Evaluation Toolkit for Breastfeeding Programs and Projects

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Readers should be aware that these resources may contain images of Aboriginal and Torres Strait Islander people who are now deceased.

The photographs on the front cover of a mother holding her baby while a nurse watches, and a mother feeding her baby, are by Michael Marston and are © The State of Queensland.
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1. Introduction

1.1 What do I need to know?

“I only work in this role 15 hours a week, so I’m very time poor, but it’s important for me to find out directly from people about their needs and how they feel about the service because you might think you know what the issues are and what people want but you might not…our service evaluation resulted in the Maternal Child Health Service opening on a Saturday morning.”
(maternal health nurse)

The purpose of evaluation is to find out how well a program or activity is working. Ideally, evaluation will also identify ways to improve what, or how, people are doing what they do.

There are many resources to help service providers evaluate their services. Some are designed specifically for breastfeeding services, and others are designed to help health services more generally to look at what they do. (We’ve provided a list of some of these resources in section 6 of this toolkit.)

This toolkit is designed to help breastfeeding services to evaluate their own programs, by bringing together in one place the basic ideas and tools for evaluation. We know that many services are already doing evaluations, and others would like to start but can’t find the time or the people to do that in the midst of busy schedules. We hope this resource will make it a little easier to get started.

The toolkit has been developed as part of the Australian Government’s action under the Australian National Breastfeeding Strategy 2010-2015. Evaluation of breastfeeding programs may also assist service providers to identify how the activities and outcomes of particular programs align with and support jurisdictional and national goals and objectives. The goals of the Australian National Breastfeeding Strategy 2010-2015 are listed later in this toolkit. These goals, and information on the broader policy context, can be found in Appendix A.

1.2 Who is this toolkit for?

This toolkit was designed for breastfeeding practitioners, breastfeeding program managers, and other staff working within a breastfeeding support service. While we recognise the importance of monitoring and evaluation at the national level, and at jurisdictional levels, this toolkit aims to assist people who are delivering breastfeeding support services to develop evaluations of their own services. The intention of this resource is to encourage regular data collection and analysis within services, which over time can help build a picture of what is happening in services all over Australia, and also help inform further improvements to services, if needed.

1.3 What’s inside

The toolkit is structured in roughly the same order as the steps you would take in an evaluation:

- Why evaluate? – finding the questions to ask
- Getting started – planning an evaluation
- Tools of the trade – which methods, when, how and who
- Making sense of it all – reflection and analysis
- Sharing the good (or otherwise) news – what to do with your findings when you have them
Finding help – some resources to assist.

This toolkit draws upon evaluation resources designed specifically for breastfeeding programs and projects as well as other general resources on evaluation theory and practice.
2. Why evaluate?

2.1 What is program evaluation?
At its most basic, evaluation is a judgement about how well something is working. The word ‘evaluation’ comes from Old French and Latin words which are about ‘value’. So evaluation is essentially putting a value on a program or activity.

There are many methodologies which can be used for evaluation, from simple clinical audits to rigorous randomised controlled trials. Nationally in Australia, people have been discussing the best way to evaluate breastfeeding services. At a national level, this will require consistent data systems and agreements about what information to collect. At the service level, you can make these decisions yourself and get started right away to learn more about how you are performing.

There are a number of ways to begin planning an evaluation. It can be helpful, before you get started, to ask some questions about whether in fact an evaluation is appropriate for your particular project. For instance, evaluation might be a good idea but there may be funding constraints, or there might be difficulties with getting accurate data. Four questions are provided below that you might consider before you begin planning your evaluation project.

<table>
<thead>
<tr>
<th>Four standards of evaluation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Utility (is it useful?)</td>
</tr>
<tr>
<td>2. Feasibility (is it practical?)</td>
</tr>
<tr>
<td>3. Propriety (is it ethical?)</td>
</tr>
<tr>
<td>4. Accuracy (are the findings correct?)</td>
</tr>
</tbody>
</table>


There is really no difference between program and project evaluation. Projects are often smaller scale activities which take place within a shorter timeframe. Programs are usually bigger, longer-term commitments, and may include a number of projects. Program evaluation, therefore, will differ from project evaluation primarily in scale. They will both use the same tools and approaches, but project evaluations may be more focused on a single objective or outcome whereas program evaluations may be more complex and look at a wide range of objectives. For the purposes of this toolkit we will refer to program evaluation to include both program and project evaluation.

An evaluation may focus on the processes of a program or service (this is sometimes called a formative evaluation), or on the impacts or outcomes of a program or service (this is sometimes called a summative evaluation), or on both.

Process or ‘formative’ evaluation looks at the processes that make a service function. People often conduct process evaluations when no outcome data is yet available, for instance when a service hasn’t been running for very long, or when it will take a long time to see changes in health status. Process evaluations may look at who is using the service (and whether there are any access problems for potential users), how services operate, what structures, protocols or pathways are in place and whether they are effective. It is more about the function of a service than about the outcome of a service.
Outcome evaluations, sometimes called ‘summative’ evaluations, seek to assess what impact the service has had on its users, and what outcomes have occurred as a result of the service. Some people separate out impact evaluations from outcome evaluations, the former being more about stages on the way to the ultimate outcomes. Outcomes may be clinical, behavioural or attitudinal, or relate to changed structures and processes.

An evaluation may focus on processes or outcomes within the same project, or may only consider one aspect, for instance a process evaluation looking at how antenatal breastfeeding education is delivered and who is accessing it.

‘Monitoring’ is a word often paired with evaluation. While evaluation may be the judgement, monitoring is the process that can help you get there, by providing ongoing feedback through regular data collection and review. The difference between monitoring and evaluation is discussed in section 2.3 below.

2.2 Why undertake program evaluation?

Evaluation is undertaken for a range of purposes, although ultimately all evaluations are undertaken to find out whether a program is operating as well as it might be. Some of the benefits of evaluation include:

- finding out what is working and what is not working
- identifying whether there is a good fit between planning and practice
- identifying ways of improving program or project quality
- identifying any current or ongoing program or project risks
- identifying whether any alternatives might work better
- demonstrating the appropriateness, effectiveness and efficiency of a program or activity to funding bodies and the community at large
- identifying any unintended consequences (negative or positive)
- responding more effectively to clients’ needs and improving program or project targeting
- learning what training is required for staff to perform well
- demonstrating adherence to, or establishing new service standards
- sharing good practice.

In many services, or funded programs, evaluation is a mandatory requirement. However, in the everyday performance of service delivery, sometimes evaluation does lose out among competing priorities. Some of the reasons why evaluation does not occur, even when people think it’s a good idea, are the following:

- it can be overlooked in the excitement of getting a program or project under way
- it can be seen as ‘diverting’ funds away from service delivery (especially if the funds for a program or project are limited)
- it is seen as complex or a task ‘only for the experts’
it is seen as a burden on staff

if it turns up adverse results, it might be perceived as a threat to the program, an organisation’s reputation, or people’s jobs.

However, these are not excuses for not undertaking an evaluation! Because:

• knowing the impact your program has made can be motivating for staff

• quantifying the impact of a service can help secure further funding

• including simple evaluation techniques to the daily routine can minimise the burden for any one person, or for bigger efforts you can partner with external evaluators.

• learning about your service and its performance as you go means you can continue to adjust, respond and improve the way you assist mothers and babies.

2.3 What is the difference between monitoring and evaluation?

Monitoring is the ongoing, regular collection and analysis of agreed sets of data, and then the process of analysing what that data means. The purpose of monitoring is to be alert to how a project is developing or performing, and to respond to any issues or concerns that arise and are evident in the data. Monitoring is a task which can stand alone as a part of good practice, but it can also provide data which is useful in an evaluation.

Evaluation, on the other hand, is the systematic comparison of program objectives to outcomes and assessing the extent to which a program has achieved what it was established to do. Often, if an evaluation runs for a long period of time, say for several years, the first part of the evaluation is essentially largely comprised of data monitoring, for example by observing differences in breastfeeding uptake and maintenance in a population over time. Evaluation will involve making an assessment about what has led to those differences, whether the changes are significant and what the consequences might be.

2.4 Resources

3. Planning for evaluation

“We stumble when we come to measuring what adds value, because we don’t always think it through at the start…” (breastfeeding service provider)

Evaluation can seem a burden if it has not been built into the service planning from the beginning. However, it is never too late to begin to monitor what you do, and to include simple evaluation tools into your practice.

3.1 Stages of evaluation

These can be ordered in any number of ways (some people suggest four stages, some six, some ten), but essentially what you want to do in an evaluation is:

- decide what you need to find out
- create a process for collecting the data you need
- analyse the data and reflect on what it means.

There are, of course, a number of activities behind those three. For instance, the Victorian Department of Human Services’ guide, *Planning for effective health promotion evaluation*, outlines the following six steps to an evaluation project:

**Step 1: Describe the program:** (identify the program plan – program goal, target population, objectives, interventions, processes and resources)

**Step 2: Evaluation preview:** (engage stakeholders; clarify the purpose of the evaluation; identify key questions; identify evaluation resources)

**Step 3: Focus the evaluation design:** (specify the evaluation design; specify data collection methods; locate or develop data collection instruments)

**Step 4: Collect data:** (coordinate data collection)

**Step 5: Analyse and interpret data:** (analyse the findings; interpret the findings)

**Step 6: Disseminate lessons learnt:** (what reports will be prepared; what formats will be used; how will findings be disseminated) (Round et al 2005).

Whether it is three, six or ten stages, it is important that you develop a clear process, you inform the right people about it (and get ethics approval if you need it – more on that below), and that you are rigorous in your analysis so that the findings have credibility.

3.2 Deciding what to evaluate

As you start to plan your evaluation, make time to ask yourselves some simple questions.

- What’s the purpose of this program? (e.g. to provide comprehensive breastfeeding education and support to mothers, as part of an integrated child and family health service)
- What are its objectives or intended outcomes? (e.g. to provide consistent evidence-based advice, support and clinical services to mothers and their families to encourage the continuation of breastfeeding)
- What processes are being used to try and achieve those outcomes? (e.g. drop-in centres, individual appointments with lactation consultants, midwife home visits)

- What evidence base underpins the program? (e.g. that it is worthwhile attempting to improve breastfeeding practices and rates because these have been demonstrated to have ongoing population health benefits)

- What values underpin this program and are the values consistent with the program objectives? (e.g. universal access, and/or targeted service to meet the needs of priority groups; see underlying principles on page 1 of the Australian National Breastfeeding Strategy 2010-2015 for more examples)

- Why is an evaluation being undertaken, what is being evaluated and how will the information be used?

- Who will be involved in the evaluation? (e.g. who will conduct it, what will be evaluated and who will find the results of interest?)

