

Beyond circles in square boxes: Lessons learned from health communication impact evaluations

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Introduction

I want to do two things in this paper. First to look at lessons that have emerged from Healthlink Worldwide's work with partner organisations in different developing country settings, engaged in health communication activities and the provision of health information. Second is to set these examples in the wider context of issues and trends in monitoring and evaluation practice, relating to the very possibility and viability of measuring impact, drawing on preliminary experience of the Exchange programme. With both of these I look at the processes of learning lessons from evaluation, without getting too deep into methodological debates. I recognise that demonstrating 'impact', in the wider sense of tangible evidence of progress towards very broad development objectives, is far more rare than the relatively circumscribed improvements that can be attributed to specific projects.

Introducing Healthlink Worldwide

First some words of introduction. Many of you may know of the work of Healthlink Worldwide from its days as AHRTAG (Appropriate Health Resources and Technologies Action Group), and from its work in strengthening the provision, use and impact of information in the field of health and disability, exemplified in international newsletters such as *AIDS Action*, *Child Health Dialogue*, *Health Action* and *Disability Dialogue*. Healthlink's work has always involved strong ongoing relationships with partner organisations in developing countries and recent changes at Healthlink have seen a further shift to a communicating through partnership model. Such a model places an emphasis on building the capacity of partner organisations in different developing country contexts to effectively approach the health issues facing poor and vulnerable people there. This shift will see the halting of newsletter production by Healthlink, to be superseded by a range of regionally produced newsletters. Another change will involve Healthlink's Resource Centre merging with that at the Institute for Child Health, to be reborn as 'Source' in the imminent future. In some ways these developments are a consolidation of the changes that have been implicit in the development of Healthlink's work, as we shall see in some of the evaluation examples discussed below.

Introducing Exchange

Healthlink Worldwide hosts the Exchange programme. It is under the same roof as Healthlink and shares its administrative framework, while being a semi-autonomous

programme in terms of its operational activities. Funded by the Department for International Development, Exchange emerged from a long consultation with organisations and individuals in the UK health communication sector. The consultation identified a ‘networking and learning’ approach (the approach encapsulated in Exchange’s strap-line), as the one most appropriate for bringing together and sharing the lessons being learned in health communication. Another important role for Exchange is to ensure that developing country voices and experiences are prominent in this sharing of good practice, and that grass-roots experience of the role and importance of health communication in developing country contexts directly informs the agendas of donors and NGOs in the North.

There is also a concern to strengthen what already exists, not to re-invent the wheel but to see mono-cycles turn into bicycles and beyond. Exchange is thus working with a number of partners involved in different areas of health communication. One is INASP-Health, which many of you will already be familiar with, through its health information forum meetings, its work in the field of providing medical information to health personnel in developing countries, as well as from previous IIS seminars. Another is the Communication Initiative, which many of you may be familiar with through its mine-of-information web-site covering activities in communication for development.

Emphasising communication

Exchange places an emphasis on health communication, rather than information, and it does this for a number of reasons. Firstly, the stress on communication highlights the importance of **context**. In place of the traditional information dissemination model, which was largely concerned with the one-way dissemination of particular messages, there is a recognition of the role of a variety of levels of context in affecting health behaviour and practice in any particular setting. In development circles, the awareness of the impact of poverty and wider determinants of health appear to be evidence of a growing appreciation of context in general terms. More specifically, the UNAIDS new communication framework for HIV/AIDS (Airhihenbuwa et al 2000), with its recognition of five levels of context - government policy, socio-economic status, gender relations, culture and spirituality - is an example of a recent attempt to take context seriously. Operationalisation of this framework in practical project contexts however, is still in its infancy.

Secondly, an emphasis on communication also stresses **process**, and brings the social dynamics involved in defining, negotiating and understanding health, to the fore. Issues of accountability, ownership, as well as existing resources and channels of communication, are all made visible if we focus not on the dissemination of information, but the human processes of communication in which such information is nested. Two areas of development work where such an emphasis is key, are participatory approaches to development (IDS 1998, Richardson and Paisley 1998, Estrella et al 2000), and the communication for social change approach developed by the Rockefeller Foundation (Gray-Felder and Deane 1999).

