ANALYTIC FRAMEWORK MODEL

Guidance Document for Baseline Development and Analyses of Pilot Interventions

Working with Communities to Reduce Health Inequalities: Protecting Children and Young People from Tobacco

(CHI-CY-TOBACCO)

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1. Introduction

1.1 Purpose of the Document

1.1.1 This document has two main purposes. First and foremost, it sets out the approach to be adopted in conducting analyses of the pilot interventions within the DG Sanco supported, CHI-CY-Tobacco project[1] - a project that focuses on protecting children and young people from tobacco by working with peer advocates and local communities. Secondly, this document will contribute to the development of a cross-cultural tool-kit to support interventions that engage local communities and peer groups to achieve tobacco control priorities.

1.1.2 This document sets out a framework and guidelines for the overall analysis of the pilot interventions. The framework incorporates establishing baselines and conducting qualitative analyses of the pilot interventions. It builds on and updates the preliminary evaluation model that was developed through earlier collaboration between many of the partners who are part of the CHI-CY-Tobacco project, that was funded by Liverpool Primary Care Trust. It also takes into account partnership opportunities that have emerged with CDC and its involvement in global tobacco surveillance.

[1] This document relates to deliverable 2 set out in the project contract between Liverpool PCT and the PHEA. The deliverable is part of Work Package 5 – *Analysis: Developing the analytic model and conducting analyses of process and impact*. Work Package 5 is led by Veneto Region

1.2 Context for the Analytic Framework Model

1.2.1 The analytic framework model set out in this document has been shaped to be applied to the specific pilot interventions that form part of the CHI-CY-Tobacco project. The project incorporates two distinct types of pilot interventions:

(1) First, partners from France, Latvia and the UK (Liverpool) are implementing pilot projects focusing on peer-to-peer interventions to raise awareness about tobacco-related issues and reduce smoking prevalence amongst 11 to 15 year olds. *Group A pilots.*

(2) Second, partners from Italy, Romania and the UK (Manchester / Barnardo's) are implementing pilot interventions that focus on engaging communities in protecting children from exposure to second-hand smoke. *Group B pilots.*

1.2.2 For both these type of projects, the broad approach that they are adopting is set out in the accompanying project document *Guidelines for Comparable Interventions.* Clearly, however, the projects are not exact replicas of each other. Their development is influenced by their specific socio-economic, cultural and political contexts and the precise details of the projects reflect local circumstances, experiences and practices.

1.2.3 Within each type of pilot, the primary purpose is to test innovative interventions in a way that can inform future practice and policies. Broadly, the analyses will assess effectiveness, identify outputs, assess impact and health outcomes and highlight good practice. The assessments will provide an analysis across four key dimensions. They will analyse:

(1) the effectiveness of the process of community engagement and peer to peer working;

(2) the effectiveness of the pilot interventions in achieving their tobacco control objectives;

(3) the consistency and cost-effectiveness of the project strategy, action plan and materials used;

(4) the transferability of the model of engagement and the tobacco control intervention

1.2.4 Key to achieving these goals is the need for projects to be assessed in the most robust way feasible - within the parameters of the project and the time and resources available.

1.2.5 Cluster partners[2] will carry out independent analyses of each pilot intervention. Each cluster partner has been paired with a pilot partner. The following pairings have been defined:

Group A pilots:

Pilot:	ACTIF/OFT, France
Analysis Lead:	KJNPC, Lithuania
Pilot:	Liverpool PCT, UK
Analysis Lead:	HPF, Poland
Pilot:	PHAL, Latvia
Analysis Lead:	CKPT, Czech Republic

Group B pilots:

Pilot:	REGVEN, Italy
Analysis Lead:	RNSP, Romania
Pilot:	Manchester PCT/Barnardo's, UK
Analysis Lead:	HPF, Poland
Pilot:	RNSP Romania
Analysis Lead:	ASPB, Spain

1.2.6 In completing the analyses, each analyst will triangulate the evidence compiled from:

(1) quantitative baselines and updates

(2) focus groups

(3) semi-structured interviews with key informants.

[2] Cluster partners are associated partners within the project that are not responsible for the delivery of pilot interventions – their primary role is as independent analysts of the pilots.

