

Identifying and Using Community Development Measurement Tools: An Introductory Guide

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What measurement tools are used in community development?

Introduction

First, we have to define community development. Then it is useful to distinguish this from related terms such as *community organisation*, *community participation*, *community capacity* and *community competence*, and also *social capital* which has been recently framed as a community-level phenomenon. Then there is also the set of terms that come with the idea of *empowerment*.

Setting out definitions is a little tricky as the terms are used differently in various disciplines and the field is contested. The best approach therefore is to declare a disciplinary field and be consistent in the types of concepts framed by the different phrases, recognizing that one person's "organising" could still be seen as another person's "developing". But it's not semantic, or snobbish, to draw attention to the differences between these terms. It has deep implications for how actions at a community-level might be designed and measured. How we would design an intervention to impact on personal empowerment is quite different from what might do for community empowerment. Also as seen below, there is a hierarchy in the terms - community participation is a higher order construct, one that only makes sense after there has been some community development. Above all it helps to illustrate the theme of this paper - which is *that there is no one way to measure community development*. Rather there is a multitude of choices. These should be made according to how community action is fine tuned, that is, according to the context and time frame.



Definitions

Mainly within the disciplinary field of community psychology, (Rappaport, 1977; Rappaport *et al*, 1984; Levine and Perkins, 1997) the different terms would be set out and navigated in the following way.

The foundational term is **community development**. Let's start by assuming that Maslow's hierarchy of needs applies to the individual person. That is, after basic needs are met, like food and shelter, humans need to have higher order needs met, like self actualization. Recognising that humans live in societies because societies are essential for human development, community development refers to actions taken among people to develop links to others and capacity to meet human potential through how we identify with each other and live and work together. Community can be taken in two senses, as a locality or as the relational connections and ties of commonality or interest that draw people together (Heller, 1989). Community development can be thought of as all those actions that create sense of connection, meaning and shared purpose. This includes knowledge about self and other relations, identification with the community, skills in articulating needs, skills in communicating with others, and skills in acting collaboratively. The locality definition of community is an overlooked one. But it's important. In this day and age we need to be mindful of a definition of community that privileges links to people with common interests – that sets up potential divisiveness. There is value in people having a sense of connection or affiliation to people with diverse interests as well- e.g., the people in your neighbourhood. Community is also thought of as collective political power (Heller, 1989) – we come to this again later.

As soon as you ask yourself what the goal of community development is, you arrive in the literature about **community competence** and **community capacity building**. The idea that the outcome of community work should be to build a competent community which cares for its members and helps it cope or change with external forces was first posed by Ira Iscoe in 1974. Iscoe suggested that a competent community is one which is able to tackle the problems that beset it, harnessing skills, energies, wisdom and experience (both within the community and external to it) to achieve community-determined goals. Rappaport *et al* followed up in 1975 with the argument that assessment strategies in communities should be asset-based (rather than deficit-focused) in order to promote this more positive way of framing and building community strength. Note that this contribution was many years before John McKnight wrote about asset building in communities, although he is more widely credited with the idea.

Community capacity building became popular terminology towards the end of the 1990s and a strong emphasis was placed on capacity for problem solving as its main purpose (Hawe *et al*, 1997). Community capacity building was either undertaken for its own sake, as direct way to promote health and well being, or as a secondary or parallel arm of activity alongside a program dealing more directly with say, heart disease prevention, or teenage pregnancy. A seminal paper by Goodman and colleagues defined 10 dimensions of community capacity (i.e., things seen as essential for problem solving or community



competence). These were: sense of community, citizen participation, understanding of community history, resources, networks and inter-organisational relationships, leadership, skills, a sense of the community's values, power and critical reflexivity (Goodman *et al*, 1998).

