Trends in evaluation: Preventing violence against women

Paper 1

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VicHealth

Evaluation capacity building in the Respect, Responsibility and Equality program: Report on Stage 1 (2008–10)

Dr Michael Flood

The evaluation of the VicHealth Respect, Responsibility and Equality program – utilising an evaluation capacity building approach – was undertaken in two distinct stages. The first stage spanned the period from August 2008 to February 2010 and was led and coordinated by Dr Michael Flood. The second stage spanned the period from February 2010 to August 2011 and was led and coordinated by Dr Wei Leng Kwok. Together, these practice papers summarise the approach taken during these periods and are authored by the respective Research Practice Leaders at those times on behalf of VicHealth. Together, these practice papers aim to contribute unique and relevant knowledge and perspectives to the field of evaluation in health promotion and public health more broadly.

Glossary

CDC   Centers for Disease Control and Prevention

ECB   evaluation capacity building

PCP   Primary Care Partnership

RPL   Research Practice Leader

RRE   Respect, Responsibility and Equality

WHO   World Health Organization

Since 2007, VicHealth has invested in the Respect, Responsibility and Equality program with the aim of building safer, more respectful environments for women. The program has had four distinct phases:

- Phase I (2008–9) provided 12-month grants to non-government and community organisations to develop settings-based primary prevention activities. A total of 29 projects were initially funded.

- Phase II (2008–11) provided grants to 'scale up' five of the original 29 projects for an additional three years to consolidate prevention activities in their settings.

- Phase III (2011–12) provided additional purpose-specific funding to the scaled-up projects to develop transferable tools, resources and 'how-to' guides. This funding also supported the project partners to develop strategies for program sustainability.

- Phase IV (2011–15) is a world-first, site-based saturation approach to the primary prevention of violence against women. It sees the learnings from the previous phases and the tried and tested five projects trialled in one locality for a period of three years.

Contents

Introduction and overview

In the prevention of violence against women, there is a growing emphasis on the need to evaluate the impact of one's efforts. However, community organisations face real challenges to evaluation. Therefore, there is a strong rationale for what some call 'empowerment evaluation', through which local stakeholders develop the capacity to evaluate their work.

This report describes a sustained program of capacity building in evaluation among five local projects aimed at preventing violence against women in Victoria. The Victorian Health Promotion Foundation (VicHealth) has had a significant program of activity dedicated to preventing violence against women, one element of its wide-ranging involvements in health promotion. Such activities included providing support for five projects over 2008–11. As part of this, VicHealth sought to build the capacity of these projects to evaluate their prevention efforts.

This report describes VicHealth's involvement in evaluation capacity building in preventing violence against women, the significance of and wider context for this, and the outcomes of this work. The report focuses on the first stage of this activity, over its first 18 months (2008–10), while a second report focuses on the second stage.[1] These reports represent a timely contribution to the rapidly developing fields of evaluation and evaluation capacity building.

This report aims to:

1. document and assess VicHealth's involvement in evaluation capacity building among five preventing violence against women projects in Victoria

2. contribute to growing community, professional and scholarly discussion and awareness of evaluation in violence prevention

3. enhance future efforts by community organisations to evaluate their violence prevention projects and by these and other organisations to build their capacity to do so.

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[1] The 18-month mark of the RRE program coincided with a change in RPL staffing. This paper covers the period from September 2008 to February 2010 when the RPL role was filled by Dr Michael Flood. Following this period Dr Wei Leng Kwok held the position. Dr Kwok's reading of the final 18 months of VicHealth's evaluation practice for the RRE program can be found in her paper *Evaluating preventing violence against women initiatives: A participatory and learning-oriented approach for primary prevention in Victoria* at www.vichealth.vic.gov.au/publications. The change in staffing also resulted in a significant re-development of the approach to evaluation capacity building, as described in these papers.

The report was written after approximately 18 months of capacity building activity among the five community projects. It reflects on this activity over the period from September 2008 to February 2010. This was a natural mid-point for the projects' implementation and therefore provided a milestone opportunity for reflection on the story so far.

The report begins by introducing the Victorian Health Promotion Foundation's involvements in the prevention of violence against women, including its work with five community-based prevention projects in Victoria. The report then outlines the growing emphasis on evaluation in violence prevention and more generally. It notes the challenges faced by community organisations in conducting rigorous evaluations of their involvements in preventing violence against women. It describes the emergence of models of 'empowerment evaluation' through which stakeholders themselves evaluate their programs, and the associated emergence of emphases on evaluation capacity building.

The report then provides a detailed account and assessment of VicHealth's involvement in building the capacity to engage in evaluation of the five community-based projects. It examines both the achievements and the limitations of this evaluation capacity building work. The report concludes by offering insights into the ongoing challenges, on the one hand, of impact evaluation by community organisations, and on the other, of efforts to build community capacity in evaluation.

A note on this report

This report does not offer detailed commentary on evaluation by individual projects and the coordinators associated with them. While it does give examples from particular projects and reports on the views and experiences of particular coordinators, details have been omitted to protect the anonymity and confidentiality of both coordinators and projects. In referring to individual coordinators' comments, the report uses the feminine tense throughout, although one project coordinator was male. Although the report has been authored by the evaluation researcher who was involved in the first stage of capacity building, Dr Michael Flood, he is referred to in the third person to aid the report's readability.

In assessing the impact of VicHealth's efforts at capacity building among the five violence prevention projects, this report uses several sources of information or 'data': the Research Practice Leader's experiences of and reflections on 18 months of capacity building, his assessment of the project's developing involvements in evaluation (including documents such as their evaluation and project plans and their ongoing data collection and analysis), and project coordinators' feedback on this capacity building. Data regarding the coordinators' experience of capacity building was drawn in

particular from a focus group run with most of the coordinators in January 2010. In this instance, the coordinators acted as 'key informants', providing information on the basis of their professional roles and involvements (NHMRC 2007, p. 26). Unfortunately, two of the original five project coordinators were unable to participate in the group. At the same time, three newer project coordinators participated alongside the other three original coordinators as they had recently joined the projects represented.

This report endeavours to provide a critical assessment of VicHealth's involvement in evaluation capacity building in the prevention of violence against women. Of course, this assessment may be shaped by the author's and VicHealth's own commitment to the success of these efforts. Project coordinators' feedback to VicHealth may be shaped by biases associated with both social desirability and their dependence on VicHealth funding, although as these papers describe, a key aspect of the evaluation capacity building approach is to cultivate a culture of learning within both the funder and the funded agency. Nevertheless, this report strives to present a fair account of both the successes and limitations of the capacity building effort on which it focuses.

VicHealth's violence prevention work

The Victorian Health Promotion Foundation (VicHealth) is a statutory authority dedicated to the promotion of good health.[2] While VicHealth's mandate centres on the state of Victoria, its health promotion work has had national and international significance. Since 2004, this has included a very substantial program of activity dedicated to the prevention of violence against women.

A public health model

VicHealth's work in preventing violence against women involves a public health model that:

• recognises the health impacts of violence against women

• is based on evidence regarding the determinants of violence against women and its prevention

• is oriented to the primary prevention of violence

• recognises determinants of violence at multiple levels of society: individual and relationship, community and organisational, and societal.

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[2] An overview of VicHealth's wider work and the research and program activity to prevent violence against women specifically are available at www.vichealth.vic.gov.au and www.vichealth.vic.gov.au/Programs-and-Projects/Freedom-from-violence.aspx

This work further involves:

- ongoing research intended to build the evidence base in relation to both determinants of violence against women and effective strategies for prevention

- the promotion of prevention activities across multiple levels of society

- partnerships with communities, institutions and agencies

- the elaboration and extension of the reach and impact of existing prevention efforts.

VicHealth's framework to guide action to prevent violence against women, titled *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria* (2007a), provides a sound theoretical and evidence base for prevention activity. *Preventing violence before it occurs* involved a systematic review of research and evaluation evidence regarding the determinants of men's violence against women and its prevention, and the identification of priority strategies, settings and population targets for prevention. *Preventing violence before it occurs* represents the refinement and elaboration of VicHealth's public health model of violence prevention, and it has been highly influential in both state and national policy and programming.

Two further features of VicHealth's public health model of violence prevention deserve comment. First, this framework is oriented to *primary* prevention. Activities to prevent and respond to interpersonal violence can be classified in a number of ways. One of the most common is a three-part classification of activities according to when they occur in relation to violence: before the problem starts, once the problem has begun, or after it has occurred.[3] *Primary* prevention activities take place *before* violence has occurred to prevent initial perpetration or victimisation. *Secondary* prevention involves responses immediately *after* violence has occurred to deal with the short-term consequences of violence, to respond to those at risk, and to prevent the problem from re-occurring or progressing. *Tertiary* prevention involves long-term responses *after* violence has occurred to deal with the lasting consequences of violence, to minimise its impact, and to prevent further perpetration and victimisation. Primary prevention strategies seek to remove the causes or 'determinants' of violence against women, to prevent the development of risk factors associated with violence, and/or to enhance factors that protect against violence (Chamberlain 2008, p. 3).

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[3] This summary combines and modifies the accounts given by the CDC (2004, p. 3) and Chamberlain (2008, p. 3). See both documents for more sophisticated matrices of various strategies of prevention. Note that VicHealth's own articulation of the public health model describes secondary and tertiary prevention in terms of 'early intervention' and 'intervention' respectively (VicHealth 2007a, pp. 8–9).

Primary prevention activities take place *before* violence has occurred to prevent initial perpetration or victimisation.

The second significant feature of VicHealth's public model of prevention is its recognition of determinants of violence against women at multiple levels of society. VicHealth draws on the 'ecological' model pioneered by the World Health Organization (WHO), in tandem with feminist work. The ecological model embodies the recognition that men's violence against women is the outcome of a complex interplay of individual, relationship, community, institutional and societal factors and that violence prevention too must work at these multiple levels (Heise 1998; VicHealth 2007a, pp. 26–8, 2009, pp. 14–15; WHO 2002, 2004).

