Organizational determinants of evaluation practice in Australian prevention agencies

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Received on October 10, 2017; editorial decision on March 5, 2018; accepted on April 20, 2018

Abstract

Program evaluation is essential to inform decision making, contribute to the evidence base for strategies, and facilitate learning in health promotion and disease prevention organizations. Theoretical frameworks of organizational learning, and studies of evaluation capacity building describe the organization as central to evaluation capacity. Australian prevention organizations recognize limitations to current evaluation effectiveness and are seeking guidance to build evaluation capacity. This qualitative study identifies organizational facilitators and barriers to evaluation practice, and explores their interactions in Australian prevention organizations. We conducted semi-structured interviews with 40 experienced practitioners from government and non-government organizations. Using thematic analysis, we identified seven key themes that influence evaluation practice: leadership, organizational culture, organizational systems and structures, partnerships, resources, workforce development and training and recruitment and skills mix. We found organizational determinants of evaluation to have multi-level interactions. Leadership and organizational culture influenced organizational systems, resource allocation and support of staff. Partnerships were important to overcome resource deficits, and systems were critical to embed evaluation within the organization. Organizational factors also influenced the opportunities for staff to develop skills and confidence. We argue that investment to improve these factors would allow organizations to address evaluation capacity at multiple levels, and ultimately facilitate effective evaluation practice.

Introduction

The growing burden of chronic disease, and persistence of social disparities in health status, requires continued development of evidence to underpin effective prevention strategies [1, 2]. Evidence of what works, for whom, and in which circumstances is essential to inform policies and programs that can address current population health priorities [3]. It has been widely argued that evidence generated through program evaluation can provide contextually relevant insights for decision makers and practitioners, enable accountability to funders and community stakeholders, facilitate organizational and program level learning and improve effectiveness [4–6].

Despite the known importance and demand for evaluation, there are significant challenges to undertaking evaluation and using the evidence generated [7–9]. In response to these, the need for workforce development and partnerships between research and practice organizations has been highlighted [3].
Strategies have been implemented to build capacity for evaluation practice and use to meet this demand, including training [3, 10] formation of networks and partnerships [11] and refinement of evaluation designs to improve the practice relevance of evidence generated [12]. The increased attention to evaluation capacity building is a promising sign, however there is limited evidence of what influences evaluation practice and use in prevention organizations.

Australia has a well-developed infrastructure for prevention policy and programs, encompassing a diverse range of government and non-government organizations (NGOs), yet there have been few studies of the organizational barriers and facilitators to evaluation practice in this context. Three studies used qualitative methods to explore these influences in specific health promotion settings. In the evaluation of peer-based programs, limited capacity and funding, beliefs about evaluation and a reliance on volunteers were identified as barriers [13]. In the South Australian community health setting, time, resources, culture of evaluation and limited use of findings hindered effective evaluation practice [7]. Interviews with practitioners and managers in metropolitan Melbourne prevention organizations identified funding, staff skills and access to appropriate tools for evaluation as influential within the organization [4]. Huckel Schneider et al. [14] interviewed policy makers and researchers in Australia about barriers and facilitators to evaluation, and at the organizational level identified limited time, inadequate funding, caution over negative outcomes and inadequate staff experience with evaluation as barriers, and a culture of sharing and learning as an important facilitator.

These findings align with theoretical models which highlight the importance of organizational factors as determinants of evaluation capacity [15, 16], and are consistent with what has been found in prevention agencies in other nations. A qualitative study of Dutch local government organizations implementing health programs described time, budgetary constraints, limited leadership and program experience, unclear role expectations and competing priorities as barriers to evaluation [6].

A number of authors have emphasized the importance of placing evaluation practice and use in the context of organizational learning capacity [17, 18]. From this perspective, the need to address organizational culture and systems, and to go beyond the traditional training and development approach, has been recognized as integral to evaluation capacity building. Preskill and Boyle’s [17] multi-disciplinary model of evaluation capacity building embeds evaluation capacity within a framework of organizational learning, and describes elements of organizational culture, leadership, systems and structures and communication as central influences upon the evaluation capacity of organizations.