- Are there ethical issues to address in the evaluation?

Clear responses to these questions will enable you (or the evaluation team, if you have one) to define the scope of the evaluation; determine key evaluation questions; select appropriate methods and get underway.

3.3 Establishing purpose and key evaluation question(s)

Being clear about the purpose of the evaluation is essential. Is it to meet the needs of a funding organisation? Is it to provide evidence to advocate for an expansion of services to a funding body? Is it for your own purposes, to improve the work you do? Is it to find out why something isn’t working as well as you think it should? Is it for a combination of purposes?

The most important part of any research is defining the research question. The question(s) you ask will determine what you do, how you do it, and who you will tell about it.

Evaluation usually looks at one or more of four areas:

- effectiveness – is our service making a difference?
- appropriateness – are we providing the right service to meet the needs of service users?
- efficiency – are we making the best use of our resources?
- quality – are we providing the best service we can?

Good quality health care is based on seeing the health service from the user’s perspective (Berwick 2002). The Institute of Medicine in the United States has identified six domains of quality health care, based on the experience of the service user:

“Safe - avoiding injuries to patients from the care that is intended to help them.

Effective - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
**Patient-centered** - providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

**Timely** - reducing waits and sometimes harmful delays for both those who receive and those who give care.

**Efficient** - avoiding waste, including waste of equipment, supplies, ideas, and energy.

**Equitable** - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.” (Institute of Medicine 2001:6,7).

A client focus is particularly relevant for breastfeeding services, given the intimate nature of breastfeeding, the complexity surrounding the initiation and continuation of breastfeeding for mother and baby, and the individual nature of each woman’s experience of breastfeeding.

### 3.3.1 Identifying the questions

Using these domains, here are some ideas for aspects of breastfeeding services which might usefully be evaluated:

**Safety** – what proportion of mothers report adverse experiences such as mastitis or nipple trauma? What proportion have absolute contra-indications to breastfeeding or risk factors that require extra guidance? Do staff have adequate training to assist families to make infant feeding decisions in the best interests of mother and child?

**Effectiveness** – did the service influence mothers’ breastfeeding decisions? How long do the women attending our service continue exclusive or any breastfeeding?

**Patient centred-ness** – how satisfied are women with the service we provide? Did women feel that staff had listened to them and respected their individual circumstances and goals?

**Timeliness** – how easy is it for women to get an appointment when they need to speak with a midwife or lactation consultant?

**Efficiency** – what is our throughput? How long do women have to wait to be seen?

**Equity** – who might need our services but not be able to access them? Are we addressing the needs of the local population? Were specific priority groups well targeted?

Further evaluation questions will flow from establishing the reasons you are commencing an evaluation. They will rely on the scope of your evaluation and whether the whole program or just a part of it is to be evaluated.

Evaluation questions may include the following:

- What processes are or were undertaken as part of the program? (e.g. individual counselling, mothers’ groups, clinical support, distribution of written materials, staff training etc. Did the program use any established protocols or pathways? Who is using the service and were there any access problems?)

- Did these vary from those originally planned, and what were the reasons, if any, for the change?

- What are the lessons learned as a result of the evaluation?
• How could the program be improved (if it is ongoing) or what lessons could be applied to a new program?

• What were the outcomes of the program?

Outcomes are such an important focus for evaluation that they are defined further below.

3.3.2 Defining outputs and outcomes

It may help to think of outcomes in terms of what the results of your activities or project might be; these are sometimes called ‘outputs’ when the results are early in the project and ‘outcomes’ when they come at the end of the project. Outputs are really stages on the way to your final outcomes, so they can be called early achievements or outcomes, but the word ‘outputs’ signifies that they are milestones or activities that are intended to lead to a bigger outcome, which should be a tangible and measurable benefit such as improved information-sharing or reduced waiting times. You might put it this way: your efforts (‘inputs’) will lead to products (‘outputs’) that can lead to a result (‘outcome’); the outputs will be practical items or systems, such as a new training manual, or an improved reporting system, and the outcome will be something that happens as a result of the cumulative effect of the outputs (or as they are sometimes called, ‘early outcomes’). The program logic evaluation diagram at 3.5.1 shows the way in which inputs (activities) will lead to outcomes over time.

For example, staff could create an on-line breastfeeding education module (output), leading to mothers receiving more consistent breastfeeding advice (short term outcome), followed by increases in breastfeeding rates and satisfaction with the service received (medium and long term outcome). You might then ask some additional questions about the outcomes:

• Were these the intended outcomes of the program?

• Were there any unintended outcomes?

• What factors assisted or inhibited the achievement of outcomes?

Once your key purpose for the evaluation is agreed, and some of your broad evaluation questions are developed, you can begin to develop the evaluation methodology. Before you do that, however, it’s a good idea to take a look at your stakeholders, including service users and policy makers, to make sure that your evaluation will be able to take account of others who might have an interest in or a perspective on the evaluation.

3.4 Stakeholder identification and analysis

The WK Kellogg Foundation Evaluation Handbook defines stakeholders as any person or group who has an interest in the project being evaluated or in the results of evaluation. It acknowledges that involving every stakeholder ‘may not be realistic’ but encourages consultation with representatives from stakeholder groups in designing and redesigning the evaluation plan and providing them with timely results and feedback (WK Kellogg Foundation 2004).

It is important to include stakeholders in the evaluation process, for a number of reasons:

• so the evaluation is useful to the people who actually do the work being evaluated

• so people (both staff and service users) understand how and why their data is being collected and analysed

• to engage people in the early stages of what may become a change process
so people can celebrate good news.

The guide, *Planning for effective health promotion evaluation*, suggests that people can participate in different ways, and not everyone has to be involved at the same level; for instance, people can participate in information sessions, be part of advisory groups, or simply consent to have their data collected (Round et al. 2005).

Stakeholder identification might include, for instance, some or all of the following:

- program funders/sponsors
- policy makers
- politicians
- program participants (including priority groups, if any)
- program staff
- program managers
- related agencies or organisations
- local/other spheres of government
- media/communicators
- community members at large.

Once you have identified all the potential stakeholders, it can be helpful to draw up a ‘map’ to better understand the interests of each party and the values underpinning their interest. Some stakeholders may be more interested than others, or more influential in terms of, say, ongoing funding decisions. This mapping process will also help you to decide at what point stakeholders should or could be involved in the evaluation, for instance as a member of the evaluation team or an advisory group, as a participant in an interview or a survey, or simply as an ‘interested outsider’ who should be kept informed. A grid such as the matrix below might help you ‘map’ where stakeholders sit in terms of their influence or power, and their level of interest.
There are many tools available on the internet which can assist in the stakeholder identification process, including a few which are listed in the list of resources at the back of this document.

3.5 Evaluation frameworks

There are a number of frameworks or models which can help people to plan an evaluation. Two of the most common evaluation frameworks are discussed below, plus a third, different model for exploring continuous quality improvement. We have included the latter because it can provide a starting point for teams who aren’t ready to do a full evaluation but would like to start a more formal quality analysis process. We have provided templates for each of these in Appendices B, C, and D at the end of this toolkit.

3.5.1 Program logic evaluation framework

Program logic theory is one approach which encourages stakeholders to develop a common understanding of how a program is intended to operate to achieve its objectives. In essence, a program logic is a linear model which draws a clear line from the need the program is seeking to meet, the activities undertaken to address the need and the intended outcomes. This may be depicted as follows:

![Program Logic Model](image)

The program logic model seeks to identify the assumptions or evidence behind the program, its functions, aims and activities. So in the diagram above, the logic model may describe what people think ought to
happen. An evaluation based on a program logic model can assess whether the intended outcome(s) actually did happen.

The program logic model is a generic one, which can be used to inform program planning. An evaluation framework which is built on a program logic model will start with those components of the logic model identified above, and then work through each step of the model to identify whether the assumptions on which the program were built were sound, whether the intended consequences of each logical step occurred and, if not, why not.

A program logic evaluation framework creates a matrix which will look something like the table on the following page:
## Program logic

<table>
<thead>
<tr>
<th>Program logic</th>
<th>Examples of broad evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Timing (sometimes this column is used for analysis method)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>How well were these activities undertaken? What worked? What barriers were experienced? How were these overcome?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-term outcomes</td>
<td>Were the intended short-term outcomes achieved? If not, why not?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium-term outcomes</td>
<td>Were the intended medium-term outcomes reached? If not, why not?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-term outcomes</td>
<td>What evidence is available that the long-term outcomes will or can be reached? What has been learned about achieving these outcomes? What could be improved?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For example, your program might be a mother and baby clinic, with a number of related inputs and activities such as promotion and referral from other services. The activities might include providing individual assessment and support to mums, training for student nurses, and antenatal breastfeeding classes. A short term outcome might be an increase in the number of staff trained in breastfeeding support. Medium term outcomes might include increasing the number of mothers receiving consistent, evidence-based breastfeeding advice and support from the clinic. A long term outcome might be increasing breastfeeding rates in the catchment area of the clinic.

Further guidance to help you through the steps of designing a program logic evaluation framework for your evaluation is included in Appendix B.

The advantage of the program logic model is that it takes a linear, long-term approach to the assessment of a program; this can be easier for a program which has been established for a long time or which is funded for an extended period, where the needs are clearly defined and the objectives have been clearly stated.

The program logic model may not be as useful when a program has grown irregularly over time, and when a linear progression from need to long-term outcome cannot be traced. However, even if your program’s objectives have never been written down before, it may still be helpful to use the ‘logic-based evaluation framework’ template at Appendix B to identify and clarify the relationships between your program’s activities, outputs and outcomes.

As well as reviewing documents associated with your program, policies such as the *Australian National Breastfeeding Strategy 2010-2015*, and policy or strategic framework documents from your state or territory...
can assist you in identifying how the activities and outcomes of your program align with jurisdictional and national goals and objectives. The goals of the *Australian National Breastfeeding Strategy 2010-2015* are listed in Appendix A of this Toolkit.

### 3.5.2 RE-AIM evaluation framework

Another form of evaluation framework is called RE-AIM, which is an acronym for:

![RE-AIM framework diagram]

The RE-AIM framework was developed to assess the impact of public health interventions (Glasgow et al 1999), and is used widely within the health sector. The first two components, Reach and Effectiveness, can be considered as ‘user-focussed’ – has the program reached the people who could benefit from it? Is the program effective in addressing the identified health priority? The last three components, Adoption, Implementation and Maintenance, can be considered as ‘organisation-focussed’ – has the program been adopted within the broader health service? How effectively has the program been implemented? How well is the program being maintained so that it continues to achieve its objectives?

An evaluation framework based on the RE-AIM model might look something like the table on the following page.

