Centre for Evaluation

Improving global health practice through evaluation

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

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Our Themes & Cross-Cutting Topics

Foreword

The core mission of the London School of Hygiene & Tropical Medicine (LSHTM) is to improve health and health equity in the UK and worldwide. Central to improving health is being able to measure the benefits (or disbenefits) of interventions, to provide concrete evidence that intended improvements are realized. In existence since 2012, The Centre for Evaluation has made a major contribution to the field of public health evaluation through training, research and policy maker engagement.

We are delighted to celebrate the achievements of the Centre but also look to a future in a world where the value of evidence is increasingly under threat. The need for robust evidence to inform decision making could not be greater for public health and global health communities, when resources are increasingly stretched.

The Centre is also looking beyond the current to embrace new technologies and advances in research methods, such as AI to augment existing evaluation tools. These promise to bring new opportunities and challenges.

The Centre for Evaluation exemplifies the role of Centres in the life of LSHTM in bringing together and galvanising an internal community of highly multi-disciplinary researchers as well as raising the profile of research activity to a wide range of external audiences. I extend my thanks to all involved in the life of the Centre for Evaluation and wish the Centre every success in the coming years.

Caroline Relton
Pro Director for Research and Academic Development and Chair of the Centres Forum

It is inspiring to see how the Centre for Evaluation continues to bring together a diverse community of researchers, implementers and policy makers to advance methods and approaches for evaluating complex public health interventions. Under the stewardship of an excellent management committee, the Centre has fostered a rich programme of seminars, workshops and resources that enables members to engage with cutting edge methodological issues.

Over the past decade, the Centre has expanded not only its membership – within LSHTM and among external collaborators – but also its steering committee, ensuring representation from across the School's three faculties and two MRC units. This broader leadership within our steering committee and management team was integral to guiding the Centre through the recent triennial review process. They have also enabled the Centre to take on challenging projects. Notable examples include synthesising evidence on decolonial and equitable evaluation practices, helping LSHTM and its partners engage in this critical global debate, as well as providing a platform to share evidence on the impact of changing global funding priorities. Such pioneering work ensures the Centre remains at the forefront of methodological innovation.

In an era of shifting geopolitical priorities and reduced funding for public health, the need for robust, evidence-based public health interventions is more urgent than ever. The Centre for Evaluation continues to play a vital role in meeting this challenge, strengthening the evidence base to improve health worldwide.

Liz Corbett
Chair of Centre for Evaluation Steering Committee

Now in our thirteenth year, the Centre for Evaluation continues to bring together a global community of researchers, programme deliverers, service providers, policy makers and community organisations who are committed to advance the evaluation of complex public health interventions. Our aim is to foster critical thinking, methodological innovation and collaborative learning. We champion evaluations that are theoretically grounded, that embrace complexity to understand processes, and that address questions of impact, context and equity.

Our members respond directly to the needs of policy makers and implementers by embedding evaluations into health programmes, designing pragmatic approaches, and strengthening the ways in which evidence is synthesised to inform policy and practice.

In recent years, we have expanded our management committee welcoming colleagues whose expertise spans a range of study designs, methods, public health issues and geographical contexts. This has brought not only new perspectives but also renewed energy and enthusiasm for tackling critical questions in evaluation.

Building on this momentum, we have introduced three new cross-cutting areas of work. In May 2024, we launched our programme on decolonial and equitable approaches to evaluation with a lecture by Professor Bagele Chilisa of the University of Botswana, and we look forward to hosting further seminars with leading scholars in the field. We are also preparing to launch a workstream focused on the use of participatory practices to co-design – or meaningfully involve stakeholders in – public health evaluations. Since December 2024 we have begun to explore the role of artificial intelligence in evaluation, considering both the opportunities and challenges it poses, particularly for process evaluations.

At a time when funding for public health programmes is increasingly constrained, it is imperative that we integrate evaluations into health initiatives. By doing so we can maximise opportunities for pragmatic approaches that enhance the effectiveness of interventions and contribute to reducing health and social inequalities.

This brochure highlights the diversity of evaluation designs and methods being used by our members and celebrates their vital contributions. The list of contributors and links to their work are included in the brochure directory. We are looking forward to the next phase in the Centre's work, as Mitzy Gafos steps down as co-director and Lucy Platt welcomes Aoife Doyle as the new co-director, carrying on the great work of the Centre for Evaluation and its members.

Mitzy Gafos and Lucy Platt
Co-Directors of the Centre for Evaluation

Contents

Introduction

MRC Unit The Gambia staff speaking to a woman as part of a community sensitisation programme for the launch of a new research project in Basse, The Gambia. (Credit: Dan Boaden).

Centre for Evaluation: Who are we?

Launched in 2012, the Centre for Evaluation is a network of researchers and practitioners across disciplines and public health contexts with expertise in evaluation methods.

Our network includes over 1,500 members including LSHTM staff, students and external collaborators such as researchers, implementers, funders, multilateral agencies, policy makers and community organisations. The network continues to expand building connections with a wider range of stakeholders and collaborating partners.

