Cordaid's experiences with and lessons learned on Participatory Impact Assessment

Cordaid

- ✓ Almost 900 partner organisations in 28 countries.

- ✓ Programmes:
  - ❖ Conflicttransformation
  - ❖ Disaster risk reduction and emergency response
  - ❖ Health & Wellbeing
  - ❖ Entrepreneurship & microfinance

Why Participatory Impact Assessment?

Partner organisations in general have well-developed informal feedback mechanisms

But:

- Reports and project evaluations don't give information on impact and little on outcome
- No use of comparison: no baseline data or triangulation
- Programme evaluations commissioned by Cordaid for accountability face the problem of lack of data, and therefore their quality is often substandard

Why Participatory Impact Assessment? (cont.)

- Growing public and political pressure on development organisations to show results/outcome
- CIDIN (Dutch research institute) proposed Cordaid to pilot methodology for Impact Assessment. CIDIN is responsible for data gathering and processing, Cordaid finances pilot and connects with partner organisations
- Methodology is based on with/without + before/after as a principle for evidence based impact assessment.

Objectives of Participatory Impact Assessement

a) Design and implementation of a participatory system for impact assessment
b) Generation of complementary insights from different methods, both quantitative and qualitative in PIA
c) Strengthening the capacity of partner organisations in using impact assessment as an instrument for monitoring, learning, accountability and innovation
d) Use the results of the impact assessment at the level of Cordaid for evaluation, learning, accountability and innovation

Table 1. OVERVIEW OF PIA PARTNERS/PROJECTS

Country	Programme	NGO				ACADEMIC	
		Name of partner organization	Location of partner	Name and location of project	Keywords of project intervention	Name of partner organization	Location of partner
Peru	Slumdwellers [P2]	Promoción del Desarrollo Sostenible (IPES)	Lima	*Barrio Saludable* [Healthy Neighbourhood] - Lomo de Corvina (Villa El Salvador)	Health education, hygiene practices, rational water use, environmental upgrading, strengthening local governance	Grupo de Análisis para el Desarrollo (GRADE)	Lima
		Guaman Poma de Ayala (GPA)	Cusco	Improvement of sanitary conditions in urban centre of Huasao	Access to basic services (water & sanitation), technical improvement of public systems, prevention of water-borne diseases, rational water use	Grupo de Análisis para el Desarrollo (GRADE)	Lima
Ghana	Access to Health [P6]	Catholic Diocese of Goaso	Goaso (Brong-Ahafo)	Health services provided by St. Elisabeth hospital in Hwidiem	Malaria prevention, safe motherhood, health education, HIV/AIDS	ISSER, Legon University Catholic University College of Ghana	Accra Sunyani
		Catholic Diocese of Navrongo-Bolgatanga	Bolgatanga, (Upper East)	Health services provided by three rural health clinics (Nakolo, Logre & Zorko)	Malaria prevention, safe motherhood, health education, HIV/AIDS	ISSER, Legon University Navrongo Health Research Centre	Accra Navrongo
India	Small Producers [P9]	Himalaya Action Research Centre (HARC)	Dehradun, (Uttarakhand)	Linking small farmers in Devrana Valley to markets	Farmers' federation, technological upgrading, organic agriculture, inclusion in dynamic value chains	Centre for Sustainable Development	Mussoorie / Dehradun
		Center for Development Research and Training (CENDERET)	Bhubaneswar (Orissa)	Women Empowerment through Self-Help (WETSH) Bolangir & Puri district	Savings and credit SHGs, legal empowerment of women, business development training	Xavier Institute of Management (XIM)	Bhubaneswar

Methodological approach

- **Strong statistical design (quasi-experimental);**
  - Counterfactual reconstructed through control group(s)
  - Interventions are not randomly assigned, but..
  - **Selection bias** minimized by *difference-in-difference estimation* (DiD) on matched sample
- **Mixed methods;**
  - Qualitative inquires to obtain richer picture of how interventions affect people's lives and to reveal underlying processes and societal transformations
  - Close monitoring of project progress to distinguish between *design failure* and *implementation failure*

Methodological approach (cont.)

- **Focus on *attitudes / capacities* required to sustain impact;**
  - Examples: trust, self-esteem, patience, locus of control, capacity to aspire, risk aversion, etc.
  - Survey results triangulated with qualitative studies and/or field experiments
- **Participatory (at level of partner organisation);**
  - Partner organisations involved in design, discussion on findings
  - Ultimate beneficiaries not involved in design, but can voice their opinion on project and are debriefed on survey results (pilot debriefing with treatment and control groups)

Methodological approach (cont.)

- **What's new?**
  - Using control groups and baselines: this is no common practice for (Dutch) NGO's like Cordaid, nor for partner organisations.
  - Added dimensions of attitudinal and subjective well-being indicators are innovative in impact assessment; f.i. trust in different actors
  - Participatory design: partners were involved in design and choosing control groups; discussion of results, etc.
  - Feedback: Results of surveys were discussed with treatment and control groups in one area.