Despite the increasing demand for rigorous and practice-relevant evaluation, and the growing body of literature on evaluation methods and capacity building, there are still gaps in understanding of the determinants of evaluation practice in prevention organizations. In the Australian context, studies to date have been limited in scope and not explored the determinants of evaluation practice across government organizations, NGOs and multiple jurisdictions. Furthermore, the way that organizational characteristics, structures and processes influence evaluation practice has not been explored and these insights are vital for successful capacity building. Therefore, this study aimed to investigate the influences upon evaluation described by managers and practitioners in government and non-government prevention agencies in Australia, to explore how these operate, and identify implications for evaluation capacity building.

**Materials and methods**

This qualitative study, utilizing semi-structured, in-depth interviews, was undertaken in the context of a larger mixed-methods project, in which findings from this first phase will inform future phases of the research. Forty prevention practitioners and managers were identified from four states’ of Australia. Sampling was purposive and stratified [19] including both government organizations and NGOs. Criteria were set to ensure a minimum level
of prevention experience (≥5 years) for individuals and minimum organization staffing levels (three full time equivalent prevention staff), budget ($300 000 or greater) and an organizational history (≥5 years) in conducting prevention activities. The sample size was considered sufficient to reach saturation of themes within government and NGOs, and across jurisdictions.

Interview participants were recruited from New South Wales (n = 10), Victoria (n = 11), Western Australia (n = 10) and South Australia (n = 9) and represented a mix of government organizations (n = 18) and NGOs (n = 22). Government organizations included local and state government, while NGOs comprised community health services, Aboriginal community controlled and mainstream public health agencies. All eligible participants invited agreed to participate. Participants had a mean (range) of 15 (5–30) years of experience in the field of health promotion and primary prevention and a mean (range) of 9 (0.9–25) years within their organization. Most participants were employed as managers or directors (n = 29) at the time of interview, with the next largest groups being senior practitioners (n = 4) or team leaders (n = 4). Participants held a wide range of undergraduate qualifications, and 18 participants had post-graduate qualifications in either health promotion or public health.

A semi-structured interview guide was developed based on a review of evaluation practice and capacity building literature, with particular reference to the health promotion and disease prevention field, a previous pilot study describing determinants of health promotion evaluation practice in government organizations [4] and input from experienced health promotion researchers. The interview guide explored three levels of potential influence as identified in the literature: individual, organizational (i.e. primary delivery agency) and system level (e.g. policy, accountability requirements) factors. In this paper, we focus on methods and findings related to organizational level factors, which were discussed extensively by interviewees. The interview questions explored five topics: recent organizational evaluation practice, drivers of evaluation, organizational level facilitators and barriers to effective evaluation and recommendations to improve evaluation capacity. Demographic questions were included to capture years of experience, role title, field of work, qualifications and training and organizational size and location. The final interview guide consisted of 10 open-ended questions and was piloted with 3 practitioners. The interviewer allowed the participant to guide the direction of the interview, while ensuring each topic was covered.

Interviews were conducted by author (JS) via telephone and were audio recorded. Participants were emailed an information sheet prior to the interview and consent was obtained verbally at commencement of the interview prior to recording. The interviewer has worked in the prevention sector and has qualitative research training. Prior to, and during the interview, the interviewer documented their potential biases and opinions about the subject, and maintained notes on their reactions and reflections after each interview. The interviews were conducted between February and June 2016 and averaged 42 min (range 28–62) in duration.

Ethics approval was received from Monash University HREC, Aboriginal Health and Medical Research Council Ethics, South Australian Department of Health and Ageing HREC.