Community organisation is the identification, sorting, coordinating and harnessing of community resources for community action. It comes after community development – because you have to something there to organize. That is, people have to basic skills, knowledge, linkages and capacities so that they *can be* effectively organised around some issue, like collective action to get more child care, or to prevent a rail closure. If people are so oppressed by their own affairs, so impoverished or so unconnected with the rest of the community, that they cannot take part in community organizing, then this is a cue to the practitioner that the starting point has to be community development not community organizing. Both community development and community organisation might be required before there is effective meaningful **community participation**- that is, participation by people as citizen in the decisions and democratic machinery that affect their lives. Community development, community organising and community participation are terms often thought of as a continuum and subsumed into the term community capacity building. (Figure 1).

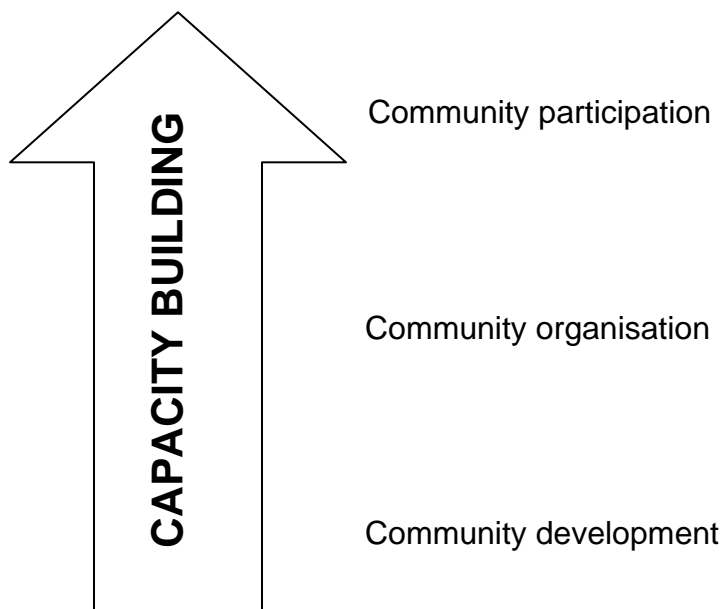


Figure 1. Conceptual linkages among some key terms



Empowerment is a term with its own history. In community psychology it was first put forward in the early 1980s by Rappaport as a way to build a bridge between community development and social action, in terms of ways of working with communities (Rappaport, 1981, 1984). Community development had been criticised at the time for being too politically conservative, for possibly focusing people on solutions which were over localized and not getting at the root causes of problems. Empowerment was originally defined as “to enhance the possibilities of people to control their own lives” (1981) and then was revised to become “the process by which people, organisations and communities gain mastery over their lives” (1984). Empowerment is a multi level construct and it has been cogently demonstrated that we can have empowerment at one level and not another (Zimmerman, 1990). For example, empowered organisations- ones that are successful in influencing the policy process and remaining viable over time are not necessarily empowering organisations - ones that develop psychological empowerment within the members of the organisation. Take AA (Alcoholic Anonymous) for example. It may be an empowering organisation for the individuals who join it but you don’t see AA contributing to the larger policy debates that could influence alcohol consumption in the population as a whole (e.g., support for random breath testing, responsible server policies, enforcement of restrictions on sales to minors). Biegel (1984) also argues the notion that empowerment must embrace two concepts: capacity *and* equity. By “equity” he means getting one’s fair share of resources.

Social capital is a term that became popular after Robert Putnam wrote his book ‘Bowling Alone’, which conjured up the idea of a future America where people have lost connection with family and friends. Although Putnam’s original work examined social capital in terms of things like voter turnout to elections, Ichiro Kawachi (a social epidemiologist) was the route to social capital’s prominence in health research because he showed a relationship between social trust and death rates measured at a state level, opportunistically in a large scale USA national survey (arguing that social trust is part of social capital.) Since that time the definition of social capital has been vexed (Hawe and Shiell, 2000). The World Bank has invested a lot in the development of social capital research and they define social capital as norms and networks that enable people to act collectively (Woolcock and Narayan, 2000). The alternative view (and one that we hold) is that social capital is the resources that people get from their social networks (e.g., information, practical aid, role models for ideas, etc) (Moore *et al*, 2005; 2006). Trust is an important social variable, as is collective behaviour, but we believe these are concepts best understood and studied as variables with integrity of their own. This is not just academic argy-bargy. We bother about these distinctions because how you would design an intervention to “increase social capital” and how you would measure an increase in “social capital” as a result, would be different if one person was essentially talking about trust, but another meant collective action, and another mutual aid and so on. Precision really matters.