I will return to this emphasis on communication when I discuss wider issues bearing on evaluation below, but first I look at the lessons emerging from Healthlink's work with partners over the last couple of decades. Some of these lessons learned may not appear to be new to some of you here, but I feel there is no harm in repeating a few practical points, which are easily forgotten. This tendency to forget was highlighted at a recent consultation meeting for NGOs and civil society organisations to feed into the Dotforce initiative of G8 countries to bridge the digital divide. Contributors at this meeting highlighted the need to start from people's actual situation on the ground in developing country situations, and from the communication channels which were already in place. It was also stressed that patterns of information technology use from the North, could not be transferred without problems elsewhere. This was essentially a plea to learn the lessons from the 'appropriate' technology movement in health and medicine, and not simply apply a uniform technological fix for what are often more subtle social or economic problems. At the very least it would help to make this fix appropriate to local conditions. It remains to be seen whether such a plea will be heard above the buzz of excitement and hype around new communication technologies.

Lessons from Healthlink Worldwide evaluations

In this section of the paper I want to draw out lessons learned as well as what we might call 'productive problems' (problems raising important issues), from a number of evaluation studies focusing on Healthlink's project partners, Healthlink's newsletters, and consultancy work Healthlink has done for other organisations. I then return to some related contemporary issues in evaluation and impact practice.

Evaluating the newsletters

The experience of producing Healthlink newsletters in international and regional language editions provides examples of good practice, and some instances where problems have been identified and fed into the subsequent development of the newsletters. I draw here on a number of evaluation studies conducted over the second half of the 1990s.

Feedback on the newsletters

A consistent feature of the newsletter evaluations was the value placed on practical, easy to read, accessible information, that was relevant and based on up-to-date research. This is something that was achieved through a number of mechanisms that are worth highlighting. One important source of review for the newsletters was the network of international advisors and external contacts who constantly gave feedback on them. The Evaluation of *Child Health Dialogue* in 1998 explicitly mentioned the importance of the evaluation forms, provided to advisors with each edition. These allowed ongoing feedback on a variety of issues, including technical questions. Also valuable were Reader questionnaires and workshops, where proposed topics and themes for newsletter content were developed. In the case of *Child Health Dialogue*, this led to a number of 'dedicated' issues focusing on particular subjects, such as maternal health. In the case of *CBR news*, the precursor to *Disability Dialogue*, focus groups were engaged to look at a range of

articles, analysing in depth what made them more or less interesting or relevant, to inform the way content was developed in future.

Adapting the newsletters for training

A number of the evaluation studies reported the tendency for newsletters to be passed around and the information shared, or further than this, for them to be used in training, sometimes in an adapted form. The evaluation of *Health Action* in 1998 showed that a quarter of questionnaire respondents reported translating or adapting the material in the newsletter for training purposes. One striking illustration of the value of the provision of accessible, up-to date research, was a number of reported cases of *AIDS Action* readers who were living with HIV, sharing information on counselling with health workers who were expected to deliver such counselling as part of their work (AHRTAG 1997). This emphasis on using the newsletter content for training also influenced the subsequent development of a number of the newsletters to include inserts and illustrated sections that could be easily adapted for training purposes.

Local content and regional editions

The newsletter evaluations called for more locally tailored content, in terms of issues covered, awareness of local cultural factors affecting the appropriateness of certain health messages, and production in local or regional languages. Decentralisation of production in one form or another was also consistently advocated, something which had already been successfully achieved for newsletter editions in Asia and Africa. In a number of cases a desire to carry this process further (beyond what was in some cases just the translation of content developed in the North) was expressed, while input from Healthlink, in terms of support and capacity building, was seen as important to facilitate the transition to regional production.

Subsequent developments at Healthlink Worldwide have seen the organisation move more towards a 'partner support' and capacity building role as I noted above, and this will see the phasing out of newsletter production in the North in the near future. These moves clearly reflect the priorities emerging from the various evaluations of programmes and newsletters. However the difficulty of sustaining support for production and distribution costs of printed materials from donors remains a problem, which some of Healthlink's Southern partners will have to engage with. Donor funding trends, are clearly an issue here, even in the face of clear evidence of the continued value and appropriateness of print materials. The example of the US newsletter *Mothers and Children* is a case in point. The newsletter was consistently highlighted as useful for health workers, particularly in local community and rural settings, in a number of reader surveys, including those conducted by Healthlink. This did not stop funding being withdrawn however, and there is no doubt that the pendulum swing towards the more excitingly perceived avenue of electronic communication, makes support for the provision of print materials ever more difficult.