Audio recordings were transcribed and provided to each participant for review and comment. Final transcripts were imported into NVivo 11 software for coding. Two researchers (JS and EM) commenced the first round of coding using the interview guide topics of individual, organizational and system-level influences as a guide and an iterative approach was taken to the development of the coding framework and new codes based on the data. JS and EM dual coded 10 transcripts, meeting regularly to discuss any discrepancies in coding until agreement was reached. The framework was discussed regularly with a senior researcher (BJS) for clarity of concept and refined and applied to the remaining data. Further rounds of coding identified processes and values and was analysed thematically by JS and EM together to identify patterns of barriers and enablers to evaluation practice, and links between themes [20].
Table I. Summary of key themes

<table>
<thead>
<tr>
<th>Key themes</th>
<th>Features and practices that facilitate evaluation</th>
<th>Barriers to evaluation</th>
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<tbody>
<tr>
<td><strong>Leadership</strong></td>
<td>Champion evaluation.</td>
<td>Lack of leadership, or frequently changing leadership.</td>
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<td>Leadership through official role or position in organization, and ability to influence others from that position.</td>
<td>Valuing and understanding evaluation.</td>
<td>Lack of understanding or value of health promotion.</td>
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<td></td>
<td>Demonstrating benefits of evaluation.</td>
<td>Lack of value of evaluation.</td>
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<td>Supporting staff to develop evaluation skills.</td>
<td>Fear of negative evaluations findings.</td>
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<td>Embedding practices into culture, systems, structures.</td>
<td>Focus on acute health service delivery.</td>
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<td></td>
<td>Facilitating partnerships, relationships.</td>
<td>Value output, ‘tick-box’ information only.</td>
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<td></td>
<td>Valuing evaluation and evidence.</td>
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<td></td>
<td>Valuing health promotion.</td>
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<td></td>
<td>Learning about program effectiveness, improvement and sharing findings.</td>
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<td>Culture that is supportive of staff learning.</td>
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<td>Long term vision and approach to evaluation.</td>
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<td><strong>Organizational culture</strong></td>
<td>Communication systems.</td>
<td>Burdensome systems.</td>
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<td>Can take time to develop, and is dependent on leadership at some stage. Connects to the values of the organization, and diverse organizational cultures can influence evaluation practice in different ways.</td>
<td>Resource allocations systems.</td>
<td>Lack of system, clarity for reporting, or agreement on indicators.</td>
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<td>Clear reporting systems and frameworks against organizational plans (e.g. work plans, strategic plans).</td>
<td>Unclear expectations of responsibility for evaluation.</td>
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<td>Dedicated evaluation role.</td>
<td>Lack of expert or ‘go to’ role.</td>
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<td>Shared and agreed indicators, goals and objectives at the project planning stage.</td>
<td>Partnerships that were felt to be unequal (e.g. being used for data provision).</td>
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<td></td>
<td>Acknowledge respective strengths, mutual benefit for each partner.</td>
<td>Partnerships that were more time consuming than beneficial.</td>
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<td>Long term relationships with evaluation advisors.</td>
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<td>Organizational partnerships with universities.</td>
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<td>Professional networks with similar organizations to share tools and other resources.</td>
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<td></td>
<td>Planning and allocating budget to evaluation in advance (including roles, external evaluators etc.).</td>
<td>Competing with delivery of programs, or the delivery of health services.</td>
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<td></td>
<td>Using students, volunteers or partners to assist in evaluation.</td>
<td>Insufficient health promotion budget overall.</td>
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<td>Allocating time for evaluation planning and conduct, reflection and use of findings.</td>
<td>Workloads.</td>
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<td>Access to frameworks, indicators and data collection instruments for health promotion priority areas.</td>
<td>Lack of access to appropriate data collection instruments.</td>
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<td>Unclear, or lack of agreement on appropriate frameworks for evaluation.</td>
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Results

Seven key themes were identified as important factors that influence evaluation practice and use in health promotion and disease prevention organizations (Table I). Within each theme, the way these factors act to facilitate or hinder effective evaluation practice and use are explained.

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<tbody>
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<td>Workforce development and training</td>
<td>Fostering positive attitudes through a belief in evaluation benefits and the value of evidence-based decision making. Support to develop technical, interpersonal and other professional skills. Pathways to access evaluation skill development opportunities. Qualifications, training and experience contribute to skills for evaluation. Evaluation requirements embedded within job descriptions and aligned with program and work plans. Recruitment practices to ensure skills and approach to evaluations match organizational requirements.</td>
<td>Culture of fear of negative findings and consequent budget cuts. Beliefs that all funding should go to delivering programs. Excessive demands on practitioners to be skilled in all areas of health promotion. Some backgrounds (e.g. sports science) had limited understanding of evaluation. New graduates had limited skills in planning and evaluation.</td>
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<tr>
<td>Recruitment and skills mix</td>
<td>Recruiting staff to ensure appropriate evaluation skills and expertise.</td>
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Leadership

Leadership to facilitate evaluation practice was described as having a range of attributes and influences evaluation practice and use in health promotion and disease prevention organizations (Table I). Within each theme, the way these factors act to facilitate or hinder effective evaluation practice and use are explained.