---

1 A useful website which discusses the RE-AIM framework is [www.re-aim.org](http://www.re-aim.org).
<table>
<thead>
<tr>
<th>Framework component</th>
<th>Sample broad evaluation questions</th>
<th>Sample indicators</th>
<th>Sample data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reach</strong></td>
<td>Who is using the service? How often? What services are women accessing? Is the service targeting the needs of women in the local area? Are there eligibility criteria, if so what are they and are they appropriate? Which particular ‘ages and stages’ of the breastfeeding experience are being targeted?</td>
<td>Number of women accessing service and comparison to expected local population need Demographic characteristics and comparison to local population</td>
<td>Service records Local demographics Interviews with local women</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td>How effective is the service in supporting women to breastfeed?</td>
<td>Number of service users who continue to breastfeed at points in time</td>
<td>Service records Survey of service users</td>
</tr>
<tr>
<td><strong>Adoption</strong></td>
<td>How is the service linked to other relevant services? How well do services collaborate or cross-refer? To what extent is the service fully embedded in the larger organisation?</td>
<td>Number and type of collaborative agreements Evidence of cross-referral or collaboration Perceptions of stakeholders</td>
<td>Organisational records Service documentation or clinical referral records Interviews with key stakeholders</td>
</tr>
<tr>
<td><strong>Implementation</strong></td>
<td>How was the service implemented? What were the barriers or enablers in establishing the service?</td>
<td>Documentation regarding implementation Perceptions of stakeholders</td>
<td>Organisational records Interviews with key stakeholders</td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
<td>How is the service funded? How sustainable is the funding? How is the service governed? What challenges face the service in meeting future community needs?</td>
<td>Documentation regarding maintenance Perceptions of stakeholders</td>
<td>Organisational records Interviews with key stakeholders</td>
</tr>
</tbody>
</table>

The RE-AIM framework is useful when a ‘point in time’ assessment is sought regarding the effectiveness of a particular intervention. It is also useful because it focuses not just on the intervention but on the organisational structures and processes which support the intervention.

Further guidance to help you through the steps of a RE-AIM evaluation framework is included in Appendix C.
Continuous quality improvement framework

A final approach which could also be considered, particularly when services are just getting started in evaluation, is the continuous quality improvement (CQI) model. This is not an evaluation framework, but is a model for active monitoring and improvement over time. It could also be called a form of ‘action research’ in that it encourages staff participation in learning from, and improving, their own practice. The CQI model was particularly popular in health services in the 1980s and 1990s, and is based on industrial processes for improving efficiency and effectiveness pioneered by a man named William Deming.

The CQI cycle is a very simple cycle of four steps, which when followed by a team over a period of time can lead to substantial improvements in working practices. The four steps are: Plan; Do; Check; Act. The strength of this model is that it forms a continuous feedback loop so that people can be continually assessing and learning from what they do. This is illustrated in the diagram below.

This process is particularly suited to involving a team in a collective self-improvement exercise. Al-Assaf & Schmele (1997:64) point out that quality improvement cycles are particularly helpful to: 1) find out more about the service users and their perspective, and 2) find out more about the ways in which health professionals work.

So, for instance a client survey can be used to identify ways of improving the service. A client survey may also be used in an evaluation, but the difference is that in CQI, action might be taken immediately to respond to what people said (‘that’s a good idea – let’s try it and see if it works’), whereas in an evaluation the survey would probably feed in to a larger process and the findings would be considered in the context of other evaluation activities before any decisions might be made to introduce changes.

The CQI model is different from an evaluation framework because the people involved are seeking to improve and change what they do as they go: they are learning while doing. The key difference is in the
fourth step, where action is taken; this does not form part of an evaluation process where the action is taken after the evaluation is completed.

The advantage of using the CQI framework is that it can be easily implemented by team members with little resources, has a practical focus on service improvement, and can be embedded into a daily organisational routine. Its disadvantage is that it does not have the objectivity of an independent evaluation, and may lack capacity to deal with substantive topics without an additional investment of time and funding.

Further guidance to help you through the steps of a CQI evaluation framework is included in Appendix D.

### 3.6 Ethical considerations

Almost every evaluation of breastfeeding programs and projects will require consideration of ethical issues, because they will involve research with consumers and/or their personal information. While the ethics approval process is sometimes considered a burden, it can be a very useful exercise in thinking through what data is really needed, and how any risk to a service user can be minimised.

The National Health and Medical Research Council’s *National Statement on Ethical Conduct in Human Research* provides nationally consistent guidelines on conducting ethically-sound research. The foundation of the statement is a fundamental obligation to demonstrate respect for individuals, with a particular concern for the needs of those who might be vulnerable in a research context, such as children and young people, people in dependent or unequal relationships (such as clinician and patient), Aboriginal and Torres Strait Islander people, and people with language or comprehension difficulties. Some of the following key ethical considerations to keep in mind when planning an evaluation include the following:

- processes for gaining informed and voluntary consent of service users, including not only direct input from service users, but whether personal data is used in any way which identifies or compromises the individual
- clear and sound processes for informing service users about the research, including consent processes
- the type of information to be collected
- processes for involving people who might not be able to give consent and need it to be given for them by a carer or guardian, for example, children or young people or those with a cognitive impairment
- processes for ensuring privacy, including the use of private rooms for interviews, making sure survey forms are kept safe, keeping people’s personal data secure
- attention to cultural issues in relation to priority groups, such as observance of and respect for cultural practices and/or use of researchers or translators from within a particular language or cultural group where required and appropriate
- declarations of any actual or potential conflict of interest, for example where a researcher or staff member may have a vested interest in a particular result (NHMRC 2007).

The Statement is also helpful in describing commonly used approaches to data collection which involve direct contact with individuals, including interviews, oral histories, focus groups, participant observation, or data collected apart from direct personal contact such as archival research and on-line research (NHMRC 2007).

You will need to find out which local ethics committee(s) may have an interest in your evaluation, and if required, the format and timing for making submissions. The relevant ethics committee may be attached to a government department, university or hospital. Obtaining ethics approval may take several months, so be sure to check early on whether this is required for your particular evaluation, and factor the timing into your planning.

It is worth noting that institutions may determine that some human research is exempt from ethical review.

### 3.7 What information should be collected?

Data can be **quantitative** (that is, something that can be counted) or **qualitative** (that is, something that describes a quality or experience). Typically, quantitative data refers to numbers such as clinical measurements or population statistics, while qualitative data refers to word-based data such as people’s interview responses or conversations in group meetings.

It is important that data is collected because it will answer the evaluation question, and not just because it is available. There may be a range of data available to answer the question you are asking, for instance exclusive breastfeeding duration may be recorded in the clinical notes (quantitative), or you could ask the mother whether she has any concerns about feeding (qualitative).

Whether it is quantitative or qualitative, there are another two categories of data, primary and secondary.

**Primary** data is collected specifically for the evaluation itself, such as surveys of clients or staff, extracting data from clinical records, clinical audit data, interview notes, or data recorded by staff while undertaking their usual tasks (for instance, recording waiting times in a reception area, or mapping the journeys of clients through the service).

Two of the biggest challenges for a service in conducting an evaluation are 1) ensuring that data collection is not a burden on service staff, and 2) ensuring that the right data is collected to answer the evaluation questions. Nothing will discourage people from doing evaluation like finding that the data they have collected doesn’t actually tell them what they want to know.

**Secondary** data is already collected and available through external sources, such as published in peer-reviewed literature, national data sets such as birth statistics, the Australian Childhood Immunisation Register, census data, survey results such as the 2010 *Australian National Infant Feeding Survey Indicator Results* or state/territory level surveys, or routine data collected through states and territories, such as perinatal data collections. This can include both published data, as well as additional unpublished data or access to datasets that may be available by contacting the organisation that collected the data or a repository such as the Australian Data Archive ([http://www.ada.edu.au](http://www.ada.edu.au)) which holds the full data from the 2010 *Australian National Infant Feeding Survey*.

Other questions to consider when thinking about data are: who are the likely contributors to your data? Are these recipients of breastfeeding services, program staff or stakeholders in other organisations? It may be that a number of stakeholder groups are involved in contributing to the evaluation data.

Note that primary and secondary data may be quantitative (for example, numbers or rates of women breastfeeding) or qualitative (for example, levels of satisfaction with a service, or perceptions of the quality of training received).
Consider whether the data sought will be informing a process evaluation (was the program effectively delivered?) or an outcomes evaluation (how did the program change breastfeeding initiation or duration?), as this will assist in deciding the data sources and the methods of data collection. Either qualitative or quantitative methods may be chosen, or both, depending upon the aims of the evaluation and the available resources.

### 3.8 What about indicators?

Indicators can describe whether there is movement towards or away from a goal or standard.

A national workshop convened by the Australian Institute of Health and Welfare in December 2010 proposed a series of indicators with the purpose of “supporting the reporting of national breastfeeding trends, and thereby the evaluation of the Australian National Breastfeeding Strategy 2010-2015 and related policies and programs”. An evaluation of breastfeeding support services could usefully assess the extent to which the service was contributing to the improvement of breastfeeding rates, by monitoring these indicators and their change over time:

- proportion of children ever breastfed (for children aged 0-24 months)
- proportion of children breastfed at each month of age, 0-24 months
- proportion of children exclusively breastfed to each month of age, 0-6 months
- proportion of children predominantly breastfed to each month of age, 0-6 months
- proportion of children receiving soft/semi-solid/solid food at each month of age, 0-12 months
- proportion of children receiving non-human milk or formula at each month of age, 0-12 months (AIHW 2011).

While these indicators are still regarded as a draft, many jurisdictions are using them, and at the service level collecting this information could usefully strengthen jurisdictional data sets. These indicators have already been reported on in the 2010 Australian National Infant Feeding Survey Indicator Results and the survey questions used to derive the indicator data are available at [http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737421321&libID=10737421321](http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737421321&libID=10737421321).

Other indicators can also be important in an evaluation. For example, using qualitative methods, you can measure whether there are higher or lower rates of satisfaction with aspects of a service or the content of a training program, or identify aspects of the service which could be improved, by talking to service users and staff, and by comparing experiences or changes in perceptions over time.

It is important that indicators are clearly stated, and that they are related to the stated objectives of the program. The clearer the objectives, the easier it will be to identify indicators of achievement. For instance, your objective may be to increase the number of children exclusively breastfed to six months of age. Your indicator statement would then be the proportion of children who are exclusively breastfed to six months of age. Your indicator should always relate directly to your stated objective.