VicHealth's prevention activities themselves, as a corollary, also address multiple levels of society. The framework *Preventing violence before it occurs* (2007a) identifies a range of desirable prevention activities in relationships and families, in organisations and communities, and in society in general, particularly with reference to gender relations, norms and inequalities. VicHealth has supported primary prevention programs and strategies across such levels.

As part this work, VicHealth supports research that builds the evidence base in relation to both determinants of violence against women and effective strategies of prevention. Such research has made significant contributions to our understanding of key factors shaping violence against women. Finally, VicHealth's work in preventing violence against women is conducted in partnership with a variety of communities, institutions and agencies (VicHealth 2007c).

Support for community-based violence prevention

One of the most significant bodies of prevention activity in which VicHealth engages is in supporting community-based violence prevention projects. Such projects have particular value in addressing determinants of violence against women at the local or community level, facilitating community engagement and development, and allowing intensive interventions among particular populations or in particular settings.

VicHealth enacts its support for community-based prevention primarily through the Respect, Responsibility and Equality: Preventing Violence against Women program. In Phase I of this program (2007–08), VicHealth provided 'seed' funding for 12 months to non-government and community organisations to develop setting-based primary prevention activities. As its overview noted:

> The main focus of the projects will be on strengthening communities and organisations to create environments which value and support norms that are non-violent and build respectful and equitable gender relations. (VicHealth 2007b, p. 1)

The projects were chosen on the basis of their fit with the evidence identified in VicHealth's prevention review and framework *Preventing violence before it occurs*. The projects fell into one of seven broad groups in terms of the primary setting or population on which they focused: the media, culturally and linguistically diverse communities, men and boys, local and regional communities, schools, indigenous communities, and workplaces (VicHealth 2007b). A total of 29 projects were funded with the aim of scoping the potential preventing violence against women work that could be undertaken in the settings.

In Phase II of this program (2008–11), VicHealth provided grants to 'scale-up' five of the original 29 projects for an additional three years to consolidate prevention activities in their settings. Rather than simply continuing their existing activities, the five projects were expected to consolidate and extend their practice, scale up their efforts, and contribute towards a growing evidence base for primary prevention.

In Phase III (2011–12), the scaled-up projects received additional purpose-specific funding to develop transferable tools, resources and 'how-to' guides, and to develop strategies for program sustainability (VicHealth 2012, p. 2).

Given this report's focus on evaluation capacity building among the five 'scale-up' projects, it addresses only Phase II of the program, with a focus on the first stage of evaluation capacity building during 2008–10. During this time, VicHealth provided support to the five community organisations running these violence prevention programs in various forms, including funding, administrative liaison, and advice. The five project coordinators and VicHealth staff met in regular 'learning circles', sharing reports on their progress and discussing issues arising in each project. A VicHealth RPL worked with the project coordinators. However, VicHealth also particularly sought to build the capacity of each project to evaluate its violence prevention work. This report returns to a detailed account and assessment of VicHealth's involvement in such work after it outlines the field of evaluation capacity building in general.

VicHealth's summary report provides a useful overview of the five 'scale-up' primary prevention projects supported in the Respect, Responsibility and Equality: Preventing Violence against Women program (VicHealth 2012), while its *Sharing the evidence* series provides detailed reports on each.[4]

The projects include engagement with a wide range of settings: faith-based institutions and congregations, a city council, a commercial company, and violence prevention networks themselves. The projects focus their efforts on diverse populations, from new parents, blue-collar coordinators, and community sector coordinators to religious leaders, Council staff, and senior managers. The projects employ a range of strategies, from face-to-face education and training, to the production and dissemination of media materials, to the development of policies and procedures. At the same time, each project is centred on a type of setting or population identified in VicHealth's (2007a) primary prevention framework as an important one for prevention. All five projects use prevention strategies that are identified in the literature as either *promising* (i.e. they show both a theoretical rationale and evidence of implementation) or *effective* (i.e. they show a theoretical rationale, evidence of implementation and evidence of effectiveness) (Flood 2007).

VicHealth invested substantially in building the five project coordinators' capacity to evaluate their violence prevention efforts; the next section outlines the context for this investment in evaluation.

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[4] The summary report is available at www.vichealth.vic.gov.au/Publications/Freedom-from-violence/Respect-Responsibility-and-Equality-program-report.aspx. The full project reports are available at www.vichealth.vic.gov.au/en/Publications/Freedom-from-violence/Sharing-the-evidence.aspx

The rise of evaluation

Evaluation has emerged as a necessary component of health promotion and violence prevention efforts. Evaluation can be defined as:

> the systematic review and assessment of the features of an initiative and its effects, in order to produce information that can be used to test and improve the project's workings and effectiveness. Evaluation is a process that can take place before, during and after a project. It has three broad roles. 'Formative' evaluation (including needs assessment) supports the development of the project, 'process' evaluations examine program delivery and uptake, and 'impact', 'outcome' or 'summative' evaluation assesses the project's impact. (Flood 2009, p. 57)

This report begins by discussing the place of evaluation in the field of health promotion, where it is institutionalised, and then turns to the field of primary prevention, in which systematic evaluation is a newer arrival.

Evaluation in health promotion and violence prevention

Evaluation is well established in health promotion. In this and other fields of public health, there is a pervasive expectation that prevention or health promotion efforts will be complemented by examination of their effectiveness. There is thus a growing emphasis on what many have termed 'evidence-based practice' – on the conscientious and judicious use of current best evidence in guiding program design and implementation.

The centrality of evaluation in public health practice is evident in the local context. In Victoria, state health policy has been guided for at least a decade by an 'integrated health promotion' framework. One of the guiding principles of this framework is that activities should be based on the best available data and evidence, so that evaluation plays a vital role in health promotion.[5] The integrated health promotion approach has involved systematic development, dissemination and implementation of evaluation frameworks and tools, and efforts to build community and organisational capacity to use them (W.L. Kwok, pers. comm., 28 March 2010). Agencies involved in these efforts include community and women's health services, Primary Care Partnerships (PCPs)[6] and local governments.

In the field of primary prevention of violence against women, on the other hand, a systematic emphasis on the need for evaluation of one's efforts is a more recent arrival. Evaluation *per se* is less

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[5] See www.health.vic.gov.au/healthpromotion/evidence_evaluation/index.htm

[6] Primary Care Partnerships (PCPs) are an initiative of the Victorian Department of Human Services (DHS). They 'comprise voluntary alliances of primary care providers, usually covering two or three local government areas … PCPs aim to improve the health and well-being of people in their communities through coordination of planning and service delivery.' (Woodland & Hind 2002, p. 1)

common as an aspect of violence prevention practice, and what evaluation does exist is often methodologically and conceptually limited (Flood, Fergus & Heenan 2009, p. 57; Carmody et al. 2009, pp. 54–5). Moreover, focused efforts in Australia to integrate evaluation practices among community agencies, let alone to institutionalise these at the state level, are rare. At the same time, there are some notable efforts internationally to do so, including US-based work in evaluation capacity building by the Centers for Disease Control (see below) and the World Health Organization's (2009) recent dissemination of evidence regarding violence prevention. In violence prevention, the absence of multi-agency and collaborative involvements in evaluation is likely to reflect the youth of this field relative to such fields as health promotion.

One significant influence on the increasing emphasis on evaluation in violence prevention is the growing dialogue between this field and that of public health. Violence against women increasingly has been framed as an issue of public health by both leading international agencies (WHO 2002, 2004) and violence prevention advocates and scholars (Chamberlain 2008; Chrisler and Ferguson 2006; McDonald 2000; McMahon 2000; Mulder 1999). Public health approaches increasingly are seen as valuable in informing the prevention of this violence (Chamberlain 2008, p. 7; Guy 2006; McMahon 2000, p. 30; Noonan & Gibbs 2009, p. 65). At the same time, there are some differences in emphasis between public health approaches and the feminist and other approaches that dominate the field of prevention of violence against women (Lee 2010; Parks 2009).

> **One significant influence on the increasing emphasis on evaluation in violence prevention is the growing dialogue between this field and that of public health.**

Evaluation is emerging as a necessary component of violence prevention. Just as in health promotion, a 'science' of prevention is emerging, drawing on knowledge gained in the behavioural and health sciences. This scholarship examines what works and what does not, the factors that mediate the effectiveness of prevention efforts, and so on (Noonan & Gibbs 2009, p. 5).

For community organisations engaged in violence prevention, there are obvious benefits to the development of a robust evaluation practice. Implementing rigorous impact evaluations means that community organisations can:

• find out whether what they are doing works, in what ways and for whom

• provide evidence of the benefits and impacts of their work

• make sure and show that objectives are met

• identify problems and weaknesses so they can be solved

- provide information to aid further development

- build capacity and understanding for future work and evaluation (Care Services Improvement Partnership 2006, p. 2).

Improvements in projects' evaluation planning and implementation also lead to improvements in overall program quality. More widely, for organisations such as VicHealth, developing effective forms of evaluation and evaluation capacity building intensifies their contribution towards the field of violence prevention and, above all, their impact on the prevention and reduction of men's violence against women.

Challenges in community-based evaluation

There is debate in the field of evaluation about ideal models of research. For some, evaluation should adopt the models of knowledge production dominant in the traditional natural sciences. Here, knowledge is seen ideally as produced through experimental studies, involving randomised distribution of participants into treatment and control groups, conducted by independent and objective observers. The 'gold standard', therefore, for evaluation is the randomised control trial (Kippax & Van de Ven 1998; Kippax & Stephenson 2005). However, others are critical of this approach and the notion of these approaches being regarded or imposed as the optimal approach to evaluation.[7]

There are three reasons why experimental designs are inappropriate for evaluations of primary prevention projects. First, not-for-profit and community organisations typically do not have the capacity to conduct evaluations based on an experimental design. Second, the programs run by community organisations typically have features that rule out an experimental design. Third, experimental designs may be politically and practically inappropriate (Goodman & Noonan 2009).