Some participants also described the type of leadership that had a negative effect on evaluation practice, including disengaged or passive leadership and organizational structures where leadership changed frequently, including disengaged or passive leadership at various levels. Leadership that had a negative effect on evaluation practice was described as having a range of attributes and influences evaluation practice and use in health promotion and disease prevention organizations (Table I). Within each theme, the way these factors act to facilitate or hinder effective evaluation practice and use are explained.

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often, limiting real influence and decision making power. A lack of understanding of health promotion practice was also detrimental to evaluation of prevention programs and use of evaluation findings.

Organizational culture
Organizational values were integral to creating a positive culture for evaluation. Valuing health promotion and disease prevention work appeared to be a necessary foundation for health promotion evaluation. Additionally, as expected, organizations that placed value on evaluation as a practice and using evidence to inform decision making and program planning also created a supportive organizational environment for evaluation.

‘... when I came into tobacco control I was struck very much by how much of a role that data and evaluation played in what was happening.’ (P25, Manager, Government).

A culture of evaluation was a clear facilitator, but not the only way to enable quality and effective practice. Participants, particularly from NGOs, described the culture of improvement, learning and sharing as crucial to undertaking and using evaluation in health promotion. Additionally, a culture of support was important to allow staff time to undertake evaluation, seek expertise and advice from evaluation specialists, engage with community members and program partners and to develop their own evaluation skills and capacity. Key outcomes of a facilitating culture were that evaluation practice was rigorous, meaningful, shared with program staff, celebrated their success and was embedded within systems and structures of the organization.

‘[Evaluation practice] is really embedded, it’s not something you turn attention to once a year’. (P22, Director, NGO).

Participants also spoke about a lack of understanding and limited value placed on prevention, often in favour of health service delivery, leading to a difficult organizational environment for evaluation. In some organizations, participants reported that a limited understanding or value of health promotion practice and evaluation was associated with a demand for minimal quantitative reporting. Practitioners reported the tension this created when working in complex programs in particular, and the challenges of reporting evaluation findings that were meaningful for decision makers accustomed to dealing with patient numbers or purely quantitative data.

‘I think being embedded within a health service can be difficult... [The board activity report] does not include any data about health promotion because we can’t count it... So because we can’t count it, it’s not viewed as being as important’. (P6, Director, NGO).

Organizational systems and structures
Effective organizational processes directly facilitated stages of evaluation, such as planning evaluation or collecting data. More broadly, systems that contributed to effective evaluation were described as those that supported clear communication within the organization and with external stakeholders, facilitated reporting against work plans and had clear pathways and timelines for approvals and resource allocation. The role of systems and structures to encourage evaluation was more prominent in responses from government agencies compared to NGOs.

The introduction of systems to facilitate effective evaluation was often related to the presence of clear organizational structures including reporting lines and dedicated evaluation positions. Leadership, culture and availability of time were also discussed as important contributors in ensuring systems were implemented and maintained across the organization.

‘I do come from an evaluation background myself so I was very keen to make sure that we had a solid evaluation protocol and discipline when I first took the job and so I made sure that all of our major program work was independently evaluated’. (P12, Manager, NGO).

Participants that described the use of organizational plans to facilitate and embed evaluation practice in
the organization tended to be from government organizations or larger NGOs.

‘... it goes to the work plans that we have and whether they’re personal work plans, team work plans, annual plans, 5 year plans monitoring and evaluation should run through every layer of that...’ (P22, Director, NGO).

These plans guided reporting and supported allocation of resources to evaluation roles, or practitioner time. Clear communication, opportunities to meet, discuss and reflect on evaluation based on the work plan was important in ensuring the document remained active and useful. The alignment of the plans added clarity across teams and the organization, promoting consistency and shared goals between teams and practitioners.