Carol Priestly from INASP-Health made this point at the IIS seminar 2 years ago, where she also made a plea for the important support and capacity building role for Northern

NGOs to be adequately recognised (and funded). The neglect of support for print materials has frequently been highlighted in discussions around the ‘digital divide’, recent contributions to the Health Information Forum e-mail list among them. In places where the telecommunications infrastructure is poorly developed, such as in many African countries (although by no means all, since such infrastructure development is very uneven, see Jensen and Richardson 1998), the provision of print information remains crucial. The evaluation of *AIDS Action* in 1998, saw a need for the paper edition of the newsletter in southern Africa well beyond 2010, and research on agricultural work in Ghana and Uganda, has shown the enduring value of paper-based material, even for illiterate audiences (Carter 1998).

Partner Support and Capacity-building

The issue of capacity-building and partner support emerges as an important theme in evaluation work with Healthlink partners in different country contexts.

Lessons from resource centre projects

The evaluation of a Resource Centre Project with the Kenya AIDS NGO Consortium (KANCO) in 1997, recognised Healthlink’s strength in the areas of information management and resource centre development. However this was also seen as being to the neglect of building the capacity of local health personnel. On the basis of this criticism and ongoing experience with the KANCO project, a number of lessons were fed into two other Resource Centre Development projects: one in partnership with the Centre for Development in Health, Arusha (CEDHA) in Tanzania, and another, the Communication for Integrated Learning project, in partnership with the Namibian Ministry of Health in Namibia. The awareness of the need for capacity building emerging from the KANCO project, was reinforced by review of the initial phase of the CEDHA Resource Centre project, which highlighted the same need. In the light of this, an emphasis was placed on training and infrastructure development, before the development of health learning materials, one of the main objectives of the original project, could be pursued. The project went much further than “just pouring books in”, to quote a member of staff at CEDHA, ultimately contributing to the strengthening of working links between the Ministry of Health’s continuing education infrastructure and the development of Resource Centres.

Lessons from the experience of the CEDHA project were also fed into the Resource Centre project in Namibia. One key issue that was identified, which again related to capacity building, was the need to develop a ‘learning culture’, so that people had a habit of self-directed learning, and got used to seeking out information themselves. In this way, the Resource Centres that were being developed would not be underused. The objective of promoting a learning culture was subsequently adopted in the Namibia project, although perhaps not surprisingly, this ambitious aim was difficult to achieve.

If we turn to another setting and Healthlink’s Middle East programme we find that capacity building was central to partnership work with organisations such as the Union of Palestinian Medical Relief Committees (UPMRC) and the Health Development

Information Project (HDIP) in Palestine and the Centre for Development Services (CDS) in Egypt. Evaluation of the programme in 1996 showed that training of Resource Centre staff had led to many staff themselves becoming trainers both locally and regionally, and strong local and regional exchanges illustrated how Healthlink's Middle Eastern partners were particularly responsive to such a way of working. In the Palestinian case, the development of a Primary Health Care course at Birzeit University, a large growth in the production of in-country health resource materials, and the local development of information systems, showed that a small amount of capacity building went a long way. The Middle East programme also brought out Healthlink's forward-looking promotion of electronic communication as particularly useful in helping to build effective local and regional networks.

Given the importance, in Healthlink's work with partners, of attempts to strengthen their capacity to develop and carry out their own health communication activities, it is not surprising that the 'partner support' role is even more central in the recent re-structuring of Healthlink's organisational priorities. In many ways this emphasis simply makes more explicit, something which has always been part of the organisation's approach to development, although as we have seen, this emphasis on capacity-building sometimes grew out of evaluations pointing to its absence.

Evaluation - issues and constraints

The above evaluation studies, in addition to highlighting lessons learned, also pointed to important constraints, some of which were not amenable to the kind of changes that are possible at a project level. A common example in both the CEDHA and Namibia Ministry of health Resource Centre projects, was the undervaluing of library and information staff. This was reflected in low wages, and in the Namibia case, the low status of the Resource Centres themselves. Below I consider a number of the issues and constraints raised by the evaluations, and link them to questions about the limits and scope of evaluation processes in a more general sense.