1.3 Aims

1.3.1 The CHI-CY-Tobacco project sets clear aims for the pilot intervention analyses to achieve. These are:

- to assess the extent that the pilots achieve their specific objectives – comparing what each pilot plans to achieve with what is actually achieved;
- to assess the effects of the pilot interventions and the changes that they have brought about;
- to analyse processes to see whether the pilots are working as planned and whether they are being delivered in the most effective way – with a particular emphasis on examining the process of community engagement and peer-to-peer working;
- to assess whether the pilot projects designs are feasible and effective;
- to identify "success factors" or, indeed "failure factors", to support judgements about the effectiveness and the potential transferability of interventions – in particular in relation to the model of engaging communities and young people and the tobacco control intervention itself.

1.3.2 It is intended that the analysis tools contained in this document could be utilised to assess and contribute to similar interventions elsewhere. Moreover, in longer-term interventions, they could:

(a) inform the ongoing delivery of interventions – essentially by being adopted as a project management tool;

(b) contribute to quality control monitoring and assessments.

1.3.3 However, the relatively short-time frame of the pilot projects – they are being implemented over a maximum 10 month period - and evaluation resource limitations, means that, for the CHI-CY-TOBACCO project, the pilot analyses will focus exclusively on retrospective judgements that can feed into recommendations for future projects.

1.4 Key Characteristics of the Pilot Interventions

Group A pilots

1.4.1 The Group A pilot projects focus on peer-to-peer interventions to raise awareness about tobacco-related issues, to influence attitudes to smoking and

tobacco and, potentially, to reduce smoking prevalence amongst 11 to 15 year olds. They are all school-based interventions.

1.4.2 Within each project, key staff from each pilot partner will engage with young people to generate peer-to-peer activities. They will identify and train young people to engage with their peers to:

- positively influence attitudes to smoking;
- raise awareness of the dangers of smoking and exposure to second-hand smoke;
- encourage non-smokers not to start smoking and current smokers to make an attempt to quit;
- challenge positive images of smoking.

1.4.3 Each Group A pilot will aim to train **15-20 young people**, aged 11 to 15 years old, **to raise awareness to 500 children**, in the same age range, about smoking and second-hand smoke.

Group B pilots

1.4.4 The Group B pilot projects focus on engaging communities in protecting children from exposure to second-hand smoke.

1.4.5 Within each project, key staff from each pilot partner will engage with local communities to develop interventions to protect children from exposure to second-hand smoke. They will identify and train community-based people to:

- raise community awareness of the dangers of exposing children to second-hand smoke;
- encourage smokers who live with children and young people to make their homes and vehicles smoke-free;
- develop local campaigns to protect children from exposure to second-hand smoke.

1.4.6 Each Group B pilot will aim to engage in the pilot intervention about **1500 households and approximately 2000 children from homes with people who smoke** to protect children from exposure to second-hand smoke.

1.5 Structure of this Document

1.5.1 The rest of this document sets out, for each type of pilot intervention:

- guidelines for developing context papers for the pilots [section 2]
- guidelines for developing quantitative baselines that will be applied to provide a benchmark and be updated to measure progress over time [section 3];
- guidelines for qualitative analysis to be conducted at the end of the pilot intervention period [section 4]
- roles and timing of analysis phases and reporting [section 5].

2. Context Information for Pilot Interventions

2.1 Purpose of Context Papers

2.1.1 The primary purpose of pulling together an information document about the context within which the pilot interventions are taking place is to provide an overview and a set of key facts that will aid the analysis of the pilots. The context papers should be succinct and relevant. They will be developed by the pilot partners and made available to the independent analysts. The formats for the Group A and Group B pilots are set out below.

2.1.2 The emphasis placed on specific elements will vary according to their pertinence in different places. Equally, the precise information provided will be shaped by its availability.

2.2 Content of Context Papers for Group A Pilot Interventions

2.2.1 Information should be provided about the pupils, schools and tobacco control context within which the pilot interventions are taking place. They should provide a profile of:

- the schools involved;
- the communities served by the schools;
- the pupils within the schools;
- critical issues - health, social and economic issues that affect the schools and their pupils;
- smoking legislation;
- the wider tobacco control agenda including youth advocacy work and stop smoking services for young people.

Schools

2.2.2 Key information should be provided about:

- Size (number of pupils) and location of schools;

- The catchment area of the schools;
- School governance;
- The educational performance of the school;
- The characteristics of the school's intake (socio-economic and educational).