### 3.9 What resources are needed to do an evaluation?

Well-planned, a perfectly respectable evaluation can be undertaken as an integral part of program or project activities, without being a drain on resources. Monitoring and evaluation activities can be embedded into daily practice and can add value through encouraging reflection on practice and quality improvement. Ideally, financial and other material resources for evaluation should be built into program budgets at the
outset, but if this is not the case, program managers can take some simple measures to ensure that information can be collected as part of regular activities. This may be as simple as:

- adding feedback questions to regular interview forms
- doing an audit once a month of waiting times in the reception area (or any other process which the service user experiences)
- shifting existing paper-based collections to computer formats for easier collection of data.

Here are some other resource questions which you might need to answer.

- Does this evaluation require the objectivity and expertise of an external evaluator? If so, you will need to set aside funds, develop a briefing document, and ensure that any outside researcher is fully informed of your needs.
- Is this a job for a team? Different people can bring different perspectives, including the views of service users.
- Are there efficiencies to be gained, for instance having students collect the data, or making use of existing data?
- Would it be helpful to work in collaboration with other services or organisations?

In all of the above considerations, ethical issues will be paramount, and measures must be taken to protect the privacy of individuals whose data may be used in an evaluation.

3.10 What skills do you need?

Clearly, specialist skills may be required for some more complex evaluations, or those involving detailed statistical analysis. However, for the evaluation of many current breastfeeding projects or programs, if the program manager or team has been able to identify the purpose and scope of the evaluation and determine the key evaluation questions (as described in this toolkit), they are already well-equipped to complete the evaluation tasks.

There are many resources already available to help you conduct an evaluation. The most important skills are an enquiring and analytical mind, being good with numbers, and being good with understanding people’s experiences. Different people may have different skills, which is also why it can be helpful to have several people on an evaluation team.

Stakeholders consulted as part of the development of this toolkit indicated that one of the most important skills in undertaking an evaluation is being able to capture the ‘words and feelings’ of participants, so that service users’ experiences are understood and can help to improve the program. In this case, the most important skill is being a good listener, and making sure that you are capturing the service users’ views, and not your own.

It can happen that neither supervisors nor staff are well trained in data collection, and this can have an impact on the quality of the data. Training will help in this case, as will monitoring or spot-checks on how data is being entered or analysed (Lung’aho et al 1996). More guidance on data collection is provided in section 4 of this Toolkit.

3.11 Resources


4. Collecting and interpreting data

“We had no way to evaluate the service and after it had been opened for a year I used Survey Monkey and devised a series of questions which we sent to mothers who had used the service over a two month period. The result was the clinic was moved to a location with better parking, responding to a complaint that the car park was always full, and the only other complaint was waiting times, hence we opened five full days a week. One year ago we repeated the survey and the women who replied were very happy with the service and if they discontinued breastfeeding had felt supported and were happy with the outcome.” (lactation consultant)

So now you have your program goals clearly stated, you have your evaluation plan, you have mapped your stakeholders and decided who is going to be involved and how you will communicate with different people, you have considered the need for ethics approval, and you have identified what you need to collect and who is going to do it. Now what?

The time has come to implement your plan. It can be good to have formal beginning and end points, so that people know that the activity has started, and when data collection has finished.

4.1 Which data collection method?

The selection of data collection methods will depend on the purpose of your evaluation and the questions it is seeking to answer, as well as the skills and resources of people who are undertaking the evaluation.

There are a lot of tools available to help you collect data, some of which are specifically for breastfeeding support services. We have provided a list of resources at the end of this document which are publicly available, mostly on the internet. We have also provided some general templates for three most commonly used tools, which you will find at Appendices E, F, and G:

- consent form
- interview template
- survey template.

These templates are intended as a guide to get you started, rather than an exact recipe. You will need to modify the templates to meet the needs of your particular program, evaluation questions and chosen framework.

4.2 Qualitative data collection methods

There are a range of methods which can be used to collect qualitative data.

4.2.1 Interviews

Interviews may be *structured* (with a standard set of questions) or *semi-structured* (with broad questions or topic headings to prompt discussion) or *unstructured* (with a single overarching question or topic to start a conversation, but no particular formal questions). Structured interviews don’t allow the interviewer to veer from the set questions, so the responses they get are more standardised. Most interviews, however, are semi-structured, with clear questions identified but with room to probe for more detail or to ask supplementary questions if something interesting is said.
In qualitative interviews, questions can be open-ended, meaning that they are structured to invite people to talk freely. Open-ended questions usually start with words like ‘why’, ‘what’, ‘how’, ‘where’, and encourage people to talk about their views or experiences. Closed-ended questions, on the other hand, are structured so that people can answer ‘yes’ or ‘no’, or answer from a limited choice of responses. Closed-ended questions usually start with verbs, for instance: ‘did you think the service was satisfactory?’, or ‘could you remember what the nurse told you?’ Closed-ended questions lend themselves more to quantitative research because you can usually count, for instance, how many people said ‘yes’, or ‘no’. For qualitative research, where your interest is in people’s perceptions or experiences, open-ended questions generally work best.

Interviews sound simple but they do require strong listening skills, empathy, critical thinking (to query or probe some answers), and a warm and friendly persona to build trust.

4.2.2 Focus groups

Focus groups are essentially group interviews, which typically last for about 60-90 minutes and which are led by a facilitator or researcher. A focus group should be no bigger than 8 or 9 people because if it is too big, participants sometimes feel inhibited about speaking out. A focus group is a good way of learning about a group of people and their experiences (for instance, young breastfeeding mothers, Arabic-speaking mothers, grandparents who are assisting new mothers with breastfeeding). It is important that a focus group takes place in a welcoming environment and where people feel safe and secure to discuss the topic freely.

Participants in the focus group may be selected according to identified criteria by an external recruiter (generally if there is a large population involved) or through an in-house process. Focus groups are not intended to be ‘representative’, but are designed as a means of exploring specific topics. The role of the facilitator is to maintain a flow of discussion and cover the desired range of topics through a semi-structured process and to ensure that all participants have the chance to speak up.

4.2.3 Case studies

Case studies can be a useful method of exploring a theme in depth through one person’s experience. They can be very powerful ways of telling a story, or painting a picture of the way in which the service impacts on a person’s life. Information can be collected through a series of extended interviews, or by a person writing down their story and then having it filled out in collaboration with a researcher. There are clearly issues of identification and privacy which need to be considered when using case studies. (This is true even when you are only using isolated quotes from a person, for instance in a larger report; it will still be important that the person can’t be identified without their permission.)

4.2.4 Document analysis

Document analysis uses documents, rather than interaction with individuals, to analyse the topic at hand. For a service evaluation, this could involve analysing minutes of meetings, annual or funding reports, financial records, clinical records, or external sources such as newspapers or government reports. This can be useful, for instance, if you are trying to identify early decisions which influenced the service’s implementation in the past and to trace their impact through the organisation over time.

4.2.5 Observational methods

Observation, including participant observation, may be most useful as a supplement to other qualitative methods, to gain a broader perspective on how a system or service operates. Observation can be undertaken by an external researcher who may, for instance, spend time in a clinic simply watching how clinicians and service users interact, or who may observe interactions in a waiting room. Participant observation means that someone engaged in the system (e.g. a staff member) is doing the observing, rather than an outsider. There are ethical issues associated with observation methods, which will need to be addressed. One of the
key factors in the success of observation methods is letting people know that the observer is there (so they are fully informed and give consent), and then having the observer become as unobtrusive as possible so that people stop being self-conscious and relax into their natural patterns. This is a skill which can take time to develop.

4.3 Quantitative data collection methods

4.3.1 Surveys

Quantitative surveys are aimed at counting, or quantifying, responses to illustrate changes to a specific population group, changes over time or to allow comparisons to be made between groups. Quantitative surveys require the use of predominantly closed-ended questions. Many surveys will also add a small number of open-ended questions (such as asking for additional comments) to a survey to allow people to expand on their answers to other questions. A survey template is provided at Appendix G to help you get started on drafting a survey.

Surveys may be conducted in a paper-based format (e.g. a satisfaction questionnaire handed to every client who attends a clinic), on-line (e.g. a survey accessed through a web address so that anyone who has access to a computer and knows about the survey can participate), or face-to-face (e.g. a short interview about accessibility of a clinic conducted in the car park and nearby bus stop). Each method has its advantages and disadvantages, depending on the audience.

- **Paper-based surveys** are useful when a population doesn’t have access to the internet or comfort with computers, or when you don’t know where to find the population other than in a defined place (such as handing the survey out to people who attend antenatal education classes).

- **On-line surveys** have the potential to reach a wider audience, but assume that respondents have access to a computer (which may leave some people out).

- **Telephone surveys** (sometimes called ‘CATI’ or computer-assisted telephone interviews) are conducted by a researcher who completes the survey on behalf of the person participating; CATI surveys are used for large, population-based surveys where randomly generated telephone numbers are called, and the person answering the phone is asked a series of closed-ended questions. Telephone surveys can also be used for smaller-scale evaluations, both for semi-structured interviews or for survey questionnaires.

- **Face-to-face surveys** are good when you want a quick response, or to engage people in an immediate fashion (e.g. what do you think about this car park, this service, this environment), or when you don’t know where to find the population other than in a defined place. This is the most resource-intensive method as it requires a dedicated researcher to interview people, but it will provide immediate responses.

Online survey software tools are available which allows evaluators to develop, collate and analyse simple surveys using multiple choice questions, matrices, rating tools, etc.². These allow for the construction of quantitative and qualitative surveys, which can be administered via websites, email or blogs.

You can also use both paper-based and on-line surveys. The service in the boxed quote at the beginning of section 4 started out using Survey Monkey and then also sent out a paper version to make sure they weren’t leaving people out who didn’t have access to computers.

² Two examples are available at: [www.surveymonkey.com](http://www.surveymonkey.com) and [www.surveygizmo.com](http://www.surveygizmo.com).
4.3.2 Sampling

A **convenience sample** is the most common in service evaluation. It simply aims to get service users to take the survey by, for instance, leaving copies in the waiting room, or by mailing a copy of the survey to every registered client. While this is convenient for contacting people who might complete the survey, it is not possible to generalise from a convenience sample to make statements about a wider population.

Another method of surveying is a **stratified or purposive sample**. It is aimed at a specific population, for instance young mothers aged 16 to 25 years, mothers from particular socio-economic or cultural backgrounds, or mothers who return to work within six months of giving birth. As with a convenience sample, you would be focusing a one part of the wider community so the findings would not be representative of all people, but a purposive sample does potentially allow you to contact more of the people who may have a perspective on your particular topic, whether or not they use your service.

Sometimes, the numbers of participants in a program or project are too great to survey everyone, so a **randomised sample** may be used. This is useful for conducting population-based surveys over large geographical areas. For this, a valid sample is required (i.e. one which can be regarded as representative of the population being surveyed, without bias), and your sampling method needs to be outlined clearly. This method can allow results to be generalised (that is, discussed with a degree of confidence in relation to other, similar, research studies). A randomised sample needs to be of sufficient size to be able to account for sampling errors and for there to be confidence in the results.