Time to reflect

An issue that was consistently raised was the need for more time for 'reflection', so that people could lift their heads above the stream of project implementation, to pause and constructively reflect on underlying assumptions, strengths and weaknesses. It was also important to ensure that key staff were not the only repositories of insight within their organisation, and to try to take the time to make good practice transparent and transferable through adequate documentation. The question of time to reflect is a perennial one, since much important experience never gets recorded or documented, often (although not solely) because people are too busy. This question is very germane to the work of the Exchange programme, which finds itself in the sometimes awkward position of urging projects and programmes large and small to document and share their learning, when many of them would do so if they only had the time. The Exchange programme in many ways is an attempt at an umbrella or meta level to bring together

some of the learning and experience that many have been unable to record and share. Ultimately however, building in time for reflection must be a priority that goes deep in every project activity, and in particular deep enough to be a baseline on donor agendas.

Documentation

One value of documentation is to make learning and good practice transparent and amenable to sharing. It is here that formal monitoring and evaluation processes can be useful as a way of developing effective ways of working for the future, rather than leaving them implicit, or as was mentioned above, in the minds or methods of key individuals. Healthlink is again an interesting example in this regard since its feedback mechanisms have been formalised only to varying degrees, being ensured as much by good ongoing communication and dialogue, as any formal monitoring or evaluation procedures. Where formal procedures have been adopted, as has increasingly been the case, these have been applied very much in a spirit of learning for the future, on the foundation of good channels of communication. Conversely, the experience of CARE International in Zambia in the early 1990s shows that adopting what seem to be the right procedures, is often not enough on its own. Despite massive investment of time, resources and training in participatory evaluation, CARE found that local communities still did not feel a sense of ownership of the process, reducing local involvement (Ward 2000: 160-161).

One more interesting example in this regard was thrown up by the interim evaluation of another of Healthlink's partners, SeHAT: the School Health Action and Training Project in Delhi and Bombay. What emerged in this evaluation was that SeHAT staff were good at reacting "in a continuous self-reactive way to monitoring data" (essentially ongoing feedback from teachers and pupils) while their formal data-handling was hampered by inconsistent monitoring instruments that changed at several stages of the project. There was thus a good deal of anecdotal evidence of the impact of the project in improving the school environment, but any rigorous evaluation analysis was not possible.

Wider evaluation issues

There is a good deal of mystique around monitoring and evaluation, which in essence, are really trying to generalise and formalise the good practice in documentation, consultation and responsiveness, that people develop when they are working well. The case of the Bolivian Miner's 'Radios Mineras' popular Radio programming in the 1970s reinforces this point: here effective monitoring and evaluation mechanisms grew directly out of the desire to consult and adequately express the priorities of the mining communities the radio programmes served (Dagron 2001). Ultimately the great potential of documenting lessons learned, in the form of more or less formal monitoring and evaluation indicators, is that it allows both strengths and weaknesses to be identified, and the possibility that these can usefully inform subsequent work (though there is a question about exactly what to document, since monitoring and evaluation processes should not be unwieldy to the degree that they get in the way of the practicalities of project implementation).

Another issue is that in many cases it is the weaknesses where most can be learned, and yet there is always a tendency to sing out the successes and bury the failures, something which has no small connection with the desire to please donors. Discussion on an electronic list of the recent publication from the Rockefeller Foundation 'Making Waves', instantly appreciated the fact that all of the short case studies of participatory communication had a section on 'constraints', allowing problems to be identified, in a spirit of shared learning. Such a transparent approach to mistakes and problems is a valuable contribution to building a collective knowledge of lessons learned, and it is vital that this sort of approach is encouraged. Given the obvious unease around 'washing one's dirty project in public', Exchange is keen to find ways of sharing the lessons from 'mistakes', perhaps through hypothetical case studies. At the same time, there is an advocacy issue here, in that learning from mistakes also needs to receive more acceptance from donors.