Communities served by the schools

2.2.3 Descriptive information should be provided about:

- Socio-economic characteristics of the main areas served by the schools;
- Health indicators for the populations within these areas – including key smoking and smoking-related statistics, mortality rates for cancer and heart disease and life expectancy compared to national norms;
- Educational indicators for the populations within these areas - for instance, levels of educational attainment;
- Demographic characteristics of these areas – especially relating to age ethnicity and household structure.

Pupils within schools

2.2.4 Descriptive information should be provided about:

- The target group – who they are, where they live and specific characteristics;
- Social and economic status;
- Educational levels;
- Cultural, religious and other key values and beliefs;
- Other relevant health and behavioural characteristics - including known smoking and other lifestyle risk factors..

Critical issues

2.2.5 This section should provide a picture of key health, social and economic issues that affect the schools and their pupils. They may include:

- Health inequalities/disparities within the school and wider community – including smoking prevalence and exposure to second-hand smoke and

evidence of other lifestyle risk factors such as alcohol, drugs, diet and physical activity;

- Traditions of engaging young people in peer-to-peer activities;
- Learning difficulties amongst pupils;
- Minority groups and their relationship with the majority in the schools and wider community.

Smoking legislation

2.2.6 Providing the independent analyst with a clear picture of the smoking legislation that is in place within the school and wider community and the effectiveness of such laws is particularly important. It should describe:

- The key elements of any smoke-free law: scope of the law, where smoking is not allowed, exemptions to the law;
- Responsibility for enforcement and how this is carried out – including an assessment of effectiveness at school, local area and wider levels;
- School policies towards tobacco use and how they are implemented - including known behaviour amongst teachers and pupils and sanctions where school policies are breached;
- Public attitudes to smoke-free laws – especially amongst young people.

The wider tobacco control agenda: including previous and pre-existing tobacco control initiatives in the community

2.2.7 A brief description should be provided, so far as they exist, of:

- Whether and to what extent tobacco control agendas are incorporated into teaching and lessons within schools;
- Tobacco control strategies at local and higher levels to protect children and young people from tobacco - including an assessment of resources and capacity available;
- Youth advocacy work to tackle tobacco control challenges;
- Smoking prevention and cessation services for young people;
- Other key tobacco control interventions - such as smoke-free homes initiatives and participation in no-smoking days.

2.3 Content of Context Papers for Group B Pilot Interventions

2.3.1 Information should be provided about the communities that are the focus of the pilot interventions to provide a profile of:

- place;
- people;
- social interactions between people and community organisations;
- critical issues;
- smoking legislation;
- the wider tobacco control agenda including previous and pre-existing smoking interventions in the community, including current stop smoking services

Place

2.3.2 Key information should be provided about:

- Geography of the community including its location, and geographical setting (e.g. place in city/region, urban/rural, travel links);
- Boundaries – maps should be provided delineating the boundaries of the community engaged in the intervention;
- Economic characteristics of the community – including a profile of the local economy and key sectors within it;
- Political context – local government, local powers.
- Environmental characteristics – including a description of the built environment, air quality and other important environmental aspects.

People

2.3.3 Descriptive information should be provided about:

- The size of the population in the wider city and region;
- The general population within the wider community – which may differ from the households targeted by the intervention;

- The target group – who they are, where they live, specific characteristics of the group;
- Demographics (if available provide a profile by: gender, age groups, ethnicity, nationality, family and household status etc);
- Migration patterns - such as migration from the community, immigrants coming into the community;
- Key health indicators – including smoking prevalence and tobacco related diseases/mortality;
- Social and economic status and well-being;
- Levels of educational attainment;
- Sense of belonging and sense of community including the strength of social networks;
- Cultural, religious and other key values and beliefs;
- Other relevant behavioural characteristics.