The most important reason why not-for-profit and community organisations rarely use experimental designs in evaluating their primary prevention programs is that they simply do not have the capacity to do so. Very few are funded to implement such standardised and resource-intensive evaluations of their work. In addition, very few community workers have the research expertise – the methodological and theoretical skills – to undertake such evaluations. (This does not rule out the

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[7] The critical analysis of the 'gold standard' is explored further in the second paper of this series, Kwok, WL 2013, *Evaluating preventing violence against women initiatives: A participatory and learning-oriented approach for primary prevention in Victoria*, Victorian Health Promotion Foundation, Melbourne.

possibility that university-based researchers may gain funding to conduct external evaluations of community programs, and this is one important way in which evaluations that meet standards of experimental design occur.)

A second obstacle to evaluation using experimental design among community organisations is also practical – community programs typically have features that make it impossible to achieve the criteria for the classic experimental model. Because they focus on only one or a few programs, there is insufficient statistical power to conclusively show an association between the program and outcomes. Because many complex, interacting and shifting factors contribute to program outcomes, one cannot necessarily assume or show that program implementation occurs before the outcomes. And because many potential external factors shape outcomes, one cannot necessarily demonstrate that the association between the program and desired outcomes is not caused by other factors (Goodman & Noonan 2009, pp. 115–125)

Finally, experimental designs may be inappropriate in the emerging field of primary prevention. There are practical and political problems with randomised assignment. In community contexts emphasising programs' efficient use of scarce resources, stakeholders may not be able to wait until the program is over to see whether it is having desired outcomes. Instead, it may be more appropriate to find ways to make effective corrections to program implementation in mid-course (Goodman & Noonan 2009, p. 125). Moreover, as discussed in the second paper in this series (Kwok 2013), a key driver of evaluation in the field of primary prevention is to contribute to knowledge and practice, and experimental designs may not be suitable to fulfil this purpose.

In response to the challenges of evaluation by community organisations, there has been an increasing emphasis on building local capacity to evaluate.

Evaluation capacity building

One of the most significant trends in evaluation theory and practice is an increased focus on stakeholder participation (Campbell et al. 2004, p. 252). This focus has coalesced in efforts to build evaluation capacity. The first decade of the 21st century marks an important stage in the development of evaluation, a focus on evaluation capacity building. North American commentators note that in organisations dedicated to or involved in evaluation, there has been an increasing focus on designing and implementing strategies to help their members to learn about and engage in evaluation (Preskill & Boyle 2008, p. 443). An emphasis on evaluation capacity building is evident too at the local level. In Victoria, this has been an important element of evaluation-related efforts; for example, by the Department of Health through its Evidence, Evaluation and Policy team (W.L. Kwok, pers. comm., 28

March 2010).[8] However, there has been very little thorough assessment of the impact or effectiveness of local efforts in evaluation capacity building.

Definitions of evaluation capacity range from the narrow to the broad. In a narrow definition, evaluation capacity refers simply to the ability to carry out an effective evaluation, while broader definitions may refer also to organisational cultures' support for and valuing of evaluation skills (Naccarella et al. 2007, p. 232). Nevertheless, most accounts of evaluation capacity building (ECB) emphasise that it refers to efforts to equip staff within organisations with the appropriate skills to conduct rigorous evaluations, and, beyond this, to integrate evaluation into routine practice (ibid., p. 232). The following definition is typical:

> the design and implementation of teaching and learning strategies to help individuals, groups, and organizations, learn about what constitutes effective, useful, and professional evaluation practice. The ultimate goal of ECB is sustainable evaluation practice – where members continuously ask questions that matter, collect, analyse, and interpret data, and use evaluation findings for decision-making and action. (Preskill & Boyle 2008, p. 444)

In essence, capacity building in evaluation involves nurturing evaluation knowledge, attitudes and skills, in order to build sustainable evaluation practice among individuals and in organisations.

In essence, capacity building in evaluation involves nurturing evaluation knowledge, attitudes and skills, in order to build sustainable evaluation practice among individuals and in organisations.

While evaluation capacity building shows growing prominence in recent discussions of evaluation, its principles and practice have been evident for a long time in feminist, community development and health promotion work. Here, there have been longstanding emphases on egalitarian models of program design, implementation and assessment, in which power, control and resources are shared (Campbell et al. 2004, p. 253). Feminist and community development organisations have strived to build their workers' skills and capacities, as part of collaborative, empowering, decentralised visions of their purposes and processes. In this sense, evaluation capacity building is not new. Contemporary interest in evaluation capacity building in the evaluation field represents the elaboration and refinement of this work, and indeed the evaluation of the success or otherwise of such efforts.

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[8] One noteworthy example of evaluation capacity building in Victoria is the Victorian Government's Narrative Evaluation Action Research (NEAR) project (www.health.vic.gov.au/healthpromotion/steps/evaluation.htm). Involving community and women's health agencies, this project sought to support agencies to evaluate their health promotion efforts through narrative technique combined with action research methodology (W.L. Kwok, pers. comm., 28 March 2010).

Empowerment evaluation

One of the most significant expressions of evaluation capacity building is 'empowerment evaluation'. Empowerment evaluation has the following key characteristics (Campbell et al. 2004, p. 252; Goodman & Noonan 2009, p. 125):

• It is aimed at empowering local stakeholders to build capacity to improve their programs.

• Evaluation is not carried out by external academic researchers or hired expert consultants, but by community workers and organisations themselves.

• Evaluation experts or professionals act as facilitators, teaching program staff how to conduct their own evaluations and serving as coaches throughout the evaluation process.

• The evaluation does not conform to classic standards of experimental design.

In empowerment evaluation:

> Program stakeholders conduct their own evaluations and typically act as facilitators; an outside evaluator often serves as a coach or additional facilitator. Key facets include training (evaluators teach stakeholders to conduct their own evaluations), facilitation (evaluators serve as coaches or facilitators to help others conduct a self-evaluation), collaboration (evaluation is a group activity, not the individual work of an evaluator), democracy (program staff and evaluators work as equals), and self-determination (the evaluation furthers the expressed goals and purposes of the program). (Noonan & Gibbs 2009, p. 75)

Empowerment evaluation has obvious advantages as a strategy for the evaluation of community-based programs. First and foremost, empowerment evaluation is dedicated to capacity building. While empowerment evaluation may seem identical to collaborative or participatory evaluation, its proponents argue that empowerment evaluation is distinguished by a greater, even unique, commitment to self-determination (Fetterman & Wandersman 2007, p. 185). Empowerment evaluation shows a greater degree of participation and stakeholder control than other models of evaluation. It represents a strategic way to maximise the skills and investment of the people delivering programs (Graffunder & Charles 2009, p. 715). Building evaluation-capacity also builds other capacities that are important to ongoing implementation and sustainability of prevention and promotion efforts. Empowerment evaluation, therefore, is seen to generate benefits both for program design and implementation and for organisations' overall success (Graffunder & Charles 2009, p. 715).

Empowerment evaluation shows a greater degree of participation and stakeholder control than other models of evaluation.

This model for evaluation practice also minimises the delays between discovery and delivery – between findings regarding program effectiveness and improvements to program delivery. Empowerment evaluation typically involves assessment of all programmatic stages as they occur, allowing timely evaluation feedback and mid-course corrections to programs and thus continual quality improvements (Goodman & Noonan 2009, p. 135). The model allows the immediate adoption of refinements or changes based on evaluation findings (Graffunder & Charles 2009, p. 715). Community organisations' adoption and implementation of programs are accelerated by both feasibility and buy-in, and both are more likely to be in place in processes of empowerment evaluation (Graffunder & Charles 2009, p. 715).

Given that this report focuses on the evaluation of primary prevention programs, it is particularly important to note that empowerment evaluation has been taken up in the field of violence prevention. Recent expressions of this include the adoption of this model by the US Centers for Disease Control and Prevention (CDC) in relation to the assessment of sexual violence prevention efforts, as described in a special issue of the journal *Health Promotion Practice*. In the context of a lack of evaluation evidence, the CDC had recognised their inability to identify and recommend well-evaluated sexual violence prevention programs. One of the CDC's strategic responses to this was to use empowerment evaluation (Noonan & Gibbs 2009, p. 65). Empowerment evaluation is a valuable response to the need for evaluation approaches that are 'sustainable, low cost, and flexible' (Noonan & Gibbs 2009, p. 75).

Participatory and empowering methods, such as those used in empowerment evaluation, may be particularly relevant to the violence prevention field given the emphasis on such methods in the feminist violence against women movement (Campbell et al. 2004, p. 253).

Building capacity to evaluate violence prevention

VicHealth's work in building the capacity of five community-based projects to evaluate their violence prevention efforts can be understood only in the context of VicHealth's commitment to evaluation, and beyond this, the wider story of evaluation capacity building in Victoria.

Context for VicHealth's work in the evaluation of violence prevention

Starting at the level of the organisation as a whole, VicHealth supports evaluation as a vital element of its promotion of health promotion (VicHealth 2009b). Evaluation is positioned as a core component of health promotion research and practice. As a consequence, VicHealth includes evaluation in its own development and dissemination of health promotion efforts, expects that outcome evaluation will be conducted by the external agencies it funds, and supports evaluation-focused research. One expression of this commitment to evaluation was VicHealth's Research Practice Leader (RPL) program.[9]

Evaluation, therefore, is an integral part of each domain of VicHealth activity, including preventing violence against women. VicHealth takes it as given that programming and policy must be based on evidence and guided by evaluation and monitoring, as its prevention framework articulates (VicHealth 2007a). VicHealth's Preventing Violence against Women program has a significant research component, particularly through the RPL program. More generally, the RPL played a role in supporting VicHealth and its field collaborators to build networks and capacity for research to address the prevention of violence against women in Victoria.