One place to see this play out is in how people talk about social capital and health inequalities. It has become popular to think that strengthening social capital will improve the lot of our poorest segments of society. This is associated with Putnam and Kawachi’s views and those of the World Bank. The alternative is to take the opinion that the



resources we get from our social networks (i.e., the alternative way of viewing social capital) helps to drive those inequalities. That is, people at the top can access more (information, assistance, advice, power, etc) and advantage themselves further. In that sense social capital is the means by which social inequalities (and the health inequalities that result from them) are perpetuated.

Implications for measurement tools

It follows that *if you define things differently, you measure things differently.*

The World Bank has produced a book on *measuring social capital* (Grootaert and van Bastelaer, 2002). Their Social Capital Assessment Tool (SOCAT) can be downloaded from a CD rom that comes with the book. It assesses social capital at the level of the household, the community and the organization. The household questionnaire (designed for all residents) asks about: demographics, the house's building materials and amenities, membership of groups and associations, the characteristics of up to 3 of those groups and organisations, the decision making style of those groups and organizations, the effectiveness of the group or organization's leadership, the extent to which respondents think they have gained skills from being members of this group or organisation, various questions about how this village/neighbourhood would respond to scenarios affecting the whole village/neighbourhood, how differences in gender/wealth/age cause social divides, access to services, collective actions taken to address community issues, community spirit in terms of participation in its own affairs, extent to which people feel they can make a difference to local events, who they would turn to for help in various scenarios, trust and cooperation, how conflicts and disagreements are usually handled at a village/neighbourhood level.

Many of the items in the SOCAT are based on well researched concepts that have existed in the sociology and community psychology literatures for some time, such as sense of community, community attachment, collective efficacy, i.e., community confidence in problem solving together (Chavis & Pretty, 2000; Craig & Maggiotto, 1982; Kasarda & Janowitz, 1974). They are useful and valid. We just don't agree that it helps to call this collection of separate constructs "social capital".

Empowerment measurement tool development predates a lot of the social capital work as well and the accomplishments in this field are best exemplified in the work of Barbara Israel, Amy Schulz, Marc Zimmerman and colleagues who have been developing ways to assess and capture the effects of community development interventions in low income racially segregated Detroit neighbourhoods for a period of 20 years. They have developed measures at an individual, organisational and community levels (Israel *et al*, 1992; Israel *et al*, 1994; Parker *et al*, 1998; Parker *et al*, 2001; Schulz *et al*, 1995; Schulz *et al*, 1997; Schulz *et al*, 1998; Schulz *et al*, 2002; Zimmerman *et al*, 1988; Zimmerman & Rappaport, 1990; Zimmerman, 1992). They appear to have done the most work of research teams anywhere trying to disentangle 'real' community-level effects from what could just be thought of as the aggregated responses of individuals.



This is a very important idea. Empowered individuals don't necessarily add up to an empowered community. Indeed the tendency to "individualise" community development (*and* community empowerment *and* social capital...) continues to plague this field (Shiell and Hawe, 1996). It is only likely to be handled better when we move away from the reliance on measures on individuals and start measuring the properties of different units - either constituents of communities (like organisations and groups, and there has been some progress in this domain) or the characteristics and structure of the networks which link people and groups and surpass geographic boundaries.

Measuring people's personal social networks has a long history and this field is already well developed as a means to assess people's well being and to assess the impact of interventions to improve well being (Israel, 1985). In the last decade or so people have also started ***measuring the networks of community groups and organisations*** as a way of getting a handle on collaboration patterns in communities (Provan and Milward, 1995). Tracking changes in collaboration networks has been suggested as a means to assess the impact of community development interventions (Hawe *et al*, 2004). It has also been used as a means to assess different levels of capacity among groups tackling various types of problems at a community-level. The pioneer in this field was Wickizer who examined and compared the density of the networks of agencies tackling issues like tobacco control with those in adolescent pregnancy and drug abuse prevention (Wickizer *et al*, 1993) in California.