Time constraints

The fact that projects may be assessed over a relatively short time span, means that there is not enough time to allow for the impact of particular interventions to be demonstrated. It is now being recognised that demonstrable impact on the ultimate objectives of health interventions may not be apparent for many years. This is because the specific contribution of particular projects is very difficult to disaggregate from the multiple inputs in a real life situation (Webb and Elliot 2000). The project, in this sense, may not be that useful as the unit of analysis for assessing development impact (Carden 2000:175), and the inadequacy of the short-term funding cycle is also highlighted in this regard. One clear lesson from Healthlink's experience is that effective relationships take time. In many ways it is the long-term nature of many of Healthlink's partnerships that has allowed trust and dialogue to build, so that channels of communication remain open, and lessons learned from practice on the ground are effectively fed back into ongoing work. The same point can be made in relation to health and health communication interventions more generally. This was illustrated by a contribution from the Ugandan Minister of Health at the Exchange international video conference on HIV/AIDS in March 2001, where he stressed a need for patience and a long-term, determined commitment in programme activities. The remarkable achievements of Uganda's struggle against the disease clearly demonstrate the value of such a consistency in approach.

Objectives/indicators

A related problem is that the intended objectives of a programme which are encapsulated in monitoring and evaluation indicators may rule out an accurate grasp of unintended or unpredicted consequences. Translating everything onto the grid of a log-frame and its objectives and measurable indicators, can mean that programmes are unable to capture the unexpected, or be flexible enough to deal with the unfamiliar. Some have even argued that the 'project space', constituted through participatory workshops, is an artificial creation, that may have little real impact beyond its own narrow and often quite self-defined criteria of success (Green forthcoming). Ideally tools such as the log-frame should be used as guidelines, but the pressure of funding constraints can often act like the proverbial wind change, and freeze a temporary expression into a permanent disposition,

so that a projected milestone may become a millstone. Again, advances have been made in participatory approaches that recognise the importance of reflecting the needs of a variety of different stakeholders, as well as the process of involvement, in generating appropriate indicators for projects.

The Stakes of different Stakeholders

However the political questions of power, relating to who evaluation is for and why we do it, remain. Peers and Johnston (1994) note that: “pursuit of good practice is not a democratic process... power relations between funder and funded are real, and imply various, non-negotiable obligations. In other words not all voices are heard and even when they are, they are inevitably weighted in terms of influences”. If this is the case, it raises questions about the role of participatory approaches, and highlights the potential conflict of interests at the heart of any evaluation. Is there a danger that ‘participation’ is ultimately reduced to co-option, where people are asked to take responsibility and find yet more energy and resources to tackle problems that may have been created and be being sustained by a global economy beyond their ‘local’ control? The pragmatic focus of many programmes, which put an emphasis on achievable and operationalisable goals also tends to rule out adequate consideration of the constraints of wider determinants of health. Yet these may bear vitally on the feasibility of the project. A pragmatic focus also ensures that wider political questions, which form the background economic and social priorities of any project setting, remain invisible. This has led some critics to suggest that participation may in fact be a ‘new tyranny’ (Cooke and Kothari (2001).

A related issue here is the way that the notion of ‘accountability’, in much evaluation parlance, has come to be narrowed to mean adherence to financial frameworks/constraints. Such a definition is not restricted to the field of health communication but forms part of the new managerialism which has spread across many areas of ‘public policy’ in the North, if not globally (Shore and Wright 1997). Yet the importance of involving a variety of stakeholders and taking their participation seriously is generally recognised as being vital for the success of any project. Such a recognition points to a richer notion of accountability, that implies a responsiveness to the needs of the different groups affected by the project, not least its supposed beneficiaries.

The request by organisers of the People’s Health Assembly (held in Bangladesh in December 2000) for the Exchange programme to be involved in monitoring and evaluating the assembly will no doubt bring some of these questions to the fore. The conduct and processes of the assembly, which spanned over a year of local and regional consultations, and put global economic and political frameworks at the heart of their concern, pose the serious challenge of finding an approach that can encompass all the different interests and factors in one evaluation framework.

Within ethnographic studies, the dangers of exclusively focusing on the local setting, to the neglect of wider factors that impact on such a setting, have been approached by taking a ‘vertical slice’ (Nader 1980) approach. Such an approach highlights the importance of studying various different contexts that impinge on any particular local study, including

institutional settings and policy frameworks. Unless these different levels of influence are taken into account, the limits of any particular evaluation need to be clearly recognised.