The wider context for VicHealth's involvement in evaluation and evaluation capacity building includes the growing emphasis on both in fields of programming and policy related to health promotion and violence prevention in Victoria and nationally. For more than a decade, there has been a sustained Victorian effort in evaluation in integrated health promotion. For example, in recent years, the Victorian Department of Health has contributed to the development of frameworks and manuals for evaluation planning and implementation, such as *Measuring health promotion impacts* (2003) and *Planning for effective health promotion evaluation* (2005).[10] Nationally, there has been considerable attention to evaluation capacity building in the general practice and primary healthcare sector (Naccarella et al. 2007, p. 231). In Victoria, various community agencies and networks, including

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[9] The original program is detailed further in the *VicHealth Letter*, 2008, No. 32, p. 8 available at:
www.vichealth.vic.gov.au/Publications/VicHealth-Letter/Using-Research-to-Create-Healthy-Communities.aspx

[10] See the following website:
http://docs.health.vic.gov.au/docs/doc/32F5DB093231F5D3CA257B27001E19D0/$FILE/planning_may05_2.pdf

community and women's health services and Primary Care Partnerships (PCPs), show growing integration of evaluation into their health promotion practice, including in relation to the prevention of violence against women. For example, during 2007–8, Women's Health West facilitated a capacity building action research project partnering with local councils, PCPs and community health services to support, plan and evaluate their own violence prevention projects (L. Murphy, pers. comm., 28 March 2010).

A growing emphasis on evaluation is also visible in state and national policies and plans regarding violence against women. Both the previous Victorian Government's *A right to respect – state plan to prevent violence against women* and the proposed national framework for preventing violence against women emphasise the need for ongoing evaluation of violence prevention efforts (Office of Women's Policy 2009; National Council to Reduce Violence Against Women and their Children 2009). The state plan explicitly states that it will support strategies that build the capacity of organisations to undertake impact evaluation regarding the prevention of violence against women (Office of Women's Policy 2009, p. 32). Emphases on evaluation are also visible in Australia's *National plan to reduce violence against women and their children 2010 to 2022*, released in August 2010, and the Victorian Government's *Action plan to reduce violence against women and their children*, released in October 2012. Thus, VicHealth's approach is part of the wider story of evaluation capacity building in Victoria and the nation.

Building capacity among community-based projects of violence prevention

VicHealth supported five primary prevention projects in Respect, Responsibility and Equality Phase II (2008–11). As one might expect, given VicHealth's commitment to evaluation, evaluation and evaluation capacity building has been built into VicHealth's support for these projects.

The following describes this evaluation capacity building activity over the first 18 months, from September 2008 to February 2010, effectively the first stage of evaluation capacity building. There were three overlapping components to VicHealth's evaluation-related work with the five projects:

• partnership arrangements involving requirements regarding evaluation

• VicHealth-based research and evaluation, through the Research Practice Leader

• direct support and capacity building in evaluation.

First, the partnership arrangements between VicHealth and the community organisations hosting each primary prevention project included requirements regarding evaluation. Evaluation was identified as a necessary component of each project in the funding guidelines associated with the

second phase of funding. Projects were expected to include planning regarding impact evaluation of their activities, participate in evaluation meetings, and liaise regularly with the RPL (VicHealth 2008).

Second, through the Research Practice Leader program, the RPL worked closely with the five projects to conduct and support their evaluation. It was envisaged that the RPL would act as a coach for or facilitator of the projects' evaluations. He supported projects' development of a framework or plan for evaluation, working with and supporting the project coordinators to accomplish this, through both group instruction and one-on-one consultation. More widely, the RPL was tasked with examining and drawing on scholarship on evaluation and violence prevention and sharing such knowledge with the five community projects and VicHealth.

Third, and overlapping with this, VicHealth provided direct support to each project regarding evaluation, oriented towards building workers' and community organisations' to evaluate their violence prevention activity.

VicHealth's work in building evaluation capacity in violence prevention represents one of the most well-developed Australian efforts to build the capacity of multiple programs to evaluate their work in preventing violence against women. As is often the case (Preskill & Boyle 2008, p. 446), project coordinators' and community organisations' involvement in developing their evaluation capacity was driven in part by external demands – the requirement from the funding body, VicHealth, that they participate. But it also reflects the growing emphasis on evaluation at state and national levels, coordinators' and organisations' interest in documenting the impact of their work, and other internal motivations.

> **VicHealth's work in building evaluation capacity in violence prevention represents one of the most well-developed Australian efforts to build the capacity of multiple programs to evaluate their work in preventing violence against women.**

VicHealth engaged in evaluation capacity building among the five community-based projects of violence prevention by two main methods: structured instruction and individual coaching. VicHealth provided (a) structured instruction in evaluation concepts and methods in regular meetings, and (b) tailored or program-specific technical assistance. The former took place through the quarterly learning circle for all five projects, typically a five-hour meeting with space for discussion, reflection, and direct instruction in evaluation. The latter took place through one-on-one consultation, whether face to face or by telephone and email.

Both the instruction and coaching were provided in particular by an academic with expertise in evaluation (Dr Michael Flood), part of the Research Practice Leader program at VicHealth described above. His position involved contributions to a range of projects, and his work in capacity building was complemented by efforts among project management staff at VicHealth. VicHealth also contributed to evaluation capacity building among the five projects by making available resources it had commissioned on measures for examining attitudes and behaviours related to violence against women and assisting with other resourcing and administration.

Teaching and technical assistance

In terms of structured instruction, VicHealth provided group teaching in evaluation concepts and methods. A section of each of the quarterly meetings among the five projects and VicHealth staff, typically 60–90 minutes of the five-hour meeting, was devoted to instruction in evaluation. Over the 18 months that are the focus of this report, the evaluation workshops covered the following topics:

• an introduction to evaluation

• project evaluation frameworks

• building a greater partnership

• logic models

• refining the prevention logic

• final reports (including evaluation reporting)

• data collection and analysis.

Instruction among the project coordinators begun in August 2008 with an overview of the entire process of evaluation: defining evaluation, planning evaluation, setting objectives, developing outcome measures, gathering and analysing data, and utilising and disseminating findings. The second learning circle meeting, in February 2009, focused on the projects' development of evaluation plans. At the third meeting, in May 2009, models of empowerment evaluation were presented and discussed, and the evaluation section of the meeting also addressed projects' development of logic models. The following meeting, in August 2009, extended the latter by moving from logic models to theories of change, and addressed a number of ways in which to refine each project's articulation of its contribution to the prevention of violence against women. (Further detail on this is given below.) The fifth learning circle focused on methods for collecting and analysing data.

For each workshop, handouts and lists of key resources were distributed by the RPL, and the workshops were conducted through both didactic presentation and interactive discussion. Resources

prepared by the RPL included an overview of evaluation practice, including a checklist for evaluation and a guide to further print and online resources on evaluation; a 54-page guide to existing measures of impact related to violence against women; and handouts and excerpts from evaluation guides on such topics as logic models, theories of change, and methods of data collection.

The tailored or program-specific technical assistance took place primarily through telephone and email consultations, as well as site visits and face-to-face meetings, by both the RPL and other VicHealth staff. The technical assistance was 'tailored' in the sense that it was shaped to the specific needs and concerns of the primary prevention project in question.

Figure 1: Teaching and technical assistance
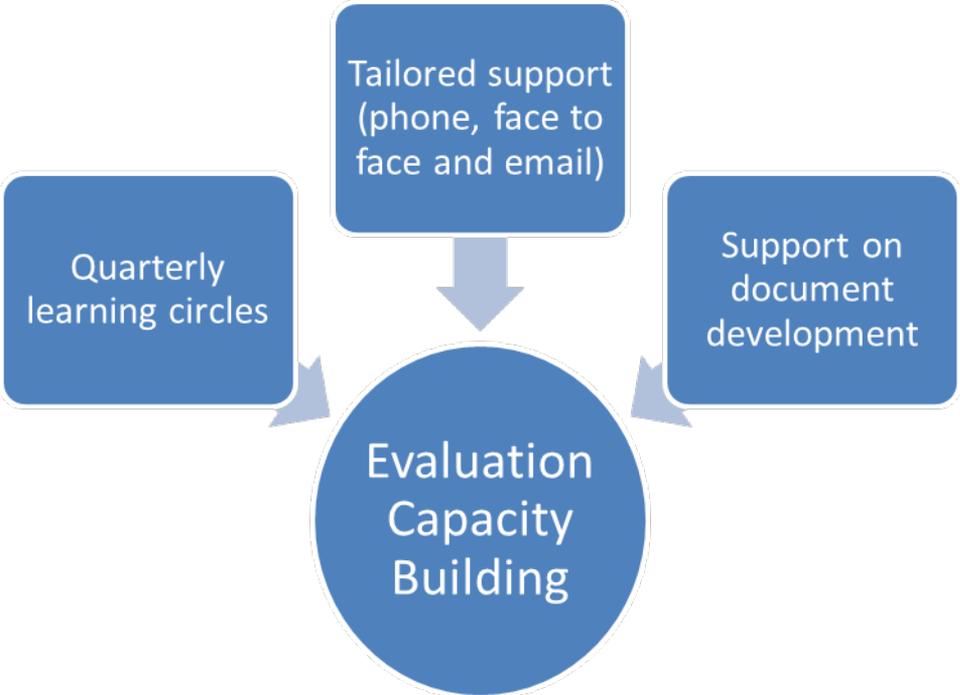
The structured instruction and tailored technical assistance worked to complement each other. For example, given that each learning circle involved requirements for project coordinators to report on their projects' progress or to achieve certain benchmarks such as the development of an evaluation plan, the RPL assisted particular projects with these as each learning circle approached. In turn, given that questions and issues related to evaluation also arose during learning circle meetings themselves, the project coordinator or the RPL followed these up in the periods after the meetings.