Our research team at the Population Health Intervention Research Centre has an established program of work using social network analysis (see website for SNAP- Social Network Analysis Program under "research" at www.ucalgary.ca/PHIRC). We are examining inter-agency networks in a low income Calgary neighbourhood; maternal and child health networks in Australia; a Safe Communities city-level project in Australia; and the process of interdisciplinary research collaborations (a case study across USA, Canada, Australia and the UK). We are also using these methods to investigate social networks of children and adolescents in Calgary schools and to evaluate the impact of organizational development interventions in schools with teachers. Also, among women living in low income neighbourhoods of Calgary, we have investigated whether personal social networks influence the preferences recent mothers have for different types of perinatal care (e.g., nursing, lay home visitor programs).

In the Australian state of New South Wales ***measurement of capacity building*** was kick started in the late 1990s when the state health department there initiated a series of research grants over a period of several years designed to get practitioners in the health services (clinicians) interested in devising ways to measure health outcomes. This was part of an accountability drive that recognized, first and foremost, that the people delivering the services should have a say in designing the means to assess their effectiveness. While the bulk of the grants were awarded to asthma specialists, surgeons, cancer services, primary care and so on, a proportion of funds was awarded to prevention practitioners, in particular those working in health promotion who wished to assess the "invisible side" of health promotion - that is, the capacity building done with colleagues,



teams and communities to increase their problem solving capacity. The argument was that for a health promotion program to be truly worthwhile, it should not just have a measurable impact on the problem it hand. It should make a sustained difference to how the community would deal with the next problem it wished to tackle. Practitioners, organisations and residents should be rendered more capable and better prepared, so that subsequent program work would be easier and more likely to be successful. A program of work across three years involving focus groups with practitioners, literature review and the developing and testing of indicators of capacity led to the development and publication of nine checklists that are used extensively in Australia and also to a lesser degree elsewhere (Hawe, *et al*, 1997, Hawe *et al*, 1998, Hawe *et al*, 2000).

The Australian checklists were mostly focused on problem solving capacity, as opposed to capacity to deliver a particular type of service or intervention (a notion more akin to workforce competencies) but they also included an instrument to assess the likelihood that a particular program would be sustained after a period of initial funding. All checklists were field tested for face validity and utility and eight checklists were subject to inter-rater reliability checking and internal reliability.

See www.health.nsw.gov.au/public-health/health-promotion/capacity-building/indicators/index.html for (1) a copy of the literature review and theory used to guide the endeavour, (2) the checklists and (3) some case studies of their use in a variety of settings by practitioners. The checklists were designed to encourage practitioners to think about the people, processes and environment of everyday practice within which there are factors either working positively (to create capacity) or negatively (to work against it). Overall, they define capacity in terms of commitment, skills and resources for action, focusing on the conditions for these things to be created and maintained.

The eight checklists are:

- 1 assessing the strength of a **coalition** (collaboration of agencies and organisations)
- 2 assessing opportunities for **incidental learning** among health practitioners
- 3 assessing opportunities for **informal learning** among health practitioners
- 4 assessing if a program is likely to be **sustained**
- 5 assessing the **learning environment of a team** or group
- 6 assessing capacity for **organisational learning**
- 7 assessing **capacity of a particular organization** to tackle a particular health issue
- 8 assessing the **quality of program planning**
- 9 assessing **community capacity** to tackle community issues

The final checklist was not field tested in communities due to funding constraints. It was developed and tested with community development practitioners only. We had one concern with it. Although, like Goodman *et al* (1998), we could come up with ideas for appropriate domains for assessment of community capacity, two things remained unresolved: (1) how would these domains (like sense of community) be manifested in different cultural contexts; and (2) who is to say what emphasis or quantitative weight should be given to each domain - assuming of course that not all domains are equally



important to each community or relevant in the context of particular programs. We could take this instrument no further without confronting these issues by researching them more fully. We did not wish to contribute to the problem that “community” measures have inherent problematic tendencies to individualise macro level phenomena (Shiell and Hawe, 1996).