Also discussed was the concept of flexibility within plans to allow for unexpected opportunities and changes. Systems that were too rigid and burdensome could hinder evaluation through untimely approval processes, unwieldy paperwork, or missing opportunities. At the other end of the spectrum a lack of reporting systems around health promotion program work and evaluation appeared to contribute to ad hoc and piecemeal evaluation practice.

**Partnerships**

It was notable that NGO participants described more barriers and challenges to partnerships compared to government participants. Government participants described more benefits.

Effective partnerships for evaluation were formed on the basis of shared clear goals, and agreed indicators, as well as respect and acknowledgement of the respective strengths each partner could bring. Early planning for the evaluation between partners, and the time spent on negotiating the goals of the evaluation so that benefits were shared, was an important foundation.

‘...it was about having that steering group together at the beginning and actually setting out, what is it that we need to evaluate, because everyone’s putting in different elements...’ (P9, Manager, Government).

Participants described a range of partnerships, from informal support, to multi-year funded collaborations. The importance of building an ongoing working relationship over time between organizations was critical for effective evaluation, including when working with paid consultants or universities. Mutual benefit could be achieved in a partnership through the exchange of skills and evaluation expertise for access to data, or assistance to engage with the community.

‘...[this partnership] was awesome because they have an evaluation team, they have a marketing team, so the fact that we can partner on our [program], and then say to them, “look we’ll run it we can get you the participation.” ... But can you assist us in kind with writing a media release, with writing us up an abstract, with helping us evaluate it?’ (P26, Manager, NGO).

In many situations where skills and relationships were currency in the partnership, there was an expectation of a degree of capacity building. Where this expectation was unmet, tension and disappointment could arise.

The complexity of partnership arrangements or a power imbalance affected agreement on evaluation priorities or methods, and one participant described the pressure to reduce the rigour of methods when working with partners unskilled in evaluation. Several participants describing challenges of partnership also highlighted that despite the difficulties, it was worthwhile to conduct evaluation in partnership.

Partnering with universities and academic researchers was a common theme when discussing evaluation practice. Some practitioners identified that improvement was needed in the academic and practitioner partnerships to spend time to build relationships, ensure collaborative work with shared benefits and develop a mutual respect for each other’s skills and knowledge.

‘...they have their researchers and they have their money and they do their great work and we come in as fringe dwellers if they need input from us but it would be lovely if not only were we there to either provide the
name or the brand or to comment but we could even be integrated just into some of their training . . . ’ (P8 Executive Officer, NGO).

Despite identifying academic researchers as skilled in evaluation methods, participants also felt some researchers had limited understanding of their program context and ways of working. Several participants discussed cost as a barrier to partnering with universities, and some rural participants described distance as an obstacle to accessing academic support, although this could be overcome by having access to effective networks and lists of skilled evaluators available in that region.

Resources
‘Resources’ or ‘capacity’ were general terms used by participants, or were discussed in terms of funding, staff, expertise and time. Resources for health promotion and evaluation were reported to be limited within the sector broadly, in addition to resource allocation being limited within the organization. In general, NGO participants discussed resource limitations much more than government participants. Health promotion managers that had control of the budget were able to allocate funding to evaluation as they saw appropriate, while others may have had control and were looking for further guidance about the necessary resource allocation.

Several participants described compromise as a product of limited resources. This caused evaluation to become piecemeal, lower quality or be completely cut in favour of program delivery and practitioners to undertake evaluation tasks beyond their skills and experience. A key theme that arose from the interviews was that challenges associated with limited resources appeared to be heightened by unrealistic expectations about what could be achieved with the available resources.

‘. . . if people expected to do the same thing, it’s pretty frustrating when money is so tight and they’re working their little butts off and they’re not meeting the indicators and there seems to be just more blame than sort of understanding . . . ’ (P13, Senior Practitioner, Government).