Social interactions between people and community organisations

2.3.4 An overview of key communication channels within the community – including social networks - should focus on;

- Family structures;
- Community-based groups and organisations - including recreational groups;
- Traditions of community-based activity and engaging communities in local policy and health priorities;
- Virtual communications (if it is the case) within the community

Critical issues

2.3.5 This section should provide a picture of key social, economic and political issues that affect the community. They may include:

- Health inequalities/disparities within the community and with the wider society – including variations in smoking prevalence and exposure to second-hand smoke and evidence of other lifestyle risk factors such as alcohol, drugs, diet and physical activity;
- Lack of political power

- Disability in the community
- Mental health in the community
- Minority groups and their relationship with the majority

Smoking legislation

2.3.6 Providing the independent analyst with a clear picture of the smoking legislation that is in place within the community and the effectiveness of such laws is particularly important. It should describe:

- The key elements of any smoke-free law: scope of the law, where smoking is not allowed, exemptions to the law;
- Responsibility for enforcement and how this is carried out – including an assessment of effectiveness at local and wider levels;
- Public attitudes to smoke-free laws.

The wider tobacco control agenda: including previous and pre-existing tobacco control initiatives in the community

2.3.7 A brief description should be provided, so far as they exist, of:

- Local and higher level tobacco control strategies and priorities - - including an assessment of resources and capacity available;
- Smoking prevention and cessation services in and for the community;
- Other key tobacco control interventions - such as smoke-free home interventions, young people's tobacco control advocacy and anti-tobacco campaigns

3. Baseline Content and Methodologies

3.1 Context and Purpose of the Baselines

3.1.1 The project's partners worked together at the initial CHI-CY-Tobacco seminar in Venice[3] to develop the content and methodology for compiling baseline data for the pilot interventions. For both types of project, the baselines are designed to:

- be relevant to the focus of the intervention being evaluated;
- be replicable - so that changes over time can be assessed;
- take into account resource and time limitations.

3.1.2 This section sets out baseline guidance, developed within the seminar, for each type of pilot. It presents:

- the primary aim of the baseline;
- the specific focus of key indicators;
- the questionnaire to be deployed;
- the sampling size and methodology;
- the survey administration approach;
- time-line for the baseline and its update.

[3] The seminar was held in Venice at the end of January 2009 and built on a preparatory workshop in Paris the preceding November.

3.2 Baseline for Peer-to-Peer projects (Group A – France, Latvia, UK [Liverpool])

3.2.1 Aims of the Group A Baseline Studies

3.2.1.1 The baseline studies need to provide evidence to support assessments of the pilot interventions' achievements and to enable changes over time to be measured. They should explore children and young people's awareness, attitudes and behaviour for a range of key smoking-related aspects. Specifically, they should provide evidence of:

- levels of awareness of the dangers of smoking
- levels of awareness of the dangers of exposure to second-hand smoke;
- the extent that smokers within the target group make attempts to quit smoking;
- attitudes to smoking amongst young people;
- smoking prevalence amongst the target group;
- attitudes to second-hand smoke;
- frequency of smoking in the presence of children to reduce the negative effect of peer "role models"
- learning about smoking and tobacco issues at school;
- personal information for cross-sectional analyses.

3.2.1.2 The questionnaire set out in annex 1 is the primary tool for generating this evidence.

3.2.2 Focus of Key Indicators

3.2.2.1 The questionnaire comprises a series of closed questions to address the research objectives. Most of the questions used have been drawn from the validated, extensively applied and WHO recognised *Global Youth Tobacco Survey* (GYTS). Its questionnaire is internationally recognised as the pre-eminent tool for tobacco-related survey work with young people[4]. Specifically, the survey deployed for the pilot interventions seeks to generate quantitative evidence of:

[4] The World Health Organization (WHO) and Centres for Disease Control and Prevention (CDC) Office on Smoking and Health developed the Global Youth Tobacco Survey (GYTS) to track tobacco attitudes and behaviour among young people across countries using a common methodology and core questionnaire.

Levels of awareness of dangers of smoking

The questionnaire seeks information about:

- awareness of the risks and dangers of smoking;
- awareness of the benefits of not starting smoking;
- awareness of the benefits of quitting smoking;
- knowledge of available support aids to quit and how to access them.

perceptions of the extent that second-hand smoke is harmful to themselves and to specific types of people including babies, children and pregnant women.

Attempts to quit

The questionnaire seeks information about:

- the history of young smokers quit attempts – including the number of quit attempts made;
- intentions about quitting.

Attitudes to smoking

The questionnaire seeks information about:

- young people's perceptions of the popularity of boys and girls who smoke;
- other perceptions about people who smoke;
- the likelihood of smoking if a good friend offered them a cigarette;
- perceptions of whether smoking is harmful.