Gibbon, Labonte and Laverack (2002) have built on and expanded on the community capacity checklist. Although, like us, we note that these and other authors are now similarly cautious about whether whole-community checklists can ever overcome some of the unresolved issues mentioned above (Laverack and Wallerstein 2001).

Work by subsequent investigators has developed some of the checklist areas more extensively, such as Branner and Sharpe’s helpful review of coalition measurements (2004). Rosenthal has published a checklist on racial and cultural inclusivity of coalitions (Rosenthal, 1997). An instrument has been developed by Schulz and her colleagues to assess the climate created within community-research partnerships and its conduciveness for promoting productive, satisfying and effective work (Schulz, *et al* 2003).

Overall, the literature reveals a wide array of measures that can be used in different contexts depending on what the focus of action is. *Measures are operationalised at different levels (individual, group, organisation) and the focus is on knowledge, skills, attitudes, resources, structures, processes or procedures.* This draws attention to the fact that the “best measures” are those that exactly fit the context and purpose within which they will be used. There is also no one best “overall” measure. Rather capacity or empowerment across a community might best be thought of as a layered mosaic, with each piece appropriate to the particular context of action or level of accountability. So, an intervention which increases people’s sense of connection or attachment to place might be appropriately assessed with a sense of community measure. But this is not the same as saying “this intervention increased this community’s strength or capacity.” You could only say “this intervention increased people’s average sense of community.” To say that an intervention increased community capacity you would need to draw in evidence of other changes in other structures (groups, organisations and networks) and, by laying the changes side-by-side or layer-by-layer, show that the picture overall has changed. More on this later.

It should be noted that relative to measures used in clinical contexts, like blood pressure or depression, the field of measurement in community development, community empowerment or community capacity building is still very new. This means that while most measures have passed “the first test” in that they seem to measure things that look sensible, are theoretically valid and have acceptable psychometric qualities; this is not the same as what is considered “the real test.” This refers to whether they are sensitive to change. In other words, the sensitivity of empowerment measures to actual changes in empowerment or the sensitivity of capacity measures to actual changes in capacity is for the most part not yet tested. There is a LOT of work still to be done. Also because there are relatively few applications of instruments to field contexts there is a paucity of comparison data. That is, once you measure, say, coalition functioning or density of



collaborative networks in your community, how do you know if “yours” is better or worse than elsewhere? This is becoming less of a problem for some established measures, like sense of community indices (Chavis and Pretty, 1999). Nonetheless even in the *absence of what is known as “normative data” for many instruments*, people report that filling out checklists creates new conversations about projects and surfaces ideas and values previously unknown. In and of itself this helps with evaluation and practice improvement.

What are some examples of best practices in the field of evaluation in community development?

There are three dimensions to consider when considering best practice in evaluation.

- how well did the measures chosen in the evaluation reflect the values of the program and the people associated with it
- how well were the intended beneficiaries of the program involved with its planning and evaluation (this is particularly important in community development evaluation)
- how well did the study design and execution capture program processes and effects and rule out rival explanations as to why effects occurred

These will be discussed in turn with examples to illustrate “best practice” methods and processes.

Getting the right measure for the program

In 1977 Joseph Wholey coined the term “evaluability assessment” to refer to the process of becoming familiar with a program and getting it ready for evaluation. A series of seven steps have become customarily associated with evaluability assessment and it has become routine practice in fields like health promotion. Time and care taken to do this process is a sign of good practice (Hawe *et al*, 1990, Thurston and Potvin 2003).