A key point of sampling is that everyone who might be eligible to be included has an equal opportunity to be included. For convenience samples, you might leave surveys out in the waiting room (so for instance, everyone who attends the service in that week has the same opportunity to participate if they want). A convenience sample won’t include everyone who might possibly have a view, but within the bounds of what is convenient, it tries to include as many who might be available at that time. For stratified samples, it would be important to research the target population and come up with ways to reach as many as possible who might be eligible. You will need to know how many of that target group could be found within the local population (for instance, the percentage of the community which speak Chinese as a first-language, or are women under the age of 25, or women between 25 and 40). Your survey would seek to reach a good proportion of that population, which means you might have to go out and find them. You might, for instance, seek to reach women under the age of 25 through secondary and tertiary educational facilities, community centres or local recreational facilities, general practice surgeries and women’s health centres. Your study will be strengthened by being able to report that a certain percentage of all eligible females under the age of 25 had participated in your survey.

Randomisation requires even more rigorous sampling. This may require assistance from statistics textbooks, colleagues or evaluators who can help determine your target population, your required sample size and the most appropriate methodology for your survey.

4.4 Other considerations

4.4.1 Recompense of participants’ time

While many people will be willing to fill in a survey or participate in a short interview, participation in longer interviews or focus groups, or being part of an evaluation advisory group, may involve transport and time costs. It may be appropriate when asking people to participate in research which may involve this type of inconvenience to offer some sort of reimbursement, either for travel money, or by providing lunch, or perhaps cash or a store voucher to recognise their contribution.
4.4.2 Managing an evaluation

It is important to nominate a person who will be responsible for taking charge of the overall evaluation project. This person’s key tasks will be to make sure that data is being collected accurately and when required, that there is a clear process for analysing data, and that information and findings are communicated to all stakeholders. Depending on the size of the project, this person may need to let go of other duties for the duration to make sure they have time to oversee the evaluation. Of course, this needs to be decided at the beginning of the project, so everyone is in agreement about tasks and responsibilities.

4.5 Analysing and interpreting data

The analysis approach will depend on the kind of data you collect.

Some data may be extracted from clinical software systems and gathered together into spreadsheet software, where simple calculations of rates and proportions, means and medians can be done. More complex cross-tabulation of results or multivariate analysis may accompany complex numeric evaluations, but these exercises are likely to be undertaken by specialist evaluators and are not usually required as part of a general analysis as to whether the outcomes of a program is moving toward or away from its objectives.

If you are collecting data on an audit sheet, or other template in which activities or interventions are being counted, this data can be entered into spreadsheet software and analysed. Alternatively, in a small service, it might be as easy to do this with pen, paper and a pocket calculator – it depends on your own needs and your resources.

For a qualitative analysis there are a variety of approaches one can take. The most direct is simply to read through interview notes or survey responses in a structured way, writing down themes or phrases which occur again and again, noting responses which are unique (it may be that one person is very unhappy but everyone else is satisfied), and building up a picture of the collective experience of the respondents. There are rigorous approaches to qualitative coding and analysis which ensure that the interpretation of words is clear, however on a small scale it can be as efficient to simply read and consider the responses (if there aren’t too many of them). It is also possible to quantify this data by counting numbers of times people say certain things, but generally this is not so important since the experiences are personal and can’t be taken to be representative of all service users.

Once you have the data in a collective form (either statistics or experiences) it can be useful to sit down (with others, as possible) and consider what the data are telling you. Here’s a diagram which depicts an analysis process:
It is important to check your analysis of the results and to ensure that possible factors that have led to a particular finding are not overlooked. This can be done by discussing the conclusions with a few of the people who provided the data.
5. Sharing Evaluation Results

5.1 Who is your audience?
If the evaluation is just for you and your team, you may need no more than a brief report which summarises what you’ve done and what you’ve learned.

If the evaluation is for a funding body, it may need to be more formally presented, with an explanation of what you were evaluating and what you discovered, and the implications for the service and the funder.

If your clients have been involved in the evaluation, it will be important to let people know what came out of the project. This can be achieved by a simple notice in the waiting room or, if the implications are significant, it might be worth sending out a letter to clients to let them know what resulted from the evaluation. You can return to the stakeholder identification activity and consider whether different stakeholders need different information.

Of course, as discussed in section 3.6, depending on the project there may be ethical considerations in how the information is presented, and there can be valid reasons for keeping evaluation results internal to the service, particularly if problems have been highlighted which need to be addressed.

Your evaluation may also be of interest to other similar services in your area, elsewhere in Australia, or even overseas. It may be helpful for others to learn about how your program operates and what it has achieved.

5.2 A report presentation format
In general, the evaluation report should include:

- an overview of the program objective; the purpose of the evaluation and the evaluation methods used
- a summary of the key findings
- a description of the program, in sufficient detail to understand what has been evaluated
- discussion of implications for the population group and program, if appropriate
- recommendations or potential future directions
- acknowledgements of people who contributed to the evaluation.

5.3 Disseminating results
The dissemination of evaluation results will, again, largely depend upon the intended audience(s) and presentation styles; the budget for dissemination; the nature of the report content (i.e. confidential or public) and the role of the evaluation report in contributing to broader change processes. In general terms, printed reports are often costly, so consideration could be given to online publishing and/or targeted use of other media such as email communication to interested stakeholders, blogs or websites, or radio, as appropriate. The use of evaluation reports to inform further rounds of program planning may also determine the process for disseminating results. Evaluation results may also form a basis for ongoing public health campaigns.

The Victorian Department of Human Services guide: *Planning for effective health promotion* (Round et al 2005) suggests that it is important to think through a number of aspects of sharing the evaluation findings, such as who should have access to the results (taking into account the ethical requirement for privacy); the
ideal formats for dissemination of results; and the storage of evaluation results in the agency to ensure future programs can build on the existing knowledge base.

The Public Health Agency of Canada describes practical processes which increase the likelihood of stakeholders using evaluation results, including the use of clear language and local presentations designed to ‘spread the word’ in a targeted way, presenting findings to local groups who might be interested, preparing a press or media release, and presenting at a workshop of other professionals to share what you have learned (Health Canada 2000).
6. Resources

6.1 Documents relating to the Australian policy context:


6.2 International resources specific to the evaluation of breastfeeding programs:

6.3 Useful health or human services program evaluation toolkits currently in use in Australia:


6.4 Overseas health program evaluation resources:


### 6.5 Stakeholder identification resources:


Appendix A - Policy context

Policy context

The Australian National Breastfeeding Strategy 2010-2015 was endorsed by the Australian Health Ministers’ Conference (AHMC) on 13 November 2009. The aim of the Strategy is to contribute to improving the health, nutrition and wellbeing of infants and young children and the health and wellbeing of mothers, by protecting, promoting, supporting and monitoring breastfeeding. AHMC (now known as the Standing Committee on Health or SCoH) brings together the Commonwealth Minister for Health and Ministers for Health from respective state and territory government jurisdictions. The Strategy and a range of other relevant publications are available from the Australian Department of Health and Ageing’s website: http://www.health.gov.au/breastfeeding.

The Strategy outlines a series of strategic goals across the breastfeeding continuum of ‘ages and stages’, underpinned by key objectives and an evidence-base of ‘what works best’. The goals are as follows:

- increase community acceptance of breastfeeding as a cultural and social norm
- mothers feel comfortable and supported in their breastfeeding relationship
- breastfeeding friendly communities, public spaces, workplaces and child care environments empower mothers to continue breastfeeding
- community leaders and role models value and enable breastfeeding and are supported to breastfeed
- improve the availability and access to antenatal education with information on the value of breastfeeding
- pregnant women establish breastfeeding support networks and are linked to support groups in the community
- improve breastfeeding initiation rates
- improve the consistency of breastfeeding advice provided by health professionals
- increase the number of birthing services with documented breastfeeding policies and workplace supports
- improve breastfeeding training for health professionals
- improve continuity of care between birthing and health and community services, and breastfeeding support services and networks. Ensure mothers and their families know what breastfeeding support services are available and how to access them
- ensure mothers receive appropriate breastfeeding supports and referrals, including access to trained peer breastfeeding counsellors
- increase the percentage of babies who are fully breastfed from birth to six months and continue breastfeeding with complementary foods to 12 months and beyond
- increase the access to parental leave
increase the number of model breastfeeding friendly workplaces, services and environments (p 34-37).


- Only a small proportion of mothers are exclusively breastfeeding their babies for the first six months of life, as recommended by the WHO and the NHMRC.

- There is no national breastfeeding data collection system and there is a lack of quality data on the effectiveness of measures to promote breastfeeding and improve initiation and duration of breastfeeding.

- Multifaceted influences on breastfeeding practices create challenges in researching and distinguishing the impact of particular interventions or programs.

- While successful strategies for promoting and supporting breastfeeding exist, lack of coordination can be an issue in terms of policies and procedures. Barriers to initiating and continuing successful breastfeeding were identified as including cultural perceptions and practices; low levels of education or literacy; low socioeconomic status; lack of ongoing support or access to support and lack of appropriate education and ongoing advice.

In recommendations particular to the preparation of this evaluation toolkit, the Inquiry proposed Australian Government leadership in the coordination and oversight of a national strategy to promote and support breastfeeding; in monitoring, education and coordination; in specific strategies to improve baby-friendly health initiatives across the health system and in the monitoring, surveillance and evaluation of breastfeeding rates and practices in Indigenous communities (p xvii-xx).

The Australian Government Response to the House of Representative’s Inquiry was provided in December 2008. Importantly, this included a commitment to the development and implementation of a National Breastfeeding Strategy (2009), with state and territory governments, through AHMC (p 4).

The Response included other comments with implications for this Toolkit. For example, in relation to Recommendation 2, it noted the work being undertaken by the Department of Health and Ageing with stakeholders to update the breastfeeding data indicators recommended in the 2001 report Towards a national system for monitoring breastfeeding in Australia, using new research and guidelines from Australia and international sources, including the World Health Organization and support for a basic set of indicators in the context of developing a National Breastfeeding Strategy (2009, p 4). This work has progressed, and in 2011 the AIHW published the National Breastfeeding Indicators Workshop Report and the Australian National Infant Feeding Survey: Indicator Results.

In relation to recommendations 3, 4 and 9, the Australian Government priority to evaluate the impact and effectiveness of programs intended to increase breastfeeding rates was noted, along with the intention to canvass priorities for evaluating best practice programs with state and territory governments as part of the National Breastfeeding Strategy (2009, p 5). The Toolkit is intended to contribute to these outcomes.