Conclusions - towards a learning-based evaluation

Addressing some of the issues of power and levels of context raised above holds out the possibility of a more complete process of learning. Such an evaluation process would be democratic, reflexive and provide a means of constantly building on best practice. As such it could be advocated as an antidote to the funder-driven model, which makes many people feel manipulated and suspicious. If people are to embrace the reflective and learning potential of evaluation however, it must as a process adequately address and begin from people's reality on the ground. It must also point both inward and outward: inward to the detail of local interactions and practice, and outward to the wider contexts which bear on the lives that people are able to sustain. More time for reflection, documenting and sharing of lessons must be something which is valued and funded, not seen as an add on or after-thought. De-linking the processes of learning from funding and project cycles may also be important, since there is evidence that this is where evaluation is most productive (Carden 2000: 188).

Healthlink, as I have shown, has tended to approach evaluation very much as an opportunity for improving future work and has often invited, what one evaluator called a 'productively critical' approach (AHRTAG 1997) in this spirit of learning. However, this emphasis on learning is quite different from the classic end of project external evaluation, which many have experienced as a punitive management tool or merely as a justification for withdrawal of funding. The emphasis on learning is one that the Exchange programme is also keen to champion in its work, and which it is hoping to track in a 'mapping' exercise which is currently underway.

Much of the work under the rubric of participatory approaches, has already developed in this direction, promoting local involvement and ownership, capacity building, and a learning focus (IDS 1998, Estrella et al 2000). For example Canada's International Development Research Council, has an approach that is explicitly labelled 'learning-based evaluation'. This uses a framework for institutional assessment (Lusthaus et al 1995) to facilitate participatory self-assessment in a number of country contexts (Carden 2000). There are also points of contact with work in the area of Communication for social change, which puts people as agents of their own change at centre-stage (Gray-Felder and Deane 1999).

Healthlink's experience shows that it is as important to build the capacity of organisations and individuals, as it is to become fixed on particular formal procedures of evaluation. At the same time, the importance of a dynamic process of monitoring is highlighted, so that people are able to feed back lessons learned quickly into their activities. In this way people can effectively determine their own development priorities, and are likely to maintain effective communication and dialogue, as part of their own desire to learn. A central issue then becomes to find a way of sharing learning that does

not require a uniformity of approach, so that lessons learned in different contexts can contribute to and enrich an overall understanding.

Again, such work is already under way. The Effectiveness Initiative of the Bernard Van Leer Foundation provides an example of such a flexible approach. In this case a diversity of methods applied in various different projects focusing on early childhood development, were shared in an ongoing way, allowing the lessons learned in each setting to inform the others (see Early Childhood Matters No.96). From a quite different angle, the growth of South-to-South initiatives in sharing skills, experience and capacity building through staff exchanges, such as in the current work of Partners in Population, also point to ways of sharing experience from diverse contexts in practical and useful ways (PPD 2000).

The question of developing indicators which have some universal validity and applicability touches on the same problems. Recent attempts to employ a human rights framework and use it as a basis for indicators, such as the attempts by the Harvard School of Public Health's work with the United Nations convention on the Rights of the Child (Tarantola and Ruskin 1998), have come up against the problem of the language of rights-based approaches being applicable at a governmental rather than local organisation/project level, and the fact that the universalism of the rights based approach may be incompatible with the particularities of local settings (Webb and Elliot 2000). There is a growing awareness in work looking at the impact of information (Menou 1993) of the social context of health communication, and thus the need for some 'pluralistic' framework in which to understand this (Menou 2000).

Another promising approach can be found in the recent attempts to develop indicators based on the quality of the communication process and the relationships of communication, rather than on the detail of particular projects. Warren Feek, the director of the communication initiative outlined this approach in a recent issue (82) of the electronic newsletter 'Drum-beat' providing a list of indicators that were applicable quite generally, but flexible enough to be applied operationally in quite different situations. Examples of these indicators are: 'Do the people most affected have an increasing 'voice' in the communication interventions', 'Is there an increase in both the number and scale of social and organisational networks focussing on the issues in question?' and 'Is there increased sensitivity to differing perspectives'. Ultimately it is important to find ways of learning from a diversity of experiences, while in some way bringing them together to share for the greater good, without compromising their specificity. This is something to which the Exchange programme aims to contribute.

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