One part of the evaluability assessment process is to engage the program staff and intended beneficiaries/participants in dialogue about the objectives of programs and what they might mean. For example vague objectives “like to empower people” have to be translated and operationalised into recognizable activities leading to unambiguous outcomes in order to be evaluated. Teasing out the program logic in this way and trying on different ways of thinking about program activities and effects is what evaluability assessment is all about. So, prior to measurement, the program activities might be changed to better match the goals. Alternatively the goals might be changed to better fit



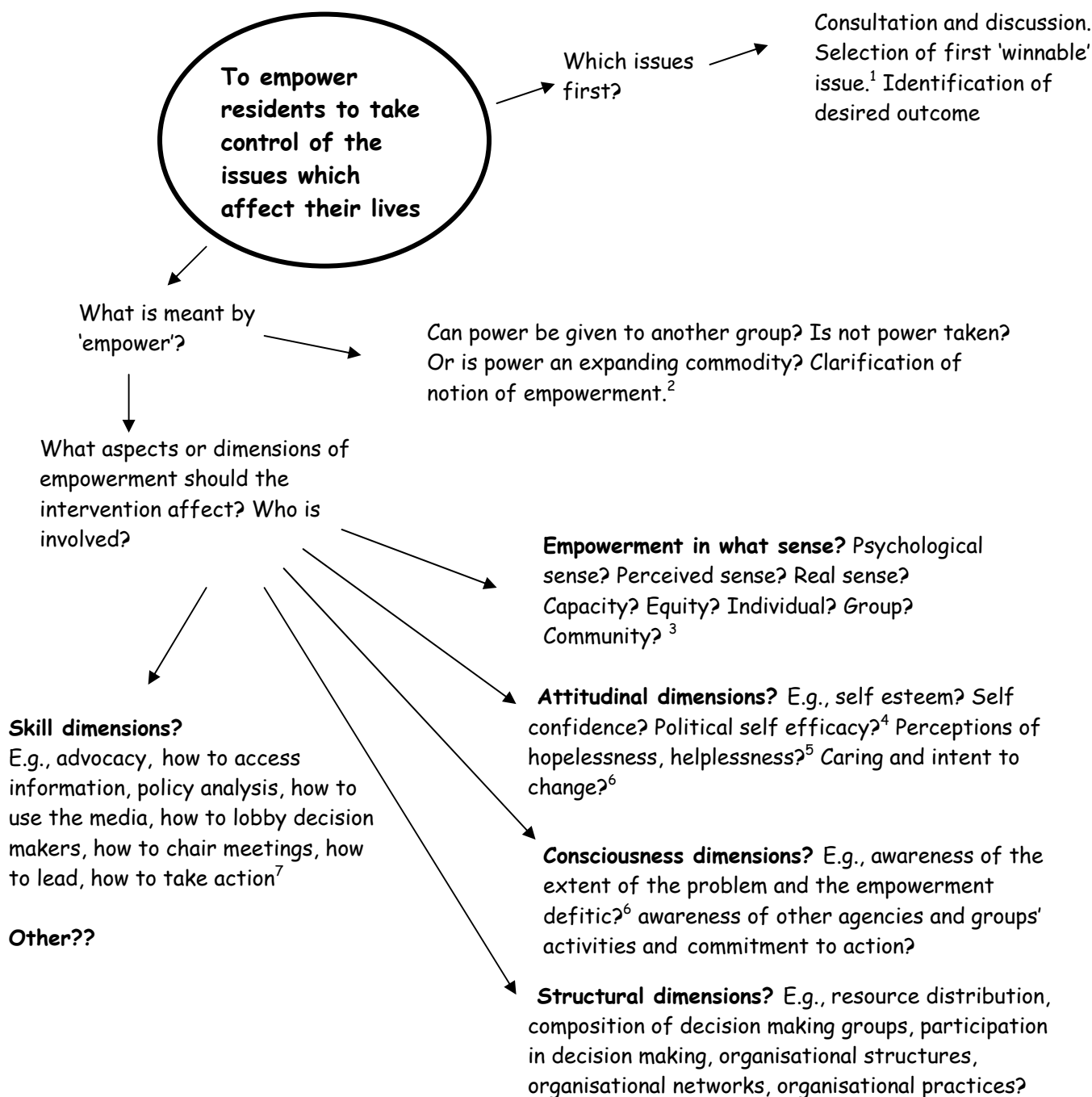
the program. Either way talking about how something might be measured surfaces ideas, contradictions and viewpoints that might otherwise go undetected.