In relation to recommendation 19, the Australian Government reported inclusion of a measure of breastfeeding practices, under the Aboriginal and Torres Strait Islander Health Performance Framework, as one way of providing leadership in the monitoring, surveillance and evaluation of breastfeeding rates and practices in Indigenous populations in both remote and other areas (p 10).
**Evaluation Toolkit for Breastfeeding Programs and Projects**

**Infant Feeding Survey: Indicator Results** includes breastfeeding rates reported by Aboriginal and Torres Strait Islander mothers or carers.

**Indicators and national statistics**

In an article on complexities in measuring and reporting on breastfeeding in the *International Breastfeeding Journal*, Hector (2011) notes that simple, valid and reliable indicators are critical in public health monitoring to describe progress toward a goal.

As described in the previous section, an update of indicators was proposed as part of the Australian Government response to the 2007 Parliamentary inquiry into breastfeeding. A national workshop was convened by the Australian Institute of Health and Welfare (AIHW) in December 2010, designed to make decisions on a set of breastfeeding indicators with the purpose of ‘supporting the reporting of national breastfeeding trends, and thereby the evaluation of the *Australian National Breastfeeding Strategy 2010-2015* (2009) and related policies and programs’ (p v). The Workshop report notes that the following draft set of indicators was agreed in principle:

- proportion of children ever breastfed (for children aged 0-24 months)
- proportion of children breastfed at each month of age, 0-24 months
- proportion of children exclusively breastfed to each month of age, 0-6 months
- proportion of children predominantly breastfed to each month of age, 0-6 months
- proportion of children receiving soft/semi-solid/solid food at each month of age, 0-12 months
- proportion of children receiving non-human milk or formula at each month of age, 0-12 months (p 12).

It is worth noting that the workshop report defines ‘aged x months’ as being in the x +1 month of life (e.g. a child aged 6 months has lived 6 complete months and is in the 7th month of life). However, the potential for misinterpretation of this indicator both at the application and analysis stages remains. Similarly, there is a view that indicators should be broadly consistent with standards, recommendations and practice and in this regard it has been pointed out that the National Health and Medical Research Council (NHMRC) guidelines (2012) related to breastfeeding recommend “that infants are exclusively breastfed until around 6 months of age when solid foods are introduced”. As Hector (2011) indicates, this is likely to create some problems in indicator development as the timing issues are juxtaposed.

These issues also suggest there is likely to be a need for ongoing guidance around the use of indicators relating to the goals of ‘exclusively’ and ‘predominantly’ breastfed.

The AIHW 2010 *Australian National Infant Feeding Survey: Indicator Results* (2011) utilises the national workshop indicators as part of a baseline national survey on estimates of prevalence and duration of breastfeeding as well as exploring barriers to initiating and continuing breastfeeding, using a sample drawn from the Medicare enrolment database. An initial sample of 52,000 was used and a response rate of 56% achieved. The report also highlights the definitional difficulties referred to above, in relation to current age of child and descriptions of selected infant feeding practices (p 2-4). These are addressed by use of a ‘time to event’ analysis technique as well as by strict adherence to the use of ‘exclusively breastfed’ and ‘predominantly breastfed’ definitions in the survey process. Other limitations of the data included estimates based on the recall of infant feeding practices and sample size issues for subpopulations (p 56).

The report’s main findings are as follows:
- Breastfeeding was initiated for 96% of children aged 0-2 years (p 7).
- Approximately 69% of infants received some breastmilk at 4 months of age, although only 39% were exclusively breastfed to less than 4 months and approximately 60% were receiving some breastmilk at 6 months, but only 15% were exclusively breastfed to less than 6 months (p 7,8).
- 47% of infants were predominantly breastfed to less than 4 months and 21% were predominantly breastfed to less than 6 months (p 10).
- Less than 1% of children aged 1 month received soft/semi-solid or solid food, rising to 35% of infants aged 4 months, 92% of infants aged 6 months and 95% of children aged 12 months (p 11).
- Approximately 40% of infants aged 1 month received non-human milk or infant formula, with a gradual rise in this rate to 55% at 6 months. Nearly 80% of children aged 12 months received non-human milk or infant formula (p 12).
- Higher initiation rates and intensity of feeding for longer periods were associated with older mothers/carers, mothers/carers with tertiary education and with higher gross household incomes and infants who did not regularly use a dummy (p 14, 18, 22, 26).
- Similar associations were made for these groups in relation to lower and later rates of introduction of non-human milk and soft/semi-solid/solid foods (p 30, 34).
- The reasons most cited in the report for giving the child breastmilk were: healthier for child (94%), convenient (64%) and helps with mother-child bonding (64%) (p 38).
- Reasons most cited for not breastfeeding (amongst the 4% who never breastfed) were: previously unsuccessful experience (38%), to enable partner to share feeding (29%) and infant formula as good as breastmilk (26%) (p 39).

The report (2011) highlights the lack of consistency in data collected and indicators reported for breastfeeding rates and duration between different jurisdictions and surveys.

**National Women’s Health Policy 2010**

The National Women’s Health Policy (2010) provides an overarching policy framework for the improvement of the health and wellbeing of all women in Australia, in particular those at greatest risk. It includes the health priority area of sexual and reproductive health, including the importance of the health of mothers prior to conception, during pregnancy and in the post-natal period in terms of profound and long-term effects on their own health and that of their children.

The National Women’s Health Policy (2010) acknowledges breastfeeding as a key protective factor for both maternal and infant health in terms of the best nutritional start and immunological protection for infants, the promotion of infant bonding and attachment and other maternal health benefits such as promotion of recovery from childbirth and reduced risks for breast and ovarian cancer. The policy recognises the Australian dietary guidelines recommendation for exclusive breastfeeding for infants until six months of age and quotes the Australian Institute of Family Studies report with breastfeeding initiation rates at 92 per cent in 2004, declining to 56 per cent of infants fully breastfed at three months and 14 per cent at six months. The policy also notes that younger, less educated and more socioeconomically disadvantaged Australian women are less likely to breastfeed (p 62).
State and territory policies

Most state and territory jurisdictions have breastfeeding policies or frameworks and operate a range of programs and projects which are either specific to breastfeeding or focused on generic health objectives (for example maternal and infant health, nutrition, obesity etc.). These activities are variously delivered through health and other government agencies, non-government organisations or jointly.

Other relevant documents

A qualitative research report developed by Woolcott Research for the Department of Health and Ageing in 2009 (Exploratory Research Regarding Infant Feeding Attitudes and Behaviours) found that breastfeeding rates are affected by women’s changing and evolving attitudes, expectations and experiences from pregnancy until the time the child is around six months of age (p 3). The report observed that “more committed breastfeeding were likely to be slightly older, have achieved higher levels of education, and from higher socio-economic areas” (p 6). This finding is broadly consistent with the AIHW 2010 Australian National Infant Feeding Survey results.

The Woolcott report (2009) also found a lack of awareness among mothers and partners about breastfeeding guidelines; variation in the types of information, advice and support available to women and a range of involvement by and accessibility to health professionals with regard to infant feeding (p 7-10). It recommended implementation of social marketing activities to ‘normalise’ breastfeeding, improved information for mothers, partners and family members; promotion of the importance of exclusive breastfeeding; conduct of an audit of breastfeeding-related education and training to professionals and the conduct of further research on specific culturally and linguistically diverse groups’ awareness and attitudes regarding breastfeeding (p 11-13).

The NHMRC Infant Feeding Guidelines: Information for Health Workers (2012) documents the evidence base and provides Australian recommendations on breastfeeding and infant feeding practices. This in turn further informs the policy, programs, research, indicators and evaluation used to protect, promote, support and monitor breastfeeding in Australia.

References


Appendix B - A logic based evaluation framework

(These instructions can be deleted once you have finalised your document.)

This template provides a structure for designing an evaluation based on program logic. Complete the sections below and then use these to fill in the table on the next page. It’s a good idea to involve a number of people in this exercise (perhaps clinicians, program managers and other staff, and consumers if felt appropriate). While a program logic is sometimes completed at the beginning of a program you can do this exercise at any time by articulating the actual early steps and their intended consequences. The text below provides an example that illustrates the kinds of things to think about but the nature of your service may be quite different and your plan could be simpler or more detailed than this example.

1. Program being evaluated

Type your answer here

e.g. local mother and baby clinic breastfeeding support program

2. Target population/priority subpopulation(s)

Type your answer here

e.g. mothers and babies (up to six months) from Southside catchment, area with a particular focus on meeting the needs of teenage parents and Aboriginal and Torres Strait Islander families.

3. Length of program (ongoing, time limited)

Type your answer here

e.g. ongoing since 2009.

4. Evaluators (internal, external, team or individual)

Type your answer here

e.g. evaluation being undertaken internally by local clinic team, with support from Health Department/Medicare Local and nearby university.

5. Resources required (financial, time, staff, etc.)

Type your answer here

e.g. 4 months, 0.1 manager, 0.3 staff, $5,000 for statistical advice on survey sample size and data analysis.
6. The specific identified need(s) which the program is aiming to address:

*Type your answer here*

e.g. local mothers have high breastfeeding initiation rates but often lack the knowledge and family/community support needed to overcome breastfeeding challenges and continue breastfeeding past the first month or so. The clinic aims to increase the breastfeeding knowledge of mothers and their families/support people, and to provide additional individual and small-group support and clinical advice where needed.

7. The specific activities which have or will be implemented to address identified need(s):

*Type your answer here*

e.g. antenatal breastfeeding education classes, and postnatal breastfeeding support through a combination of home visits, phone support, drop in centre and individual appointments for mothers requiring more specialised clinical support.

8. If all those activities are implemented well, what will you expect to see in the short-term? (you will need to put a timeframe on this, for instance 6 months from implementation)

*Write your agreed short-term outcomes here – there may be several. These should be written as full-sentences, e.g.:

More women in our catchment area will learn about breastfeeding and know about our services before they give birth.*

9. If all those outputs occur, what will you expect to see in the medium-term? (you will need to put a timeframe on this, for instance 1 year from implementation)

*Write your agreed medium-term outcomes here – there may be several. These should be written as full-sentences, e.g.:

The number of women who contact our breastfeeding clinic and use our services will increase.*

10. If all those medium-outcomes occur, what will you expect to see in the long-term? (you will need to put a timeframe on this, for instance 2 years from implementation)

*Write your agreed medium-term outcomes here – there may be several. These should be written as full-sentences, e.g.:

Women who receive support from our breastfeeding clinic are able to breastfeed for longer than they would have otherwise.*

11. Now, write all those statements from questions 6-10 into the table below in the left-hand column. Each logic statement should have one row in the table. We have provided some text as examples in the table, but these are just examples. You can add as many rows as you need to put in all of your logic statements.
12. Once you have your activity and outcome statements in the table, you need to identify what questions will help you find out whether that outcome has been achieved. What questions might you need to ask? Write them in the second column, next to each outcome statement.