Lack of time was considered a barrier to effective evaluation practice. Participants felt that there was not enough time to conduct rigorous evaluation in their day to day roles, as well as over the life of a funding or program cycle. Particularly time consuming aspects of evaluation practice described were preparing evaluation plans, seeking ethics approval, analysing data to the degree desired, working in partnership for evaluation and using evaluation findings to improve programs. Some participants did not feel that resources were a limitation to evaluation, with one describing a well-funded evaluation that still produced disappointing reports and others satisfied with the level of funding available, despite time being a challenge.

Some participants, particularly from government agencies, identified strategies to minimize the impact of limited time by planning ahead, especially for the time consuming elements of evaluation as identified above.

‘Actually saying, “. . . when we plan out this particular project, you know, we need to build in some time and dollars as well to allow for, you know, measurement and evaluation.”’ (P3, Team Leader, Government).

A number of participants reported access to templates and frameworks for evaluation planning, data collection and reporting that they considered helpful for evaluation practice. The guidelines provided by funders and other partners were often welcomed, but some participants expressed need for more detail and structure, and some sought tools relevant to non-health disciplines, especially when working in cross-sectoral partnerships. Participants reported that updated and validated data collection instruments were required to meet current needs and population groups, as well as consistency between regions and organizations to enable comparison. Only a small number of participants reported being in a position to adapt existing instruments appropriately.
Workforce support and development

The organization was recognized as having a key role in the development of practitioner beliefs and attitudes towards evaluation, as well as evaluation knowledge and technical skills. Participants reported that staff attitudes and beliefs about evaluation were influenced by colleagues and managers who provided leadership and acted as role models in the use of evidence for planning and decision making. These leaders sought ways to embed evaluation into everyday practice, demonstrating to practitioners the benefits of evaluation.

Additionally, negative attitudes towards evaluation were overcome by leadership and an organizational culture that supported learning and the sharing of findings. A common attitudinal barrier to evaluation was described as a fear of negative evaluation findings leading to loss of resources or major changes to programs. However, several participants mentioned that they had seen this attitude decline due to positive experiences of evaluation within their organization.

‘...the people who think like that for whatever reason haven’t been exposed to the power of evaluation and once you are and once you can see what it can do for you there’s no point in having those attitudes anymore’. (P25, Manager, Government).

Many participants described how the evaluation knowledge and skills of staff were influenced by organizational factors, particularly to engage with partner organizations, internal evaluation teams, or professional networks that provided access to expertise and mentoring. Additionally, effective leadership was described as an important facilitator of staff access to structured evaluation training, or technical support to learn on the job, particularly for staff who demonstrated strengths or interest in professional development opportunities for evaluation.

A small number of participants identified some managers and practitioners who saw program delivery as the only aspect of a practitioner’s role as a frustrating limitation to evaluation practice and the development of evaluation capacity.

‘... [Programs with centralized evaluation] turns health promotion officers who work on it into implementers rather than project designers and evaluators. So it kind of limits their skill development’. (P10, Director, Government).

In addition a few participants, and notably those at an earlier stage in their career, were exasperated by the wide range of competencies a practitioner was expected to hold within their organization and felt evaluation was better suited to specialists.

Recruitment and skills mix

Recruitment practices and clear organizational structures ensured those who valued evaluation, had a willingness to learn and had qualifications and skills in evaluation were available to support evaluation practice and use. Health promotion managers, particularly in NGOs, used job descriptions and recruitment processes to ensure the expectations concerning evaluation required were made clear to prospective employees. This was challenging to some participants where recruiting to roles in which health promotion program delivery was the primary purpose of the role.

‘When you’re looking at recruitment you’ve got to take into consideration that those evaluation skills maybe needed to be developed...they’d have different skills or value for delivering the program. So it would be difficult to find people to have the coverage of skills required’. (P24, Manager, NGO).

‘... Your professional background...really influences how you go about evaluating and the approach that you probably tend to take...' (P31, Director, NGO).

Participants described the wide range of professional backgrounds in health promotion teams as a potential strength for the team that brings diversity in opinion and skills. Notwithstanding this, a number reported that a health promotion background was associated with an awareness of the importance and frameworks used in evaluation, a shared language around
evaluation and often a positive attitude towards evaluation compared to those from other backgrounds. These qualities were also important for people in positions of management.