Figure 2 is a reproduction of “white board style” dialogue undertaken during evaluability assessment with an economically depressed rural community involved in the design of a community development intervention (taken from Hawe, 1994). The central objective was “to empower residents to take control of the issues which affect their lives”. But to make this evaluable, each assumption and idea in the objective had to be dissected and talked about as the Figure records, in order to decide exactly *what the intervention could achieve in the time frame and how that effect could be captured in the evaluation design*. The references attached to each of the “arrival points” in the discussion refer to the theory and evidence available to back up the distinctions made. For example, attitudinal dimensions of empowerment are diverse. Political self efficacy (i.e., confidence in ones own ability to influence the political process) is a laudable and measurable goal of an empowerment program. But it’s not the same as self esteem. It’s also a different ball game to the notion of learned helplessness, which has been applied to community development thinking and processes - a seminal paper from South Africa is notable on this point (Gordon, 1985). The point is that these fine nuances have to be brought out so that precise constructs (or even sub constructs) can be pinpointed as candidate evaluation measures. To not do this would risk constructing an evaluation which showed “no program effect” simply because the wrong measure was used. This is considered a cardinal sin in the evaluation field!

The advantage of the process is that once the appropriate measure appears to have been identified, program planners can go back and check that everything that they are doing in the program makes sense in terms of having a likely effect on that measure. It can be a very positive and valuable process. At the end of it agreement should be reached on what is to be measured, and why, and people should be confident that this will capture the true ‘essence’ or value of the program. It makes the program stronger.



Figure 2 Interactive dialogue to help clarify an objective prior to evaluation.



1 Minkler (1990); 2 Gruber & Trickett (1987), Heller (1989), Swift & Levin (1987); 3 Biegel (1984), Zimmerman & Rappaport (1988), Zimmerman (1990); 4 Craig & Maggionto (1982); 5 Gordon (1985); 6 Friere (1973), Swift & Levin (1987); 7 Balcazar et al (1990)

Reproduced from Hawe P. (1994) Capturing the meaning of 'community' in community intervention evaluation *Health Promotion International* 9(3):199-210.



Getting the community involved in the evaluation design

Participatory action research has a long tradition with many projects now giving insights into meaningful ways communities can be involved in choosing evaluation measures and collecting, analysing and interpreting data. Evaluation skill building is part and parcel of this approach and there are numerous texts and articles that point out best practice (Israel *et al*, 1998; Minkler & Wallerstein, 2003). Occasionally there are articles that discuss what goes wrong when the community is involved in the evaluation. These accounts are especially useful (Smith *et al*, submitted)

The term '*empowerment evaluation*' has become popularized to reflect this field (Fetterman *et al*, 1996). It incorporates similar ideas to the interactive dialogue reflected in the earlier section and it is committed to participative processes and decision sharing. Investigators have developed logs to capture changes in people's lives as a result of being involved in participatory projects and their evaluation. For example, Mayer (1996) has published a checklist for women engaged in empowering evaluation activities to record actions and decisions taken on their part that have improved their lives. The log-keeping idea builds on work by Francisco *et al* (1993) who published a method for community coalitions to record their actions and impacts on policy, environments, the media and so on. Our team has used Francisco's methods as part of a study of 8 communities over 2 years engaged in a community development intervention to prevent post natal depression. Part of the value is the approach can be tailored to your own context – that is, you can choose to identify and count events in whatever domains you and your community choose. They provide a guide.

There are now systematic overviews of best practice in getting communities involved in research (Israel *et al*, 1998) as well as instruments to assess the degree to which communities have been involved in the planning, conduct and evaluation of particular projects (Bjaras *et al*, 1991). Additionally, there are tools to assess how well community partnerships are functioning (Schulz *et al*, 2003), as mentioned previously. Visible and mutually agreed "rules for engagement" are an example of best practice illustrated in these reviews. Hausman *et al* (2005) have recognised that for so called "indicator-development work" with communities to be successful we need to use methods which explicitly surface the different reason why different parties/organisations may wish to be involved with a project. They call this their "value template process." Recognising that it takes a particular skill set and readiness to work well with communities, a checklist has even been devised to help local health authorities assess their own capacity to venture into this domain (Parker *et al*, 2003).