Project coordinators sometimes were asked to prepare materials (other than progress reports required by VicHealth as the funding body) for the evaluation workshops in the learning circles. For example, the August 2009 evaluation workshop focused on 'refining the prevention logic' of each project. It sought to extend each project's articulation of how the project's intended outcomes will

contribute to the prevention of violence against women and how project activities and resources will achieve these intended outcomes or impacts. The workshop used preparatory writing exercises and discussion to achieve this. Each project worker was asked to bring to the learning circle a 'report from the future': one to three paragraphs, written in the past tense as if they had been produced at the project's conclusion, about the project's impacts. Coordinators were asked to include discussion of how they were able to establish or measure the project impacts or outcomes discussed (e.g. 'This survey showed that …'; 'Interviews with key informants documented that…'). The coordinators were also invited to bring notes and reflections on the following questions:

- What problem(s) does the project address? (Who, what, why, where, when and how.)

- What are you trying to accomplish over the life of the project? (What will success look like? Note that there may be different types of change, at different levels, in the short term and long term, and/or in particular groups or settings.)

- How does having an impact in these areas contribute to the prevention of violence against women?

- What activities will be used to create these impacts, and *how* will they create these impacts? (i.e. how does a particular activity produce change?)

- What external factors may shape these outcomes?

- How will you know that change has occurred? What measures or indicators is the project using in assessing impact?

- What methods will the project use to gather data on its measures or indicators, particularly in impact evaluation but also in process evaluation (of implementation)?

Refining the model

Capacity building in evaluation was central to VicHealth's support for and partnerships with the five primary prevention projects. It had been built into VicHealth's institutional arrangements, research program, and direct instruction and assistance, as outlined above.

Over the course of the first 18 months of Respect, Responsibility and Equality Phase II, there were some refinements to VicHealth's evaluation capacity building work with the five projects. While VicHealth had established evaluation as integral to the projects from the start, it also envisaged that its capacity building activities would be further developed as the projects progressed. This was both planned and expected, as VicHealth's involvements in evaluation and evaluation capacity building represented work in progress. A key element of the RPL's role was to investigate scholarship on

evaluation and disseminate evaluation-related practices and approaches, and VicHealth planned for resulting refinements in its support for the five projects as the program progressed. In addition, VicHealth expected that as projects themselves began crafting and carrying out evaluation, their needs for evaluation capacity building would develop and shift.

In this context, there were two refinements to VicHealth's capacity building work among the five projects over the period covered by this report: an increased framing of this work in terms of 'empowerment evaluation', and an intensification of the technical assistance in evaluation. Over the first year and a half, the RPL broadened his own expertise in evaluation and reviewed existing scholarship on evaluation capacity building, as intended in the RPL role, and this was complemented by investigations and reflections among other VicHealth staff. As a result, in May 2009, VicHealth staff and the RPL began to link VicHealth's efforts to a wider body of practice and theory centred on empowerment evaluation for evaluation capacity building. While VicHealth's efforts represented a de facto model of empowerment evaluation from the beginning, starting in mid-2009 there was an increasingly explicit locating of VicHealth's work within the field of evaluation capacity building in general and empowerment evaluation in particular.

This was a shift in language rather any fundamental shift in practice, as the model of capacity building already in use among the five violence prevention projects already embodied the practices recommended in the literature on evaluation capacity building. VicHealth's model of evaluation capacity building is very similar to others used in the field of violence prevention, such as that adopted in the CDC's Evaluation Assistance for Sexual Violence programs in the US (Gibbs et al. 2009, p. 435). Its combination of structured and program-specific technical assistance is described as the best approach to empowerment evaluation in such contexts (Gibbs et al. 2009, p. 435).

The second refinement was an intensification of the technical assistance in evaluation. There were three overlapping drivers of this shift (in no particular order): reflections by VicHealth staff and others, knowledge gains by the RPL, and feedback from the project coordinators themselves. First, there was an increasing realisation among the VicHealth staff and RPL that more intensive work with the projects and community coordinators was needed in order to build capacity to plan and conduct evaluations. Second, and overlapping with this, in the course of doing further research on evaluation capacity building in early 2009, the RPL came across published materials describing or advocating more systematic approaches to evaluation capacity building, including materials on empowerment evaluation. Third, the project coordinators themselves had called for a more intensive and structured approach to the development of their evaluation planning and implementation. This emerged in particular at the May 2009 learning circle, in which VicHealth staff had solicited feedback on the process of 'partnership in evaluation' thus far. This represented a basic form of process evaluation of

VicHealth's efforts at evaluation capacity building to this point. In mid-2009, therefore, it was proposed that VicHealth's capacity building work in evaluation become more intensive, collaborative and pro-active. The report returns to the issue of the intensity of technical assistance in the section below.

What actual impact have VicHealth's efforts had on the projects' capacity to evaluate their violence prevention work by the end of stage one in 2010? The following section reports first on the achievements generated by these efforts over the course of the first 18 months of Respect, Responsibility and Equality's second phase, from September 2008 to February 2010. It then addresses their limitations.

The data for this assessment are threefold, as mentioned above: the RPL's reflections, observations of the project's developing involvements in evaluation, and feedback by the project coordinators themselves as 'key informants'. Quotations from project coordinators derive from a focus group run with the coordinators in January 2010. Comments and quotations are anonymous to protect the identity and confidentiality of both coordinators and projects.

A report card on the first 18 months

Achievements and successes

VicHealth's efforts over 2008–10 had a significant impact on the capacity of the five project coordinators to evaluate their violence prevention projects and on the quality of the evaluation they have planned and are undertaking. From the focus groups and ongoing meetings, it was clear that all the project coordinators now had taken on evaluation as part of their work. Over the course of the first 18 months, coordinators gained knowledge about evaluation, developed skills in evaluation, and felt more positively about evaluation. Beyond this, the coordinators and their projects had some sense of participation in a common partnership with VicHealth and a wider community of evaluation practice.

> **Over the course of the first 18 months, coordinators gained knowledge about evaluation, developed skills in evaluation, and felt more positively about evaluation.**

Coordinators' progress in developing evaluation knowledge and skills is likely to have been shaped by a number of factors, including coordinators' and their organisations' own efforts to develop their evaluation capacity, and cannot be attributed solely to VicHealth's efforts. At the same time, there is evidence that VicHealth's direct involvement in capacity building had been influential.

The following material focuses on positive shifts in coordinators' evaluation knowledge and skills, before examining the development of their evaluation practice itself.

The development of evaluation knowledge, skills and commitment

One way to describe the impact of evaluation capacity building among coordinators is in terms of three domains: cognitive, behavioural and affective. These refer to coordinators' knowledge of evaluation, their skills in evaluation, and their feelings about evaluation respectively (Preskill & Boyle 2008, p. 452). Preskill and Boyle (2008, p. 450) provide a useful framework with which to evaluate these three dimensions of evaluation capacity. While this report does not use these systematically to assess coordinators' capacity, it does draw on them in describing capacity.

In terms of the *cognitive* domain, all the coordinators had gained some familiarity with the language and techniques of evaluation. All had developed an awareness of the value and necessity of both process and impact evaluation, an awareness of basic concepts of program evaluation, and an understanding of key aspects of evaluation planning. These shifts were clear from the May 2009

learning circle, in which some coordinators referred to their 'learning experience' and the validation of their emerging efforts at evaluation design.

In terms of the *behavioural* domain of evaluation capacity, all five project coordinators had worked to build evaluation into their project planning (and all were required to do so as part of their funding obligations). Each had developed a credible evaluation plan, chosen data-collection methods and tools appropriate to the areas of impact in question, and begun collecting relevant data. As one coordinator commented in the January 2010 focus group:

> I had used an evaluation framework before, in at least two or three other projects, and felt confident to use it. I was familiar with evaluation concepts … but this work has drawn out my evaluation skills, particularly in particular areas like evaluating policy.

At this mid-point for the five projects, it was hoped that the project coordinators would later demonstrate further skills in evaluation, such as skills in analysing qualitative and quantitative data, interpreting results, and communicating and reporting their findings.

In terms of the *affective* or emotional domain of evaluation capacity, the project coordinators had demonstrated an increased commitment to evaluation; stronger positive beliefs about data and evaluation; and decreased fear and anxiety regarding evaluation (Preskill & Boyle 2008). These shifts in coordinators' feelings about evaluation were evident both in discussions in the learning circles and in one-on-one communications. For example, in feedback solicited in the May 2009 learning circle, project coordinators reported that they felt intimidated and overwhelmed by evaluation, and this lessened to some degree after this. In the January 2010 focus group, one coordinator commented that she:

> has a helluva lot more confidence now [about evaluation] than I did at the start. It feels like I can talk the talk, give guidance to other workers, and marry academic perspectives with on-the-ground capacity with workers.

Another reported that she felt 'more personal commitment to the value of evaluation'. She described feeling 'more confident, less scared … I feel much more pragmatic. I'm aware of the limitations of my role. This is the evaluation plan, this is where I'm at.' This is not to say that all five coordinators at this point felt highly confident about their evaluation knowledge and skills, but to varying degrees they had developed greater familiarity and comfort with the field of evaluation.

More intensive, rigorous and comprehensive forms of impact evaluation

VicHealth's efforts to build evaluation capacity had, by necessity, addressed both coordinators' own skills and the quality of the evaluations they undertake. The RPL and VicHealth staff worked with the

primary prevention projects to refine the logic, flow and comprehensiveness of their evaluation planning, and in connection with this, their project planning. As a result of this and their own efforts, the projects adopted more intensive, rigorous and comprehensive forms of impact evaluation. There are at least five dimensions to this:

1. greater attention to evaluation

2. more precise and rich examinations of program impact

3. the use of quantitative and qualitative measures

4. the use of standardised measures

5. the development of data collection and analysis skills.