Smoking prevalence

The questionnaire seeks information that provides evidence of:

- smoking prevalence amongst young people
- specific aspects of their smoking history – such as the age that they started smoking;

- young people's parents or guardians smoking habits and those of their close friends.

Awareness of and attitudes to second-hand smoke

The questionnaire seeks information that provides evidence of:

- whether young people's families have discussed the harmful effects of smoking with them;
- perceptions about whether second-hand smoke is harmful;
- perceptions about whether young children, adults, and pregnant women should be exposed to second-hand smoke

Smoking in front of other children and young people

The questionnaire seeks information about:

- the extent that young people are exposed to second-hand smoke indoors, at home;
- the extent that young people see actors smoking in films, DVDs and television.

Learning about tobacco issues in school settings

The questionnaire explores:

- if and when discussions about smoking have taken place in school;
- whether pupils have been taught, at school, about the dangers of smoking;
- whether pupils have been taught, at school, about the reasons why young people smoke.

Personal information about respondents

The questionnaire will identify respondents:

- age, gender and school year

3.2.3 Questionnaire

3.2.3.1 The questionnaire, incorporating each of the above dimensions, is set out in annex 1.

3.2.4 Sampling and Survey Administration

3.2.4.1 The survey will target young people in school aged 11 to 15 years old.

3.2.4.2 It will aim to generate completed questionnaires from 500 young people, in the target age group, from all schools involved in the pilot interventions.

3.2.4.3 The sampling frame will include all classes where young people have been engaged in the project. Specific classes will be selected by systematic sampling with probability proportionate to size (with a random start) of classes within the sample frame. All students in the selected classes will receive questionnaires to be completed for the survey. Questionnaires will be self-administered and completed within classes.

3.2.4.4 Surveys opting to provide controls from non-participating schools should ensure that they are from similar catchment areas.

3.2.5 Survey Data Analysis

3.2.5.1 Data from completed questionnaires will be scanned into CDC databases.

3.2.5.2 A series of statistical analyses will be carried out. First, the survey data should be analysed according to a range of key variables – such as age, gender, ethnicity and smoking status. The data should also be examined to explore the relationship between variables such as attitudes to smoking and intentions to quit.

3.2.5.3 The full range of recommended analyses will be incorporated within the project's final tool kit.

3.2.6 Time-Line

3.2.6.1 The initial baseline survey will be administered before the interventions with young people begin.

3.2.6.2 The updated baseline survey will be administered after the intervention has been completed.

3.3 Baseline for Community Engagement to Protect Children from Second-hand Smoke Projects (Group B – Romania, Italy, UK [Manchester])

3.3.1 Aims of the Group B Baseline Studies

3.3.1.1 The baseline studies need to inform assessments of the pilot interventions' achievements and enable changes over time to be measured. For the Group B interventions, they should be able to provide evidence of:

- levels of awareness of the dangers of exposing children to second-hand smoke;
- levels of awareness of the dangers of smoking
- attitudes about people smoking;
- the extent that homes and private vehicles are smoke-free and the extent that children and young people are exposed to second-hand smoke
- frequency of smoking in the presence of children to reduce the negative effect of peer "role models";
- smoking prevalence and smokers' attitudes to quitting
- personal information for cross-sectional analyses.

3.3.2 Focus of Key Indicators

Levels of awareness about second-hand smoke

- the dangers of exposing babies, children and pregnant women to second-hand smoke;
- the dangers of exposing smokers and non-smokers to second-hand smoke;
- the specific health risks of exposing children and adults to second-hand smoke

- the benefits for children and young people of parents and carers quitting smoking;
- knowledge of available support aids to quit and how to access them.

Levels of awareness about dangers of smoking

- the health dangers of smoking

Attitudes to people smoking

- perceptions about men and women who smoke

Frequency of exposure

- extent that homes are smoke-free;
- extent that private vehicles are smoke-free when children or young people are in them;
- extent that smoking takes place in front of children.

Smoking behaviour and intentions

- smoking prevalence
- previous quit attempts
- intentions about quitting
- motivations to quit smoking

Personal information about respondents

The questionnaire will identify respondents:

- age, gender and ethnicity

3.3.3 Questionnaire

3.3.3.1 The questionnaire, incorporating each of the above dimensions, is set out in annex 2.

3.3.4 Sampling and Survey Administration

3.3.4.1 The survey will aim to generate completed questionnaires from 200 households in each pilot area, from all households with children involved in the pilot interventions.