‘... [in health promotion degrees] there is a real culture of evaluation, ... they’ve obviously had that hammered into them and that’s part of becoming a health promotion professional, so I think there is an expectation and a culture within people trained in the field that evaluation is important’. (P34, Manager, NGO).

Some participants described only having resources to employ graduates, and expressed concern that junior practitioners were not equipped to undertake evaluation tasks required in their roles. Staff who held a masters degree, including public health, were seen to have well developed knowledge and skills in problem solving, evidence-based practice and evaluation and research. In particular, a background in research or evaluation was valuable to understand and overcome challenges of evaluation and champion evaluation within the team.

**Discussion**

This is the first multi-jurisdictional study to describe the important facilitators and barriers to evaluation practice in the Australian prevention context. Our findings contribute needed explanations of how these factors interact within government and NGO prevention organizations and highlight the essential factors that need to be addressed to improve evaluation practice and use. The central role of the organization in determining evaluation capacity is highlighted in our study and supported in studies outside the Australian prevention sector where authors have applied organizational learning theory to frame evaluation capacity, emphasizing the role of leadership, organizational culture, systems and structures and communication [17, 18].

The cumulative influence of the facilitators to evaluation practice could possibly be explained by increased opportunities for practitioners to take part in evaluation, affecting both their individual capacities and the wider culture of their organization. Patton [21] describes the organizational learning and program benefits that can occur from process use, defined as ‘changes in attitude, thinking and behavior that result from participating in an evaluation. Process use includes individual learnings from evaluation involvement as well as effects on program functioning and organizational culture’ [21, p. 99].

It is interesting to note that practitioner comments about influences on evaluation practice included frequent references to evaluation use, particularly the demand for evaluation use within organizational program management and planning systems, or the demonstrated use of evaluation findings by champions and leaders. In their conceptual framework for evaluation capacity building, Cousins et al. [22] highlighted the interdependent relationship between capacity to use and do evaluation, and emphasizing the importance of organizational capacity to use evaluation within evaluation capacity building frameworks. While our study does not focus explicitly on identifying factors influencing evaluation use in prevention organizations, the demand for increased use of evaluation findings appears to be an important driver of evaluation capacity building in the Australian prevention sector. This demand arises from the use of evaluation for program improvement [23], to enhance evidence-informed policy and decision making in government [1] and to demonstrate program effectiveness [24].

Our findings revealed leadership within organizations as a pivotal determinant of evaluation by influencing organizational culture, systems, structures and support for staff to gain evaluation skills and experience. This concurs with previous findings about the relationships between leadership and evaluation practice in government organizations through managerial skills, communication and mentoring [25] and the value leaders placed on evidence in human service organizations [26]. We found leadership and culture appear to play a greater role in determining how competing priorities for evaluation are managed within NGOs, which may partially be explained by resource constraints in some NGOs and the expectation of practitioners to undertake
multiple roles. This relationship is supported by a study that found voluntary sector managers were able to use evaluation findings to a greater extent due to their often dual responsibilities of program and evaluation management [18].

Organizational culture was another crucial factor in our study, as it impacted other organizational determinants of evaluation. Organizational culture ‘reflects the traditions, values and basic assumptions shared by its members and that establish its behaviour norms’ [25, p. 301] and our findings reveal a relationship between supportive organizational cultures and resource allocation to develop staff skills and confidence, and embedding evaluation in organizational systems. Additionally, the range of different cultures that facilitate evaluation practice in prevention organizations demonstrated the opportunity for influence on multiple fronts. For example organizations could address organizational values concerning evidence-informed practice [26], learning and improvement [23, 25], support of staff, or a specific focus on a culture of evaluation itself [6, 17].

Organizational systems and structures enable evaluation to be embedded within an organization in the longer term [17]. Participants described systems to ensure expectations around data and evaluation were clearly communicated between levels of management, and systems to access technical support and capacity building for evaluation. Organizational systems to facilitate evaluation practice, such as formal requirements for data collection and internal plans and reporting mechanisms have been highlighted as important elsewhere [6, 15, 23, 26].