13. When your questions have all been agreed, you need to identify what indicators will help you answer the questions. These might include new mothers’ levels of knowledge about a service, satisfaction levels, or clinical rates of particular breastfeeding issues. Write these down next to each evaluation question. There may be more than one indicator for some questions.

14. Now, where will you find the data? Will it be in the clinical records or other documentation, or do you need to create a new way to collect the information? Do you need to talk to people – staff or clients – to find out about their experiences? Is some of the data you need already collected through local services, your local, state or territory government or available through national or state/territory level surveys or other published or unpublished research? Write your data sources in that column next to each indicator.

15. Finally, when will you be looking for the data? Is it already available (for instance, in your own clinical records) or do you have to wait for it (for instance, the release of a national survey by a government agency)? If it’s a survey or a series of interviews or focus groups, when will you conduct these?

16. After all of this, you should have a completed table which identifies the following:
   - what you expect to happen if your program is working as you intend
   - what questions you can ask to find out if your program is achieving its outcomes
   - what indicators will provide answers to those questions
   - where you will find the data you need
   - when you will be collecting it.

17. Once your framework is completed, it can be useful to share it with others to get their perspective. Sometimes explaining things to others can help make it clearer to your team, and also allow others to ask questions you may not have thought of.

18. Now you have a plan to evaluate your program. Go for it!
## A logic-based evaluation framework

<table>
<thead>
<tr>
<th>Program logic</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity 1 antenatal breastfeeding education classes</td>
<td>How well were these activities undertaken? What worked? What barriers were experienced? How were these overcome?</td>
<td>Participant’s satisfaction with availability, teacher, information provided, format, venue Participants awareness of available breastfeeding support pathways.</td>
<td>Survey of participants Optional on-line ‘quiz’ following attendance at class.</td>
<td></td>
</tr>
<tr>
<td>Activity 2 postnatal breastfeeding support</td>
<td>Identify staff views of areas for improvement</td>
<td></td>
<td>Brainstorming session with key staff</td>
<td></td>
</tr>
<tr>
<td>Short-term outcome 1 More women in our catchment area will learn about breastfeeding and know about our services before they give birth.</td>
<td>Were the intended short-term outcomes achieved? If not, why not?</td>
<td>Proportion of women birthing in local hospital who attended breastfeeding classes Number of hits on clinic webpage Number of sites posters/flyers displayed</td>
<td>Hospital records Web administrator</td>
<td></td>
</tr>
<tr>
<td>Short-term outcome 2</td>
<td>What was evident as a result of the activities which were undertaken?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Program logic

<table>
<thead>
<tr>
<th>Medium-term outcome 1</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased satisfaction with the service</td>
<td>Were the intended medium-term outcomes reached? If not, why not?</td>
<td>Satisfaction with specific aspects of the service and encounters with staff</td>
<td>Survey of service users</td>
<td>Survey provided while waiting for immunisation visits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medium-term outcome 2</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of women who contact our breastfeeding clinic and use our services will increase.</td>
<td>Numbers of women using each aspect of the service</td>
<td>Appointments book, Phone records, Clinical records</td>
<td>In-house audit conducted twice a year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long-term outcome 1</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>What evidence is available that the long-term outcomes will or can be reached? What has been learned about achieving these outcomes? What could be improved?</td>
<td>What evidence will demonstrate success? Enter these here. E.g. satisfaction of clients and/or staff, clinical indicators, increased efficiencies – be as specific as possible</td>
<td>Where will you find your data? Will it be in the clinical records? Do you need to survey clients or staff? Is it documented or do you need to do a survey about people’s experiences? How will you collect that data if it isn’t already available?</td>
<td>When will you be collecting this data? When will it be available?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long-term outcome 2</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who receive support from our breastfeeding clinic are able to breastfeed for longer than they would have otherwise.</td>
<td>Increase proportion breastfed to six months of age and exclusively breastfed to two and four months of age</td>
<td>Records from clinical support encounters, breastfeeding survey questions at routine immunisation visits, phone survey of sample of service users</td>
<td>As per immunisation schedule</td>
<td></td>
</tr>
</tbody>
</table>

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<td></td>
<td></td>
<td>As per immunisation schedule</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 + 3 months after last encounter with breastfeeding service</td>
</tr>
</tbody>
</table>
Appendix C - RE-AIM evaluation framework template

(These instructions can be deleted once you have finalised your document.)

This template provides a structure for designing an evaluation based on the RE-AIM model. RE-AIM stands for:

This is a good framework to use when you are implementing a service which provides a point in time intervention, rather than a program which has a longitudinal focus. It was first developed to evaluate public health interventions so is well suited to short-term clinical engagements with consumers.

Complete the sections below, and then use these to fill in the table on the next page. It’s helpful to involve others who will have an informed view about what you are trying to accomplish.

1. Program being evaluated
   
   Type your answer here

2. Evaluators
   (internal, external, team or individual)
   
   Type your answer here

3. Resources required
   (financial, time, staff, etc)
   
   Type your answer here

4. REACH - Who are you trying to reach? Be as specific as possible, e.g. women within the first month post-partum, pregnant women in the 3rd trimester, young pregnant women, first-time mothers
   
   Type your answer here
5. EFFECTIVENESS - What services are you providing? How will you know if they are effective? Be as specific as possible.

Type your answer here

6. ADOPTION - How will your service be advertised? What place does it have in the local network of health services? How will you ensure it is adopted by both the health system and by consumers?

Type your answer here

7. IMPLEMENTATION - What will you do to implement the service? What needs to happen to make it work – financial resources, staffing, management, clinical protocols or pathways, referral processes?

Type your answer here

8. MAINTENANCE - What is required for the service to be maintained? For instance, is funding secure? Will your service have a natural ‘use-by’ date or could it run forever? What needs to happen for it to continue to operate in the long term?

Type your answer here

9. Now that you have considered all those things, sit back and reflect for a bit. What questions do you need to ask to discover what you have achieved in each domain? It can be helpful to consider the framework in two sections:

- ‘RE’ focuses on the consumer; who are you trying to reach? How will you know you are effective?

- ‘AIM’ focuses on the organisation; how does your service fit into the broader system? Does your service compete or complement other services? How well has it been implemented? What needs to be done to maintain the quality of the service?

10. In the table below, enter the questions which you have identified for each domain in the second column (evaluation questions).

11. When your questions have all been agreed, you need to identify the indicators which will help you answer the questions. Are they measures of personal experience such as satisfaction, or are they indicators which will be clinically measured? Write these down next to each evaluation question. There may be more than one indicator for some questions.

12. Now, where will you find the data? Will it be in the clinical records or other documentation, or do you need to create a new way to collect the information? Do you need to talk to people – staff or clients – to find out about their experiences? Write your data sources in that column next to each indicator.
13. After all of this, you should have a completed table which identifies the following:

- what you expect to happen if your program is working as you intend
- what questions you can ask to find out if your program is achieving its outcomes
- what indicators will provide answers to those questions
- where you will find the data you need.

14. Once your framework is completed, it can be useful to share it with others to get their perspective. Sometimes explaining things to others can help make it clearer to ourselves, and also allow others to ask questions we may not have thought of.

15. Now you have a plan to evaluate your program. Go for it!
<table>
<thead>
<tr>
<th>Framework component</th>
<th>Evaluation questions (samples below)</th>
<th>Indicators (samples below)</th>
<th>Data sources (samples below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach</td>
<td>Who is using the service? How often? What services are women accessing? Is the service targeting the needs of women in the local area? Are there eligibility criteria? If so, what are they and are they appropriate? Which particular ‘ages and stages’ of the breastfeeding experience are being targeted?</td>
<td>Number of women accessing service and comparison to expected local population need; demographic characteristics and comparison to local population</td>
<td>Service records Local demographics Interviews with local women</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>How effective is the service in supporting women to breastfeed?</td>
<td>Number of service users who continue to breastfeed at points in time</td>
<td>Service records Survey of service users</td>
</tr>
<tr>
<td>Adoption</td>
<td>How is the service linked to other relevant services? How well do services collaborate or cross-refer? To what extent is the service fully embedded in the larger organisation or network?</td>
<td>Number and type of collaborative agreements Evidence of cross-referral or collaboration Perceptions of staff/stakeholders</td>
<td>Organisational records Service documentation or clinical referral records Interviews with key staff/stakeholders</td>
</tr>
<tr>
<td>Implementation</td>
<td>How was the service implemented? What were the barriers or enablers in establishing the service?</td>
<td>Documentation regarding implementation Perceptions of staff/stakeholders</td>
<td>Organisational records Interviews with key staff/stakeholders</td>
</tr>
<tr>
<td>Maintenance</td>
<td>How is the service funded? How sustainable is the funding? How is the service governed? What challenges face the service in meeting future community needs?</td>
<td>Documentation regarding maintenance Perceptions of staff/stakeholders</td>
<td>Organisational records Interviews with key staff/stakeholders</td>
</tr>
</tbody>
</table>
## Appendix D - Quality improvement cycle template

(These instructions can be deleted once you have finalised your document.)

Using the quality improvement cycle can be helpful in encouraging teams to reflect on their own practice and to identify ways of improving service performance.

Teams can use this cycle in many ways, but one of the most common is to identify a small group of people who can take the lead in the project, and to take responsibility for feeding back findings to the bigger team. Of course, in a small team this may just be one or two people, or the whole team together.

Generally it is useful to meet together to identify the topic or issue for exploration. Is it that waiting times seem to be getting longer? Or to find out the reasons why people do not attend the clinic? Or to examine whether a particular approach to breastfeeding support is more effective than another?

### Our quality improvement plan

<table>
<thead>
<tr>
<th>Stages of quality improvement</th>
<th>What will we do?</th>
<th>Who is responsible?</th>
<th>When will we report back?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan</strong> (defining the problem, designing a method to assess what’s happening, getting buy-in from stakeholders)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do</strong> (implementing intervention, monitoring processes, collecting and analysing data)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Check</strong> (reflecting on findings, identifying opportunities for improvement)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Act</strong> (implementing improvements, maintaining high performance, telling people who can promote good practice)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Appendix E - Interview guide template

(These instructions can be deleted once you have finalised your document.)

Here’s an example of how you might structure an interview template. You can change all of the text in this template to suit your own purposes. Please note that the statements about confidentiality can only be used if you will really be able to offer confidentiality, so any participant should be clear about how their responses may be used. Think about whether you will ask some or all of the demographic questions at the beginning or the end of the interview; some respondents might be more comfortable providing these details after they know what other questions were asked.