3.3.4.2 The sampling frame will include all households that have been engaged in the project.

3.3.4.3 The survey will adopt a convenience sampling methodology. Given the diverse settings of the interventions, these will differ from place to place. In Romania, participants will be randomly selected from the family doctor's database of inhabitants. In Veneto, a parent of all children participating in the project will be invited to complete the survey. In Manchester, a convenience sample of those participating in the project and who visit the Children's Centre to register births or attend ante-natal classes will be invited to complete the survey. Surveys will be administered by a trained interviewer and completed face-to-face.

3.3.5 Survey Data Analysis

3.3.5.1 Survey questions will be coded and data inputted into an appropriate database.

3.3.5.2 A series of statistical analyses will be carried out. First, the survey data should be analysed according to a range of key variables – such as age, gender, ethnicity and smoking status. The data should also be examined to explore the relationship between variables such as attitudes to smoking and intentions to quit.

3.3.5.3 The full range of recommended analyses will be incorporated within the project's final tool kit.

3.3.6 Time-Line

3.3.6.1 The initial baseline survey will be administered before the interventions with the local community begins.

3.3.6.2 The updated baseline survey will be administered after the intervention has been completed.

4. Qualitative Analysis

4.1 Overview of Qualitative Assessments

4.1.1 Qualitative analysis will be a key element of the overall analysis of the pilot interventions. Qualitative assessments will (1) aid interpretation of the quantitative data and (2) provide qualitative interpretation of progress, quality and effectiveness by key stakeholders (e.g. project managers, project workers, other implementation partners and beneficiaries).

4.1.2 At the initial project seminar in Venice, participants worked together to identify:

(1) the aims and focus of qualitative assessments;

(2) how (methods) qualitative assessments will be carried out;

(3) the key research / evaluation questions;

(4) the timing of the qualitative evaluation and how it fits with the overall evaluation.

4.1.3 For the purposes of the pilot intervention analyses, two key methods will be used for conducting qualitative assessments. These are **focus group sessions** and **semi-structured interviews**

4.2 Aims

4.2.1 The qualitative assessment will explore and identify lessons about the process of engaging communities and peer-groups in tobacco control, the appropriateness of the project's design and the effectiveness of its implementation in fulfilling their tobacco control objectives. This overall approach will apply to both types of interventions.

4.2.2 In relation to the evaluation of the pilot interventions, qualitative analysis will:

- provide a qualitative interpretation of quantitative data from baselines, baseline updates and outputs;

- provide in-depth understanding of how the project was delivered, for instance, how partners worked together, how and when young people and communities were engaged, whether there were specific circumstances or factors that influenced success or failure etc.
- contribute significantly to the policy focus of the evaluation by identifying success factors and/or barriers to success.

4.3 Focus Groups

Participants

4.3.1 Focus group sessions will be held with target groups and beneficiaries. These will be administered by the pilot partners

4.3.2 For the two types of pilot intervention, the following stakeholders will be involved in the focus groups.

Participation in focus groups

Group A pilots: **Peer-to-Peer projects (France, Latvia, Liverpool [UK])**

Focus group participants:

- pupils
- peer advocates

Participation in focus groups

Group B pilots: **Community Engagement to Protect Children from Second-hand smoke Projects (Romania, Italy, Manchester [UK])**

Focus Groups will be organized differently within the three interventions. Focus group participants will vary between the different projects reflecting the local characteristics of the pilots. Broadly, however they will include:

- **Veneto:** parents, advocates (teachers)
- **Romania:** community members (who are parents), advocates, teachers and health staff
- **Manchester:** parents, advocates, staff from various agencies and community volunteers

Key Research / Evaluation Questions

4.3.3 Specific research questions applicable to focus groups are also useful for more in-depth understanding and analysis of the extent that interventions have achieved their objectives. Focus groups sessions will be structured to generate evidence about:

- changes in knowledge;
- awareness of the target group about specific tobacco control issues;
- changes in attitudes to smoking and second-hand smoke;
- changes in smoking behaviour;
- assessing why people have made changes in their attitudes or behaviour;
- exploring barriers and enablers for project objectives (for instance, in relation to protecting children from second-hand smoke)
- whether there have been any negative impacts (for example, anecdotal evidence that working with schools and children raises anxiety in young people
- satisfaction with the intervention.