Participants from government organizations gave greater attention to the role of organizational systems compared to NGOs. This emphasis may be explained by the different drivers of evaluation in each organization type [15], for example, government agencies are likely to be driven by accountability and reporting. Cousins et al. [18] discusses the use of tools such as ‘results-based accountability’, and the use of government systems and procedures to manage budgets and ‘exert control over agencies’ as important contributors to the focus on systems for evaluation in government [18]. Our findings suggest that differences in priorities concerning evaluation between organizational types affect the role that systems play, with participants from NGOs reporting organizational systems related to governance and review of programs as facilitators of evaluation, whereas government participants more often emphasized systems for program recording and monitoring.

Role definitions, skills, qualifications and attitudes of practitioners were identified to influence efforts in evaluation. Dedicated evaluation functions appear to be an obvious facilitator of evaluation practice [17], however if responsibilities are unclear and work is not undertaken collaboratively with practitioners and managers, evaluation may not occur [6]. Finding the balance between supports for ‘doing’ evaluation and supporting the wider prevention team in program planning and evaluation appears to be crucial to meeting evaluation needs across the organization. This is a challenge when practitioners do not have dedicated evaluation time and are encouraged to prioritize implementation [13]. Our study found that a dedicated evaluation position can have an influential role in championing improvements to evaluation systems, culture and supporting practitioners.

Partnerships, although often requiring an investment of time and funding, were found to be beneficial for accessing and sharing resources. In other studies of evaluation practice, academic partnerships were highly valued for expertise, skill development [4, 6, 23, 27, 28] and ensuring quality evaluation [3], however as we also identified, these were often described as a wish not widespread practice. In line with the partnership literature [29], effective partnerships for evaluation were also based on respect, agreement of partner contributions and clear mutual benefits [6]. The relationship between partnerships and resource sharing was a strong theme, and others have noted that benefits that result from formal partnerships include sharing evaluation insights and findings, extending networks and informal mentoring and support [4, 11, 17, 23, 30].

Resource limitations have been frequently described as barriers to effective evaluation in the
health promotion and prevention sector [4, 13, 27, 28, 31]. This study confirms that budgetary constraints for prevention programs are common barriers to evaluation, and that a lack of time can be a major hindrance even if the budget is sufficient [6, 26]. Our findings further reveal how limited resources interact with other factors within organizations, in particular how leadership and organizational systems can determine resource allocation and how appropriate expectations can ensure evaluation activities can be conducted with available resources. Jolley et al. [7] described the South Australian Community Health experience of mismatch between demand for complex evaluation, and the availability of resources to implement these. The limited understanding of evaluation methodologies and inappropriate allocation of budget, time and expertise was also apparent in our study. Our findings further highlight that lack of resources and support from organizational decision makers, and pressure to focus on program delivery, are significant barriers even when the importance of evaluation is understood [6, 13, 27].

This study is unique in that it examines the perspectives of both government and NGOs in the health promotion and disease prevention sector. A limitation of this study is that participants were recruited from organizations with a minimum of three health promotion practitioners, and health promotion and prevention budgets of at least $300 000 per annum. In the Australian prevention context, there are many programs being delivered by smaller organizations than this, and it is likely that they face additional barriers to evaluation. Additionally, not all Australian jurisdictions and sectors were represented in this study, and unique challenges may exist for specialist prevention organizations, such as those working with culturally and linguistically diverse communities.

We have comprehensively described how seven important factors interact within prevention organizations to influence evaluation practice. Given the demand for improved evaluation practice, the findings from this study provide prevention organizations with a useful framework for considering evaluation capacity building strategies. The important interactions between each factor should not be underestimated, with major gains in organizational evaluation capacity building possible when considering multi-level effects of leadership, organizational culture and systems that support evaluation practice. While government and NGOs described some differences, we found more similarities overall in the mechanisms of influence between the organization types. Further research should explore the role of factors acting outside the organizations, as well as addressing gaps in objective measures of evaluation capacity in the prevention sector.

Acknowledgement

The authors would like to thank Emily McCluskey for her valuable contribution to participant recruitment and data analysis in this study.

Funding

This work was supported by the Australian Research Council [grant number DP150103575].

Conflict of interest statement

None declared.

References

Organizational determinants of evaluation practice