Greater attention to impact evaluation

The capacity building efforts with regard to evaluation prompted a greater attention to impact evaluation in project design and implementation than would otherwise have been the case. For at least one project coordinator, VicHealth's focus on evaluation had an impact on the overall strategies she uses in her project. As she commented in the January 2010 focus group: 'It's really had a huge effect in my work … I don't know if I would have adopted my focus in evaluation if there hadn't been that interest from VicHealth.' For another coordinator, the single most significant shift in her practice was away from an exclusive focus on *process* evaluation and towards the inclusion of *impact* evaluation. She commented that 'in my original submission for funding, in the section on how you'll measure the impact of what you're doing, every single thing was about process', and another worker agreed. For a fourth worker, however, with greater familiarity with and experience in evaluation prior to taking up the VicHealth-funded project, VicHealth's capacity building work had less impact on project design and implementation.

More precise and rich examinations of program impact

One area of evaluation capacity building addressed the need for substantive measures of the impact of violence prevention efforts. Traditional reporting and evaluation practices among community projects centre on *process* measures focused on implementation, such as how many people turned up to the training session, whether the policy written, and whether the materials distributed. VicHealth encouraged the project coordinators to complement these with measures of *impact*: What changes were there in people's attitudes and behaviours? Has the policy been used? How well know is it? What meaning does it have? And so on.

Rich evaluations of program impact also involve the examination of *multiple* dimensions of impact, including at the individual level in terms of attitudes, behaviours and capacities, and at more relational or collective levels in terms of power relations, networks, partnerships and formal and informal cultures. For example, one of the goals of the Partners in Prevention project was the creation of a *community of practice* among those working on youth-targeted primary prevention of violence against women in Victoria. In identifying ways to evaluate whether this community of practice had developed, the RPL and the project coordinator included *collective* and *relational* measures: the extent and nature of individuals' contacts and networking with each other, and the range of members and sectors represented in its networks.

Ideally, impact evaluations examine not only whether the intervention made a difference, but *which* aspects or components of the project generated impact and the *mediators* of program impact. The RPL encouraged the project coordinators to take up these aspects of impact evaluation, particularly in relation to projects that were already well advanced in their approaches to evaluation. For example, evaluation of the Partners in Prevention project included assessment of *which* of its various strategies – such as e-bulletin, website, quarterly network meetings, consultation – had contributed most to their sense of increased capacity to engage in violence prevention.

Evaluations should also address the possibility of *no or negative* impact. The RPL encouraged the project coordinators to look for and document challenges to and limitations on their projects' effectiveness, as well as negative impacts and harms.

More generally, the project coordinators were invited to document the richness and complexity of their projects, such as the incidents, the moments of resistance and of progress, and the obstacles. The coordinators were encouraged to reflect on both the specifics of the project, and on the more general or generalisable themes and lessons here. The first is important in terms of documenting and evaluating the program and its impact, including being able to tell rich stories of when progress is achieved and when it was limited or blocked. The second is important in terms of the project's development of transferable tools and wider insights.

The use of quantitative and qualitative measures

VicHealth's efforts at evaluation capacity building included working with project staff to adopt both quantitative and qualitative measures of impact. All five projects used both. The former include pre- and post-training questionnaires with quantitative questions, surveys of community members, and simple numerical data on such issues as resource use and distribution, participation in events and meetings, phone and email contacts, and so on. The latter include questionnaires with open-ended

questions, key informant and stakeholder interviews, focus groups, analyses of the incorporation and impact of policies, and narrative evaluation by the project coordinators themselves.

The use of standardised measures

For many of the domains of impact with which violence prevention is concerned – such as violence-supportive attitudes, perpetration and victimisation, wider gender inequalities – there are measures of these domains that have been developed by scholarly researchers, tested for validity and reliability, and thus standardised.[11] In evaluations, the use of standardised measures of domains of impact is valuable for at least three reasons. First, it is likely to increase the comprehensiveness of the evaluation's assessment of impact in this domain. Second, it increases the likelihood that the measures will be reliable and valid (trustworthy and truthful). Third, it allows comparisons with other bodies of data. Of course, relevant measures may not exist, and existing measures may be inadequate to capture the impact of project activities on the determinants of violence against women.

Through both structured instruction and tailored assistance, the RPL worked with the projects to find useful standardised measures of impact, such as measures of attitudes towards violence and of the impact of staff training. Work was also conducted with the projects to modify and shorten existing measures to make them more appropriate or practical. To give some examples of projects' use of standardised measures, in its first year Baby Makes 3 used the Sexual Relationship Power Scale – developed by Pulerwitz, Gortmaker and DeJong (2000) to measure power in sexual relationships – in the pre- and post-education questionnaires given to new parents. The Maribyrnong City Council project incorporated measures regarding violence-supportive attitudes from VicHealth's recent National Community Attitudes Survey in its annual community survey, to benchmark these against the results for Victoria and Australia as a whole (VicHealth 2009a).

While standardised measures regarding *individual*-level phenomena related to violence against women (such as individual attitudes and behaviours) are well developed, measures regarding more *relational, collective and institutional* phenomena (such as gender inequalities, community capacity, policies and violence-supportive contexts, whether formal or informal) are less well developed. Several of the five primary prevention projects are concerned with violence prevention at the level of institutions – workplaces, local councils, and faith-based institutions such as churches.

In building the projects' capacity to evaluate their prevention efforts, one task therefore was to find or construct ways to evaluate impacts also at the institutional level. The RPL searched for existing

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[11] See Flood (2009) for a compendium of such measures.

benchmarks, standards, or audit tools for organisations and workplaces. He also suggested that particular projects construct them. For example, project coordinators may have stipulated that an organisation that was working to prevent violence against women will show five characteristics, such as a policy commitment to prevention, and education and training for staff in prevention practice, and then assess their organisation against these criteria. Similar standards or benchmarks may be created for other institutional phenomena that the projects intended to achieve, including a comprehensive policy commitment to the prevention of violence against women, a gender-equitable workplace culture, and a strong partnership between organisations. The Partners in Prevention project operated among coordinators and organisations in the fields of violence and violence prevention themselves and aimed to build their capacity to engage in violence prevention, so in this project the task was also to find ways to assess the character and capacity of a network or sector.

The project coordinators gained experience in data collection and analysis and began to develop skills in these fields.

The development of data collection and analysis skills

The project coordinators gained experience in data collection and analysis and began to develop skills in these fields: administering surveys, conducting interviews, running focus groups, and conducting desk reviews of policies and other materials. As part of the tailored technical assistance, the coordinators were supported with various technical, methodological or ethical questions. In some instances, this involved simply providing answers to queries (such as 'How long is a reasonable time for long-term follow-up?'), while in other instances it involved more substantial resourcing (such as how to run focus groups or an extended discussion with a worker on how to minimise harm in asking about experiences of violence). In the January 2010 focus group among project coordinators, one coordinator commented that VicHealth's capacity building efforts have 'improved my ability to evaluate, and given me lots of ideas about how to evaluate what I'm doing'. Another commented that:

> the processes have added value to the project in a whole variety of ways. I've modified the 'happy sheets' given out to participants in the [project events], and these are generating lots of interesting information.

The development of partnerships and a community of practice

One of the significant and positive impacts of VicHealth's capacity building efforts, and its processes of engagement more generally with the projects, concerns the coordinators' and projects' *relationships* with their funding organisation and with each other. Through the learning circles and their contact and

interaction with VicHealth staff, the project coordinators developed a strong sense of participation in a partnership with VicHealth and a shared community of practice.

In the January 2010 focus group held with all project coordinators, when asked about their experience of the learning circles, the coordinators emphasised the value of the relationships with VicHealth and with each other established through these meetings and related processes. There were several aspects to this. Project coordinators emphasised the following:

- They feel part of 'a team of colleagues', 'part of something bigger', and they have a sense of connection to and ownership of all five projects. The processes of working together and sharing have been valuable, and even unique. Some coordinators noted the cross-pollination between the projects, the sharing of resources, and other forms of collaboration, and described face-to-face and phone 'debriefings' after the learning circles about their content. They noted the value of hearing of the challenges encountered by other projects.

- They value the relationships forged with individual VicHealth staff, including through visits by staff members to project sites. VicHealth staff are seen as an excellent resource, with expertise in evaluation, advocacy, and policy.

- Their relationships with VicHealth are supportive and open. They feel as though VicHealth genuinely cares about what they are doing, and about its relationships with the project and the coordinator. They feel comfortable in asking for assistance in locating resources. Such relationships with funding bodies, and the levels of contact associated with them, are rare.

- They feel that they are participants in a genuine partnership with VicHealth, on 'a shared journey'. They listen to advice and suggestions from VicHealth staff and the evaluation researcher regarding their projects, but do not feel that these are mandated or compulsory.

- There is 'an atmosphere of safety, where we can talk about what is not working and what's difficult, knowing that we won't be judged as poor workers or have our funding taken away'. VicHealth has been explicit about the desirability of reporting on the obstacles to and limitations of the projects. Participants contrasted this with being under pressure to 'keep up appearances' with the funding provider.

- In the learning circles, they have control and autonomy in relation to the planning and implementation of their projects, rather than being seen as 'just a worker'.

The learning circles, as well as other components of VicHealth's relations with the five projects and their coordinators, are a valuable aspect of VicHealth's capacity building strategies, particularly because of the ways in which they foster a 'community of practice' among the projects and staff. Such

communities of practice have been identified as an important strategy in evaluation capacity building (Preskill & Boyle 2008, p. 447). This report therefore corroborates findings in other assessments of empowerment evaluation that collaborative relationships are an invaluable aspect of the processes involved and that relationship-building is a vital component of capacity building (Gibbs et al. 2009, p. 425).