4.3.4 Other issues to explore – particularly for community advocates, teachers and health staff - include:

- satisfaction with the design of the intervention (project design evaluation)
- acquisition of skills – are they better prepared for future projects?
- motivation – how do they feel about the project and the issues it addresses?
- benefits – for themselves
- perception on the results and utility of the project
- assessments of how difficult or easy the intervention was to deliver
- assessments of materials used in the intervention
- if it is in line with their professional agenda (for health and other professionals)

4.3.5 NB. Pilot partners should consult with their respective cluster partners (independent analysts) to agree the precise issues to be addressed in the focus group sessions.

4.4 Semi-Structured Interviews

Participants

4.4.1 **Semi-structured interviews** will comprise one-to-one interviews with key informants and participants. They will be carried out by the cluster partners (independent analysts).

4.4.2 For both types of project, these will include:

Participation in interviews

- Project leads
- Project workers
- Other stakeholders with detailed knowledge of the intervention – these may include teachers, leading advocates including peer and community advocates, local health professionals, community and political leaders and local tobacco control experts.

4.4.3 The final tool-kit will provide examples of the actual people interviewed for the pilots.

Key Research / Evaluation Questions

4.4.4 Evaluators will use the interviews to identify three over-arching aspects about the pilot interventions. These are:

(1) to acquire a clear description of how the project was delivered.

(2) to examine the intervention's process

(3) to generate evidence of a qualitative assessment of achievements

(4) to draw conclusions and recommendations.

Aim: 1 Description of how the project was delivered?

- Context of the project.
- How partners worked together?
- How peer and community advocates were engaged and trained?
- How peer and community advocates engaged with target beneficiaries?
- How locally appropriate materials were developed and used?
- What was done, who did it, when was it done?

Aim 2: Examining the process

- What worked well, what worked less well – including the effectiveness of taking forward different strands of the project.
- Does the experience provide good practice lessons?
- What are "success factors" or barriers to success?

Aim: 3 Assessing achievements

- Were aims and objectives achieved – to what extent?
- Were there any unplanned effects and outcomes from the project?
- What impact has the project made? Have there been changes in attitudes or behaviour?
- Provide a qualitative interpretation of the quantitative data from baseline and its update.

Aim 4: Conclusions and recommendations

- Good practice and policy lessons – about how similar projects should develop in future and lessons for tobacco control and wider public health agendas
- Transferability – including transferability of the intervention or specific parts of it.

5. Timing, Roles and Reporting

5.1 Timing

5.1.1 There are four broad chronological stages to the analysis process for the pilot interventions. These are:

Phase 1: prior to the intervention

Phase 2: at the outset of the pilot intervention;

Phase 3: during the pilot intervention;

Phase 4: at completion of the pilot intervention.

5.1.2 **Prior** to the intervention, the context documents outlined in section 2 will be developed. These will provide key information and profiles to facilitate the independent analysts' understanding of the social, economic, health, tobacco control and other contexts within which the pilot interventions take place.

5.1.3 At the **outset** of the intervention baseline studies will be carried out. These will provide a quantitative baseline for the project and may influence how the intervention will be implemented.

5.1.3 **For the duration** of the intervention output data will be collated. It may also be appropriate to build-in immediate feed-back from beneficiaries.

5.1.4 The outcome analysis will be completed **at the end of the pilot intervention phase**. This will include updating the baselines and conducting qualitative assessments.

5.2 Roles

5.2.1 The following table sets out the respective roles of the independent analysts and the pilot partners:

Table: *Analysis process: who does what*

Task	Action by:
Draft context paper	Pilot partner
Develop baseline database	Project consultant / CDC
Administer baseline and input data	Pilot partner
Update baseline and input data	Pilot partner
Analyse data	Project consultant / CDC
Conduct focus groups	Pilot partner
Conduct semi-structured interviews with key informants	Independent analyst
Triangulate evidence	Independent analyst
Draft pilot analysis report	Independent analyst

5.3 Reporting

5.3.1 A template analysis report will be developed in partnership with the evaluators and incorporated within the final tool-kit.