Participatory community methods for evaluation are also linked with community program planning and design. There are numerous outstanding resources and tools for this purpose, the foremost being the Community Toolbox launched and maintained by the community psychology group at the University of Kansas (see <http://ctb.ku.edu>). Another highly recommended resource is Funnell *et al* (1995) on building healthier alliances (i.e., coalitions or community collaboratives).



Another stream of development in participatory evaluation has been the use of story and dialogue methods to help communities talk through the meaning of programs, their impact and their value. Some of the original work in this field was first undertaken by the Centre for Community Development in Health (1993) in Australia and further developed there by Dixon (1995). It was then adapted and brought to Canada by Labonte *et al* (1999). Story methods have not only been useful for tapping community perspectives, they have been useful in capturing the struggles and strategies of practitioners themselves, and for uncovering the “hidden” theories of community development practice (Riley and Hawe, 2005; Hawe and Riley, 2005).

Study designs and methods

It is beyond the scope of this paper to systematically review all evaluations of community development and community capacity building that have been published. Instead a flavour of the range of methods, and their usefulness, will be given. There are *plenty* of reports of needs assessments and projects, but sadly not much systematic assessment of impacts these projects make as yet.

| Study type | Brief description | Strengths and weaknesses of the design | Comments | Examples |
|------------------------|--|--|--|--|
| Case study | Data, usually both quantitative and qualitative are provided about an intervention, often from the needs assessment phase right through to the evaluation. | We get a lot of data and description of what happened. Down side is that you can't be sure that any changes observed were due to the intervention (i.e., no comparison group) so you have to look to corroborating evidence in the evaluation | This is the most common way of evaluating a community development project. | Biegel (1984) Raeburn (1986) Minkler (1986) Minkler et al (1993) Szendre & Jose (1996) |
| Pre-post survey design | Quantitative data is collected before and after the intervention. Sometimes qualitative data is collected also | Better than a case study for making causal inferences. You still can't be sure that the intervention caused the effect so you still require corroborating evidence in the evaluation | A good way to assess impact on variables like sense of community, collective efficacy, etc., provided that the sample size is sufficient to detect an effect | Hawe, Chapman & Farish (1995) Collins & Benedict (2006) |



| Study type | Brief description | Strengths and weaknesses of the design | Comments | Examples |
|-------------------------|---|--|---|--|
| Time series design | Examines the impact of an intervention on a particular variable over time. i.e., multiple time points (before before before, after after after) | Better than a case study, or a pre and post, for making causal inferences, but the down side is that the focus of the evaluation is often limited to one or two things and always to data on which there are historical, objective records | Under utilised in community development evaluation but can draw on simple data sources like meeting minutes, attendance records etc depending on the focus of the intervention. Hence can be quite inexpensive. | Balcazar et al (1990) Francisco, et al (1993) Hawe & Stickney (1997) |
| Comparison group design | Compares the intervention community with one or more similar others who don't receive the intervention, and pre and post test scores, of the health or social problem | More convincing in terms of causal inferences. Hard to find comparison communities that might be otherwise considered "equal" | Rarely used (can be expensive) but very useful for skeptics who have trouble believing that an intervention 'worked' | Vincent et al (1987) Heller et al (1991) |

Conclusion

It should be clear that there is an extensive range of tools and opportunities and that some domains are better developed than others.

The bottom line is that *there is no "one size fits all" approach*. Measurement always has to be specific to the context and purpose of the program or intervention, which has to be articulated in terms of particular changes in particular people or organisations or communities. Be suspicious of people saying that any particular tool "measures community development." Every tool necessarily privileges some values or processes over others. It's up to you to bring those values and processes to the surface - to make them explicit - and then decide if it fits your particular case. A tool that is too blunt for your purpose (i.e., insensitive to the actual changes you are bringing about) will make it look like you have failed. Your duty of care is to the community you serve – you owe it to them to accurately capture "the magic" of what your work with them has been achieving by selecting the right tool.



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