Improvements in program design and quality

So far, it is clear that the evaluation capacity building has meant that the project coordinators were more capable at evaluation, their projects involved more rich and robust evaluations, and they and their projects had a sense of participation in a partnership with VicHealth and a wider community of evaluation practice. Such shifts have obvious benefits. However, these processes also led to improvements in overall program quality. There is an intimate relationship between evaluation planning and program planning, and improvements in the former lead to improvements in the latter.

Through both the one-on-one technical assistance and the group instruction, the projects deepened their understanding of the theoretical frameworks guiding their work, refined their overall objectives, and developed more rigorous links between these and project activities. They constructed more precise accounts of exactly how project activities will generate their intended impacts. Thus, improvements in coordinators' skills and understandings and in their planning and implementation of their evaluation strategies had flow-on benefits for the quality of the programs overall. The RPL and staff at VicHealth also provided direct input into project planning, particularly to increase the likelihood that the project will have a significant and positive impact on the prevention of violence against women. For instance, they proposed ways in which to:

- extend the duration and intensity of education and training provided in particular contexts; for example, by positioning one-off educational sessions as part of a staged or cumulative model of intervention or as only one component of a suite of necessary strategies

- increase institutional commitments to prevention; for example, by building on organisations' interest in secondary and tertiary prevention to incorporate primary prevention strategies or by framing issues of violence prevention in ways that intersect with existing institutional language, values and concerns

- seize opportunities to influence factors associated with violence against women or its prevention in particular local contexts; for example, by paying attention to what factors make most difference to prevention capacity in a particular organisation or among a particular group and then seeking to influence these.

In some instances, these processes of instruction and reflection meant that some projects became *less* ambitious and *less* wide-ranging. As coordinators developed more focused, precise and realistic accounts of their projects' activities and their intended effects, in some cases they revised project activities and even scaled back the ambitions of their projects. In other words, projects came closer to an ideal espoused in one of the early learning circle meetings, in which project objectives are SMART: specific, measurable, achievable, relevant, and time-bound.

Such improvements in program quality are illustrative of the wider benefits of evaluation. Effective evaluation can help to:

• provide information for stakeholders and gain their support

• secure funding for further development

• identify staff training and development needs

• position one's work in relation to current policy, learning and best evidence

• build capacity and understanding for future work and evaluation (Care Services Improvement Partnership 2006, p. 2).

Building the evaluation capacity of particular projects and their coordinators can also have wider effects on organisations' investment in evaluation. In one of the five VicHealth-funded projects, the project worker reported that the project's attention to evaluation meant that the host organisation now has greater interest in building evaluation more systematically into its organisational planning and processes.

Challenges and limitations

Building the capacity of community-based workers and organisations to evaluate their programs involves significant challenges. This section details these, as part of this report's critical assessment of the first 18 months of VicHealth's evaluation capacity building efforts.

The most significant challenge in evaluation capacity building is that evaluation itself is a demanding skill. In expecting community workers to conduct rigorous evaluations of their projects' workings and impact, we were asking them to demonstrate high-level skills in planning, research and reporting in addition to their existing project coordination skills.

There is a widespread perception in the violence prevention community sector that while evaluation is vital, it can also be intimidating. Recent research in Australia documents that understandings of evaluation are often poor or limited in the sector, although comprehensive evaluation approaches

also are emerging (Evans et al. 2009). There is increased pressure on community organisations involved in violence prevention to conduct evaluation, but little sense of what it means, and little institutional support for carrying it out. (On the other hand, evaluation has recently been integrated to a greater degree in health promotion, as already noted.)

> **VicHealth's evaluation capacity building work involved inviting the community workers and their organisations to aspire to a high standard of impact evaluation.**

VicHealth's evaluation capacity building work involved inviting the community workers and their organisations to aspire to a high standard of impact evaluation. This standard moves well beyond the limited forms of evaluation often practised at a community level, involving process measures and simple measures of impact such as participants' satisfaction with education and training. This is the case more generally in violence prevention. In other words, the 'bar' is being raised on evaluation. This is evident from two recent reports regarding violence prevention among young people and/or in schools, in which rigorous forms of evaluation are seen as essential to effective violence prevention (Carmody et al. 2008; Flood, Fergus & Heenan 2009). For example, the more recent of these two reports suggests that impact evaluations ideally should include longitudinal evaluation including lengthy follow-up at six-months or longer, examination of processes of change and their mediators, process evaluation of program implementation and fidelity, measures of organisations, contexts, and cultures, and experimental or quasi-experimental design incorporating control or comparison groups or settings.

When project coordinators are asked to carry out comprehensive and rigorous evaluations, in effect they are being asked to be *researchers*. Conducting rigorous evaluations involves a variety of research skills: skills in designing instruments and using methods to gather data, skills in analysing and interpreting data, and skills in writing this up and reporting on it. Community workers, and the organisations they work for, vary in their research-related capacities. While some of the coordinators among the five violence prevention projects were familiar with and experienced in research practice, others were not. Like most primary prevention and community workers, most had little training in or experience of impact evaluation.

In relation to the issue of designing instruments, the five projects in primary prevention funded by VicHealth were innovative efforts to tackle domains of potential prevention that have rarely been addressed before, including workplaces. This means that, to measure impact in such domains, the projects potentially had to construct new measures for such domains; for example, of 'a workplace

which takes preventing violence against women seriously'. Doing so requires significant intellectual and creative skills.

Working at a community level imposes further constraints on project coordinators' evaluation practice. For example, while it is ideal to draw upon standardised measures of impact where available, community workers are unlikely to have the support to administer and process lengthy attitudinal or behavioural scales, and such scales may be impractical given the typical constraints of time in community-based primary prevention. A pragmatic response therefore is to shorten existing scales, but this 'scale-carving' raises its own methodological issues regarding the validity of the measures used.

Effective evaluation also involves theoretical skills; for example, in theorising about the logic of the project's contribution to violence prevention. There is a growing awareness in the violence prevention field that programs or interventions should have a 'theory of change', an account of how our efforts will lead to the desired change. Programs should be able to specify the ways in which project resources, activities and processes will be used to achieve the project's intended outcomes. However, most primary prevention programs do not have a well-developed theoretical framework, including a theory of change (Flood, Fergus & Heenan 2009, p. 33). When project coordinators were asked to identify and draw upon relevant theories of change, as they were in the August 2009 learning circle, they were being asked to offer a higher level of scholarly reflection than many community workers are used to.

VicHealth's evaluation capacity building approach in the prevention of violence against women aimed to build these skills in addition to their project coordination capacity and other existing skills and knowledge. As noted in this report, project coordinators perceived an increase in their skills during the first stage of evaluation capacity building; however, there is potential for improvement in the way project coordinators' skills are built upon and expanded.

It would be impractical for organisations involved in empowerment evaluation to expect that community-based project coordinators will have the time or energy to undertake substantial study into the theoretical frameworks relevant to their violence prevention efforts. This is one reason why it is valuable to use, as VicHealth does, a model of evaluation capacity building based on partnerships between universities and community organisations. At the same time, the RPL involved in VicHealth's evaluation capacity building believes that coordinators can construct credible, evidence-based theories of change without lengthy independent or university-based study. During the evaluation workshop in the August 2009 learning circle, the RPL provided the five projects with short, accessible accounts of key determinants of violence against women and of theories of change relevant to

violence prevention, including VicHealth's own violence prevention framework *Preventing violence before it occurs* (2007), a longer background document on which this drew, and other overviews. However, in the meeting itself, faced with coordinators' concern about the perceived expectation that they read widely on theoretical frameworks, these expectations were scaled back. Project coordinators were encouraged to draw primarily on the VicHealth framework and to spell out the assumptions guiding their projects' strategies.

Another source of the challenges represented by evaluation lies in institutional and political obstacles to evaluation, particularly organisational disinterest in or resistance to evaluation. For example, in the January 2010 focus group among the projects, two coordinators described ways in which their host organisations lacked a commitment to impact evaluation. Community organisations' lack of involvement in impact evaluation may, in turn, reflect such factors as the neglect of evaluation in governments' funding and political priorities. A further challenge to evaluation is represented by the competing demands on time and resources for carrying out and evaluating the project. Inevitably, there are trade-offs between carrying out project activities and evaluating them, if for the simple fact that as one does more evaluation, one does less direct project work, as some project coordinators noted. At the same time, evaluation is critical, and there is little point in carrying out an excellent project if at the end one has no evidence of its effectiveness.

Another source of the challenges represented by evaluation lies in institutional and political obstacles to evaluation, particularly organisational disinterest in or resistance to evaluation.

Recommendations for further development

While the first 18 months of work by VicHealth and the RPL resulted in significant improvements in project coordinators' and projects' evaluation capacities, there were also some limitations to these efforts thus far. The report now documents these, framing each in terms of what could have been done differently and what can now be done.

1. More intensive engagement in capacity building, particularly in project-specific assistance

Two of the most important ways in which the evaluation capacity building work among the five projects could have been improved were through a greater investment of *time* and, related to this, more intensive *project-specific assistance*. This is true for both of VicHealth's two main strategies of evaluation capacity building: group-based instruction and one-on-one technical assistance.

Focusing on the issue of time and looking at the first strategy, five learning circles were held over 17 months (from August 2008 to December 2009), roughly every three months. A portion of each five-hour meeting was devoted to workshops on evaluation, typically 60–90 minutes. This means that, in a group context, project coordinators received a total of 5–7 hours of direct instruction in evaluation practice in the first year-and-a-half of the projects. In addition to this direct instruction, the coordinators spent time in other sections of each learning circle discussing their developing practice in evaluation (and in violence prevention more generally). Coordinators' involvement in quarterly, half-day meetings may not seem to comprise substantial participation in group-based instruction in evaluation capacity building. However, some other empowerment evaluation projects devote less time to structured instruction, such as only three meetings over three years (Gibbs et al. 2009, p. 405).