Process from 2007 – 2010

- 2 partners in Ghana (health care), 2 partners in India (income generation), 2 partners in Peru (water & sanitation)
- 2007: ‘Design workshops’ in each country with the two partners and local research institutes, to develop the indicators for the impact assessment
- 2008: 6 base line surveys and some additional qualitative research

Process from 2007 – 2010 (cont.)

2008: ‘Feed back workshops’ with partner organisations and research institutes to discuss findings of baseline

2009 – 2010: follow-up surveys
feed-back discussion with beneficiaries and control groups in Ghana

July 2010: conference with all participants (partner organisations, local research institutes, CIDIN, Cordaid) to discuss process, results, lessons learned and next steps.

Preliminary insights of PIA

Illustration: Impact of Diocesan hospital services in Ghana

- High client satisfaction and trust. Insight in accessibility of curative and preventive services. As a result of PIA Diocese now focuses more on education in further away areas
- Comparison of insecticide-treated bednet (ITN) use between treatment and control communities suggests perverse incentive of access to *curative* care on *preventive* efforts. National health insurance (NHI) scheme reinforces incentive problem

Preliminary insights of PIA (cont.)

Illustration: Qualitative study on access to women self-help groups (SHGs) in Orissa, India

- In-depth interviews reveal that SHG access for young married women crucially hinges on attitude (conservative vs. liberal) of family-in-law, in particular mother-in-law

Illustration: Impact of water & sanitation project in Cusco, Peru

- Incidence of diarrhea decreased in households that received health education and water meters. There is a strong complementarity between the introduction of water meters and health education.

Possibilities of PIA

- Baseline and follow-up surveys, complemented with qualitative research, gave some new insights in interventions (also unintended effects)
- Surveys give detailed information at the level of beneficiaries (surprisingly enough this level of information was not always available before)
- Can be used to ‘ test’ different interventions and compare them

Possibilities of PIA (cont.)

- “Data and Dialogue”: information gives important input in discussion on intervention strategies, choice of beneficiaries, etc.
- Increased understanding and cooperation between ‘researchers’ and ‘development practitioners’
- (Some) Partnerorganisations see it as a possibility to attract other donor funds (that require evidence based assessment), esp. in Peru (Cordaid is withdrawing)

Limitations of PIA

- PIA ‘dictates’ what to measure: specific interventions at household level. Doesn’t give information on systemlevel, power relations, etc.

  => Interventions of partners are much broader than what has been included in the PIA.

- Control groups are difficult to define, spillover is a real problem. Also ‘indirect’ spillover f.i. as a result of influencing local politics
- Requires quite sophisticated knowledge on statistical data analysis, this limits ownership of methodology with partner organisations

Limitations of PIA (cont.)

- Not all indicators can be measured through surveys.
- Evidence is context specific, interventions are not necessarily effective in other context.
- It is not possible to generalise the evidence at project level to the effectiveness of a programme (consisting of more than 100 projects/partners), therefore use for accountability at level of Cordaid is very limited.

Limitations of PIA (cont.)

- Cracking a nut with a sledgehammer? Costs and time invested are very high (€ 150.000 a year PIA/ € 575.000 total investment Cordaid in 6 projects = 26%)
- Participation of partners and communities in PIA has its limits because of the rigour in methodological set-up, data gathering, etc.

Conclusion/discussion

- Pressure on more quantitative data has been translated (by researchers) in a quasi experimental statistical design as ‘ only’ way
- Evidence based should be improved, but quasi experimental design is not appropriate for most of the development Cordaid and its partners are involved in.
- Impact evaluation should follow the nature of development, not the other way around. Applying one specific method for impact assessment for different interventions is not realistic, design has to be flexible.

Conclusion/discussion (cont.)

- Cost effectiveness should be taken into account, although more resources are needed to improve M&E practice. But PIA turns out to be too expensive (replication will not be cheaper, because of intensive data gathering and data analysis)

Way forward

- Dutch Ministry demands this methodology (control groups or reference activities, baseline and representative sampling) for the evaluation of the funding period 2011 – 2015, although our own overall conclusion is not positive.
- Dutch cofinancing alliances decided to join forces to respond more easily to these requirements. A sample of 50 projects (out of 18 alliances) in 8 countries will be evaluated with baseline and control/reference.
- Proposal will be presented April 1st. Further discussion on rigorousness will follow.

Way forward

The joint evaluation for accountability purposes gives new opportunities to develop our ‘own’ monitoring, evaluation and learning approach.

This will be more oriented to:

- Development of theories of change, and underlying assumptions, together with actors involved.
- Include roles of stakeholders, their mindsets and relations.
- Invest in continuous learning and adaptability of interventions.

Participatory Impact Assessment (PIA)

Partners in PIA

• Catholic Diocese of Navrongo-Bolgatanga • Catholic Diocese of Goaso • Catholic University College Ghana - Sunyani • Navrongo Health Research Centre • ISSER / Legon University - Accra • Promoción del Desarrollo Sostenible - Lima • Guaman Poma de Ayala - Cusco • GRADE (Grupo de Análisis para el Desarrollo) - Lima • CENDERET (Center for Development Research and Training) - Bhubaneswar • XIMB (Xavier Institute of Management) - Bhubaneswar • Himalaya Action Research Center - Dehradun • Centre for Sustainable Development - Mussoorie