the community may be subordinated to the objective view of the researcher for validity reasons (Eakin et al. 1996). Again, is it the researcher or the other stakeholders such as policy-makers, programme managers or communities who determine ‘appropriate’ method? This is basically about power locus and remains a real challenge in participatory evaluation (Martin 1996). Stakeholder involvement in evaluation may further affect research reflexivity due to the exchange of views among ‘insiders’ (stakeholders) and ‘outsiders’ (the researcher) (Beattie 2003). This has the potential to affect the rigour of the findings as the researcher may not have total control (Allison and Rootman 1996).

Another challenge is that different stakeholders look at effectiveness with different kinds of lens (Nutbeam 2000) and this may limit participatory evaluation (Rychetnik et al. 2002; Rossi, Lipsey, and Freeman 2004). For instance, an attempt made by Nguyet Nguyen and Otis (2003) to involve stakeholders in the evaluation of a large-scale heart health programme in Canada was met with some challenges including lack of interest in the evaluation, conflicts with evaluation requirements, budgetary constraints and little involvement which resulted in gaps in data. That is, aside from the methodological problems associated with stakeholder involvement in evaluation, there are practical problems such as capacity of stakeholders to get involved and lack of time which may hinder stakeholder involvement in evaluation (Green and South 2006).

**Conclusion**

In a critical review paper such as this, assessing the value of stakeholder involvement in the evaluation of CBHPPs, there are many approaches that could have been used. We have focused on an approach that emphasised the critical role of the Ottawa Charter in shaping the health promotion agenda. We have critically examined the nature of CBHPPs, the methods of evaluation and the role of stakeholders in evaluation. Methodologically, we support the argument that there is the need to use multiple methods in evaluating CBHPPs since relying solely on experimental designs which hardly consider ‘how’ and ‘why’ programmes worked would barely serve the purpose of evidence-based practice in health promotion. Similarly, the nature of CBHPPs and the values and principles of health promotion warrant the use of multiple methods in evaluating these programmes. That is, the need for evidence should be balanced with an appropriate evaluation method which does not hinder stakeholder involvement (South, Bagnall, and Cattan 2008). This implies that researchers/external evaluators should aim at training stakeholders, particularly community actors to play an effective role in evaluation in order to achieve a desired balance of subjective view while maintaining the scientific rigour and objectivity. We conclude that stakeholder involvement in evaluation of CBHPPs is of importance considering the empowerment and participation values of health promotion. CBHPPs are more of a social structure with large scope in which various stakeholders are engaged in roles and activities that constitute the programme. As evaluation is done with people and not on people, stakeholder involvement should be central to the evaluation of CBHPPs rather than adopting an approach whereby the researcher is completely detached from the programme stakeholders.

**Disclosure statement**

No potential conflict of interest was reported by the authors.
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