Looking at the second strategy, the evaluation researcher's provision of tailored or project-specific technical assistance was limited in intensity. The RPL had regular phone, email or face-to-face contact with the five projects. However, his ability to maintain regular contact and respond quickly to queries was limited by other work commitments, geographic circumstances and other factors. Project coordinators themselves articulated a desire for more intensive engagement in evaluation capacity building, calling in particular for more one-on-one contact.

Project coordinators' interest in more intensive engagement in capacity building appears to have been driven in particular by a perceived need for more *project-specific* or *tailored* assistance. In the focus group held in January 2010, coordinators emphasised that project-specific education and assistance should be a greater part of *both* the group-based instruction and the one-on-one technical assistance. In other words, they called for a greater focus on efforts to build their capacity to evaluate *their*

particular projects, in both their one-on-one contact with the evaluation researcher and other VicHealth staff (where this was already the focus) and the learning circles (where it had not been). For example, in the focus group held in January 2010, a worker called for 'more dedicated one-on-one time'. She noted that she 'would have felt more supported, and with greater capacity, if we'd had e.g. four one-on-one meetings over six months, which were more targeted'.

The evaluation workshops in the learning circles had focused on general instruction in evaluation practice, and the project coordinators perceived a need for lengthier instruction in evaluation in general. However, they gave greater emphasis to the need for instruction and assistance in the evaluation of their particular projects. For example, one coordinator commented that she would prefer to use the learning circles to work on her actual evaluation framework and for workshopping of projects' evaluation plans. Another said that in the evaluation workshops, 'it would be valuable to use an actual project as the example … to see the development process in action'.

Two further elements to a more intensive engagement in capacity building were identified by the project coordinators: a more participatory teaching style, and greater structure regarding contact. In the evaluation workshops in the quarterly learning circles, the RPL used both didactic and interactive teaching strategies; that is, both lecturing and group discussion. However, at least one worker would have preferred a greater use of participatory teaching strategies, commenting:

> I'm a community development worker, not an academically minded person. So the resources, while I'm sure world-class and relevant […] Receiving a list of resources doesn't work. I'm too busy 'doing'. Receiving pages of references is not a very engaging way of furthering my understanding. Yes, it's a legitimate way of presenting information but it's not an accessible way.

The RPL's use of lecturing techniques was intended to deliver and reflect the breadth of material relevant to evaluation planning and implementation, but it should have been tempered by more interactive strategies. The second element is the inclusion of greater *structure*. In the January 2010 focus group, some coordinators called for the greater use of set dates and regular meetings.

2. More direction regarding evaluation planning

In evaluation capacity building, one issue is whether to offer a single, standardised model of evaluation planning, or to allow for local and contextual variations in this. In the materials prepared by the evaluation researcher for the evaluation workshops among the project coordinators, the latter strategy was used. The RPL presented the project coordinators with a variety of models of how to construct evaluation plans, directing them to a variety of introductory guides to evaluation design and implementation.

However, this approach may have contributed to the sense of being overwhelmed reported by some project coordinators after the learning circles. In the focus group held in January 2010, one worker noted: 'I found lots of the information useful. But I also found it overwhelming. I felt stressed after meetings.' Another commented: 'I did read stuff, but the more I read, the more overwhelmed I felt.' She went on to note that:

> When I did make progress with my evaluation planning, it was just because I picked one evaluation guide, and copied it. I needed this level of spoon-feeding: first you do this, then this …

It may be, therefore, that more direction regarding evaluation planning would have been more empowering for the project coordinators and more likely to limit their sense of being paralysed or overwhelmed with complexity. Comments by some project coordinators seemed to confirm this, with some calling for 'more structure' and 'a step-by-step process' for evaluation.

In at least one US-based empowerment evaluation project also centred on violence prevention, a single, overall model of evaluation planning was offered to the rape prevention and victim services programs involved (Campbell et al. 2004). In this example, the Sexual Assault and Rape Prevention Evaluation project decided against the use of standardised evaluation protocols (in which every program evaluates the same phenomena in the same way) in favour of local decision-making addressing local initiatives. However, it did offer a single model of evaluation planning. This project also showed a more intensive and wide-ranging engagement in capacity building, through the development of four dedicated training manuals and two further resource guides as well as training workshops, technical assistance meetings and individualised consultation (Campbell et al. 2004).

3. A more comprehensive approach to evaluation capacity building

VicHealth has worked to systematically integrate evaluation, and evaluation capacity building, into its health promotion activities, including those associated with the prevention of violence against women. As noted earlier, VicHealth applies institutional arrangements that include requirements for evaluation, works to develop its evaluation expertise and to extend its evaluation capacity building through partnerships with university researchers, and provides dedicated instruction and assistance in evaluation to the projects it supports. Just as the evaluation practices adopted in the projects supported by VicHealth are growing in sophistication, so are VicHealth's own evaluation capacity building activities.

VicHealth's model largely exemplified the recommendations for good practice found in contemporary scholarship on evaluation capacity building. There is growing sophistication in this scholarship. While there have been few comprehensive conceptual frameworks to guide practitioners' efforts or to test

the effectiveness of them, models of evaluation capacity building are emerging (Naccarella et al. 2007; Preskill & Boyle 2008). This body of research and practice suggests that there are some ways in which VicHealth's evaluation capacity building can become more comprehensive.

> **VicHealth's model largely exemplified the recommendations for good practice found in contemporary scholarship on evaluation capacity building.**

Project coordinators' abilities to conduct impact evaluations are shaped in part by their own evaluation and research skills, and by the research-related capacities of their host organisations. It might have been desirable for VicHealth's evaluation capacity building in violence prevention among the five projects to begin with an assessment of participants' needs and skills regarding evaluation (Preskill & Boyle 2008, p. 448). Organisations, too, have diverse learning and research capacities, structured, for example, by their leaderships' valuing of education, systems and structures, and communication channels (Preskill & Boyle 2008, p. 445). Such differences in personal and institutional capacity should be taken into account in planning and implementing evaluation capacity building, including in the selection of teaching and learning strategies (Preskill & Boyle 2008, p. 447). The literature on evaluation capacity building suggests that the content and form of program-specific technical assistance should be tailored to program preferences: in terms of the focus of evaluation efforts (content), the depth at which work occurs, and how this is provided.

> **It might have been desirable for VicHealth's evaluation capacity building in violence prevention among the five projects to begin with an assessment of participants' needs and skills regarding evaluation.**

Evaluation capacity building should involve the explicit articulation of one's goals and strategies, and the theories of change associated with these. This was less well developed in VicHealth's initial efforts in capacity building among the five violence prevention projects than it might have been.

Ideally, processes of evaluation capacity building lead to a sustainable evaluation practice. Among individuals, this means, for example, that individuals can transfer their evaluation skills and knowledge to other contexts (Preskill & Boyle 2008, p. 453). It is more crucial, however, that evaluation be sustained at the level of organisations. While VicHealth did not intervene directly in the overall evaluation practice of the organisations that host the five violence prevention projects,

VicHealth might explore how its partnerships with these organisations could foster greater organisational commitment to evaluation.

A more comprehensive approach to evaluation capacity building might also involve the greater integration of evaluation into VicHealth's funding and administrative protocols in relation to its work with community organisations. For example, VicHealth may wish to dedicate a specific or even standardised portion of project funding to evaluation.

4. A more rigorous assessment of the impact of evaluation capacity building

VicHealth is committed to evaluate the workings and impact of its evaluation capacity building activities. While this report goes some way towards a preliminary assessment at the midpoint of these efforts, VicHealth will continue to build this evaluation and do so in more rigorous ways. Appropriate methods for the evaluation of VicHealth's capacity building in the evaluation of violence prevention include:

- interviews with individual project coordinators or other assessments regarding their development of evaluation capacities in specified domains (Preskill & Boyle 2008, p. 450)

- analysis of projects' evaluation reports against specified criteria (Campbell et al. 2004, p. 257)

- pre- and post-intervention assessments of projects' and agencies' competency regarding specific criteria of evaluation

- evaluation of the capacity of organisations per se to conduct evaluation of their violence prevention projects (Stevenson et al. 2002).

5. The institutionalisation of evaluation at VicHealth

In its work to prevent violence against women, as in its other domains of health promotion activity, VicHealth emphasises the need for robust evaluations of prevention practice. Evaluation is a core component of health promotion research and practice. If an organisation is fostering evaluation, then:

- evaluation is institutionalised in the organisation through policies and procedures, and guided by evaluation frameworks and processes

- evaluation is supported by dedicated resources (financial, personnel and material)

- evaluation findings are used and communicated

- there is an 'evaluation culture' of shared beliefs and commitment

- the organisation integrates evaluation-related data, processes and lessons into its knowledge management

- the organisation has a strategic evaluation plan

- the organisation provides opportunities for continuous learning about evaluation (Preskill & Boyle 2008, pp. 455–6).

VicHealth's own ability to build the capacity of community projects and organisations to evaluate their violence prevention activities is being strengthened by its developing institutionalisation of evaluation. This will be further strengthened by ongoing refinements to its evaluation capacity building activities. Thus VicHealth can play a dual role, building an internal culture of evaluation and supporting partner organisations to foster these themselves.

Conclusion

VicHealth's work in building the capacity of community organisations to evaluate their violence prevention projects showed significant strengths and successes over its first 18 months. The strategies applied, combining structured instruction and program-specific technical assistance, are in alignment with other contemporary efforts in evaluation capacity building. VicHealth's efforts generated important positive changes in the capacity of the five project coordinators to evaluate their violence prevention projects and in the quality of their evaluation practice, as well as improvements to project design and implementation. At the same time, there is room to make these evaluation capacity building efforts more intensive and comprehensive and ensure the strategies are fit for purpose in the emerging field of preventing violence against women.

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