Introductory text
Hello, my name is [name] and I work at [name of service]. We are conducting an evaluation to learn [focus of research here]. As part of this project, we would like to talk with women who use our service to find out what experiences people are having. With your permission I would like to ask you a few questions today. If you agree, I will take notes as we talk but what you say will remain confidential to our team. I won’t include your name so others won’t know what it was that you said. Whether you take part or not, it will have no impact on your relationship with the service or with any provider here at [name of service].

Do I have your permission to continue?

Some questions about you

(These instructions can be deleted once you have finalised your document.)

Put in whatever demographic questions you think are most useful – just remember that if you use someone’s name you will need to ensure their answers remain private and only ask for information that is necessary to address your evaluation questions.
1. Respondents age
   Type your answer here

2. Number of children
   Type your answer here

3. Breastfeeding history
   Type your answer here

4. Additional information
   Type your answer here

5. Question
   Type your answer here

6. Question
   Type your answer here

7. Question
   Type your answer here

8. Question
   Type your answer here

9. Question
   Type your answer here

10. Question
    Type your answer here

11. Question
    Type your answer here

12. Question
    Type your answer here

Thank you for your time today. Your answers will be combined with other people’s responses and only reported as a group. Your name will not be used.

We really appreciate your help today, which will assist us to improve the services we provide.
Appendix F – Sample consent form template

(These instructions can be deleted once you have finalised your document.)

You can use this type of form when you are asking service users to participate in research. It is good practice to provide participants with an information sheet which they can keep, which will tell them what the evaluation is about, what will happen to their information, and how you will maintain their privacy. If you require ethics approval you will certainly need to create a consent form, which should also include an option for people to withdraw from the project (see page 56).

The information sheet should contain the following information at a minimum:

- what the project is about
- who is undertaking the project (including name and contact details of a nominated representative)
- what information is being collected and why
- what information the service user will be asked to supply and why
- what will happen to that information
- what impact participating (or not participating) will have on the service user
- how to give consent, and how to withdraw
- where to go for more information or to make a complaint
Consent statement

(These instructions can be deleted once you have finalised your document.)

Put this on a separate page from the information sheet as the evaluators will keep this signed statement.

I have read (or had read to me) and understood the information provided to participants on the information sheet about the evaluation of the [name of project]. Any questions I have asked have been answered to my satisfaction. I agree to participate in this interview, as described. I understand that this interview is voluntary, and that I can withdraw my consent at any time.

I understand that information about me will be collected by the researcher I speak to, and that my name will be taken off this information later so that no one will know what I have said. I understand that the report will not include any details which might identify me to others.

NAME OF PARTICIPANT

SIGNATURE

DATE

NAME OF RESEARCHER

SIGNATURE

DATE
Withdrawal of consent

(These instructions can be deleted once you have finalised your document.)

Put this on a separate page from the information sheet or consent form, so that the participant can send it in later if they want to – the participant takes this away with them, along with the information sheet.

I hereby withdraw my consent to take part in the evaluation of the [name of project]. I understand that my withdrawal will not be made known to local services and that my choice not to participate will have no influence on present or future health or other services I may choose to use.

I understand that all the notes taken at my interview will be withdrawn from the study and destroyed at this request.

NAME OF PARTICIPANT

SIGNATURE

DATE

Please return this form to [give contact details]
Appendix G – Questionnaire template

(These instructions can be deleted once you have finalised your document.)

The questions you decide to ask in a questionnaire will depend on what you are trying to learn. Generally, a self-complete survey is useful when you want to learn a lot of things about a respondent which can be easily counted, and also when you want to preserve women’s confidentiality. A paper survey can be made available in a reception area for people to complete if they want, or an online survey link can be provided, without any pressure to participate. The introduction and questions below are purely for example purposes and will need to be adapted to suit your own setting, target population, key evaluation questions and capacity to analyse the data you collect.

These types of questions could equally be adapted for hospitals, maternal/child or community health settings, support groups/organisations, etc. You will need to change the wording accordingly: for example, a survey for a lactation clinic may refer mainly to breastfeeding (and expressing), while a survey for a general postnatal service might ask about infant feeding. If the service is only for very young babies, you might not need to ask about introduction of solids. You will also need to think about who you want to include in the survey (e.g. mothers only, or mothers, partners and other carers).

If your evaluation seeks to obtain the views of people with low literacy levels or from linguistically diverse backgrounds, you will need to check that your survey can be completed by people in these groups. You may need to arrange for the survey to be translated or consider alternatives such as one on one interviews or focus groups with translator support if necessary.

Examples of additional question types, and previously used questions that could be used in your survey for comparison purposes, are available from the questionnaire used for the 2010 Australian National Infant Feeding Survey available at: [http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737421321&libID=10737421321](http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737421321&libID=10737421321). This will be particularly important if you want to compare breastfeeding rates in your survey population to national or state/territory rates.

Alternative sources of questions include state/territory surveys, postnatal hospital discharge forms, and the breastfeeding research literature.

Finally, please remember to amend the text of this survey to make sure that it suits your own service and the questions you are trying to answer.
Introduction
This survey will ask you about your experiences of [name of service]. We are interested to hear your views so that we can improve the way we do things. You do not have to fill in the survey if you don’t want to, and you are free to add any comments that you wish. We will not ask for your name or any details which might identify you, and your decision to fill in the survey will not make any difference to your ability to access any services in the future.

1. Did you receive information or advice about breastfeeding while attending [name of service]?  
   NO (please go to question 3) □
   YES □

2. If you answered Yes, was that information or advice about…?  
   (TICK AS MANY BOXES AS YOU NEED)
   □ Benefits of breastfeeding
   □ How to breastfeed
   □ Dealing with difficulties in breastfeeding
   □ Services available to help me with breastfeeding
   □ Formula feeding
   □ Other (please specify)

3. How was the information or advice provided to you?  
   (TICK AS MANY BOXES AS YOU NEED)
   □ Printed form/brochure only
   □ Video
   □ Group class/information session
   □ Individual appointment
   □ Midwife
   □ Lactation consultant
   □ General Practitioner (GP)
   □ Maternal and Child Health Nurse
   □ Other health professional
   □ Community worker
   □ Australian Breastfeeding Association volunteer counsellor or educator
   □ Other (please specify)
4. Using the following scale, how helpful was the information provided to you?

- Very helpful
- Somewhat helpful
- Neither helpful nor unhelpful
- Not very helpful
- Not at all helpful

5. If you received infant feeding information or advice from different sources within [name of service], how did that advice seem, each time you received it? Was it:

- Similar (go to question 7)
- Somewhat the same (go to question 7)
- Somewhat different
- Different

6. If it was different, in what ways was the advice different?

Type your answer here

7. How important was the advice you received in assisting your decisions about breastfeeding?

- Very important
- Somewhat important
- Neither important nor unimportant
- Not very important (go to question 9)
- Not at all important (go to question 9)

8. Did the advice influence your decision to…?

(TICK AS MANY BOXES AS YOU NEED)

(These instructions can be deleted once you have finalised your document.)

You can add or remove options depending on the focus of your evaluation.

- Initiate (or start) breastfeeding at birth
- Continue breastfeeding until leaving hospital
- Continue breastfeeding up to ____ weeks/months after giving birth (please provide number of weeks/months)
- Not to breastfeed
- Other (please state)

(If you ticked any of the above, please go to question 10)
No, I was not influenced at all by the advice (please go to question 9)

9. If the information or advice provided by [name of service] did not help you to make decisions about infant feeding, why was that?
   (TICK AS MANY BOXES AS YOU NEED)
   - Already decided to breastfeed
   - Already decided to provide infant formula
   - Already decided to combine breastfeeding and formula feeding
   - Printed information not clear
   - Advice not clear
   - Conflicting advice
   - Other (please specify)

10. What was the best thing you recall about the infant feeding advice you received from [name of service]?

   Type your answer here

11. Did you receive information or advice from other sources about breastfeeding?
   - Yes
   - No (please go to question 14)

12. What other sources provided information or advice to you?
   (TICK AS MANY BOXES AS YOU NEED)
   - Partner
   - Other family member (please specify)
   - Friend
   - Australian Breastfeeding Association
   - Other health staff (please specify)
   - Other source (internet, magazine, etc. – please specify)

13. How important was this advice in assisting your decisions about breastfeeding?
   - Very important
   - Somewhat important
   - Neither important nor unimportant
   - Not very important
   - Not at all important
14. This next set of statements is about your experiences with [name of service] staff.
(PLEASE TICK THE BOX THAT BEST DESCRIBES YOUR EXPERIENCE)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff arranged for my attendance at education session</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Staff were too busy to help me much</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Staff did not know answer to my question but offered to find information or advisor</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Staff were generally friendly and helpful</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Staff helped me to find specialist service</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Staff helped me to manage the problem and find a good solution</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

15. From your experience, if you could suggest one change to improve the way information and advice is provided to mothers using this service, what would it be?

Type your answer here

16. How is your infant currently fed? (please tick all that apply)

- [ ] Breast milk from the breast
- [ ] Expressed breast milk
- [ ] Infant formula
- [ ] Follow-on formula
- [ ] Water
- [ ] Other drinks (please specify)
- [ ] Soft/semi-solid foods
- [ ] Solid foods
- [ ] Other (please specify)
Finally, we’d like to know a little bit about you:

17. What is your date of birth?

18. What is your baby’s date of birth?

19. Are you of Aboriginal or Torres Strait Islander origin?
   
   For persons of both Aboriginal and Torres Strait Islander origin, mark both ‘Yes’ boxes
   
   [ ] No
   [ ] Yes, Aboriginal
   [ ] Yes, Torres Strait Islander

20. Do you identify with a culture other than Australian?
   
   [ ] NO - Go to question 25
   [ ] YES (please specify)

21. Do you speak a language other than English at home?
   
   [ ] NO
   [ ] YES (please specify)

22. Do you feel that [name of service] staff understood, respected and were responsive to your cultural needs in relation to breastfeeding? (Use the following scale to tick your response)
   
   [ ] Very responsive
   [ ] Somewhat responsive
   [ ] Neither responsive nor unresponsive
   [ ] Somewhat unresponsive
   [ ] Unresponsive

23. If possible, please provide an example of what helpful things staff did to respect your cultural needs in the box below.

   Type your answer here

24. If possible, please provide an example of what things staff might have done better to respect your cultural needs in the box below.

   Type your answer here

25. Is there anything else you would like to tell us about the service?

   Type your answer here

Thank you for taking the time to complete this survey.

(This instructions can be deleted once you have finalised your document.)
ADD HERE directions on what to do with the completed survey (e.g. please put your completed survey in the box at the reception desk.)