Our mission

To improve the design and conduct of evaluations of complex public health interventions by:

- Developing, applying and sharing rigorous methods
- Supporting the use of robust evidence to inform policy and practice decisions

Our aims

1. Stimulate, support, co-ordinate and promote high quality evaluation studies using innovative, rigorous and multidisciplinary methods
2. Develop and promote new methodologies that consider the context of complex interventions
3. Improve the quality, uptake and use of robust evidence in global public health policy and practice
4. Build an effective network across LSHTM to advance evaluation approaches; and
5. Raise LSHTM's visibility as a global resource for evaluation expertise

Our themes and topics

We organise our work around three themes: i) **evidence synthesis,** ii) **process evaluation,** and iii) **impact evaluation**.

Across these themes, we consider three cross cutting topics: a) **decolonial and equitable approaches**, b) **participatory practices**, and c) **use of artificial intelligence**

What we do

We strengthen LSHTM's evaluation portfolio by facilitating collaboration between staff, students and external partners. Our activities include:

- **Capacity building:** seminars, workshops, networking events and training sessions
- **Teaching:** contributing to LSHTM and external training.
- **Technical support for LSHTM members:** drop-in sessions for advice on evaluation designs and methodologies; an Evaluation Review Committee to advise on research proposals or study protocols; and resources to support grant or fellowship applications
- **Communications:** member mailing lists and newsletters; highlighting events, research, conferences, funding, training and job opportunities; sharing study findings and member achievements

Our structure

Management Committee: led by a team of co-directors and deputy directors, with experts leading each theme and cross cutting topic

Student Liaison Officers: MSc and Research Degree students representing the needs of the student body

Central Support: providing administrative and communications expertise

Steering Committee: members from all three LSHTM Faculties and both MRC Units who guide the Centres work

Together, these groups guide and sustain the Centre's work. Meet the team overleaf to learn more about the people behind the Centre for Evaluation.

Structure

MANAGEMENT COMMITTEE

Co-Directors

Mitzy Gafos
Co-Director

Lucy Platt
Co-Director

Deputy Directors

Meghna Ranganathan
Deputy Director

Shay Soremekun
Deputy Director

Farhana Haque
Deputy Director

Fiona Majorin
Deputy Director

Theme Leads

Aoife Doyle
Impact Evaluation

Julia Pescarini
Impact Evaluation

Melissa Neuman
Impact Evaluation

Ruth Ponsford
Process Evaluation

Constance Mackworth-Young
Process Evaluation

Miriam Abdulla
Process Evaluation

Mark Carew
Process Evaluation

Laurence Blanchard
Evidence Synthesis

Joelle Mak
Evidence Synthesis

Thalia Sparling
Evidence Synthesis

CENTRAL SUPPORT

Patrycja Reyes Galvez
Centres Coordinator

Matthew Dale
Centres Communication Officer

STEERING COMMITTEE

Liz Corbett
Chair

Charles Opondo

Brahima Diallo

Eugene Ruzagira

Marcella Vigneri

Timothy Powell-Jackson

STUDENT LIAISON OFFICERS (SLOs)

Jonna Messina Mosoff
Research Degree SLO

Yashi Gandhi
Research Degree SLO

Uchenna Ebenezer
Research Degree SLO

We would like to recognise the role of Student Liaison Officers from across the MSc Programmes over the last three years

- **2022/23:** Abubakar Yerima Mohammed, Amy Yung, Anu Rangarajan, Ellie Harrison, Emmanuelle Auguste
- **2023/24:** Victor Mun Hin Seck, Julia De Georgeo, Ker Ro Toh, Naomi Jayasuriya, Fumie Metoki, Kaho Shinozaki
- **2024/25:** Jiyeing Seo, Ying Jenny Chan, Whitney Langlee, Megan Arnett, Khadija Leila El Siby Diatta, Grainne Cremin, Alina Andreyevna Sichevaya, Margarethe Grupp, Ina Haydoutov Bussery

Themes

Mapping vaccine confidence issues around the world (Credit: Jon Spaull).

Evidence Synthesis

Evidence syntheses methods are increasingly diverse as research questions become more complex and aim to address issues of process, impact and policy.

Exploring the role of infidelity, romantic jealousy and intimate partner violence against women: Using meta-ethnography

Romantic jealousy and infidelity are often cited risk factors for intimate partner violence (IPV). Yet the mechanisms and pathways linking them to violence remain poorly understood and prevention programmes rarely address them directly. While jealousy is often described as a precursor to violence, some IPV frameworks define jealousy itself as a form of violence, blurring an important distinction. To clarify this ambiguity, evidence from multiple contexts and perspectives is needed.

The Collaboration on Infidelity, Romantic Jealousy and IPV brought together researchers working in Ecuador, Ethiopia, Rwanda, Tanzania and Uganda. The group pooled qualitative datasets representing diverse populations and cultural contexts including single, married and widowed individuals in the community as well as people involved in polygynous relationships in a refugee camp.

The team conducted a qualitative meta-synthesis using a meta ethnography (Noblit and Hare, 1988). This approach enabled the team to re-analyse each dataset, identify common and contradictory themes, and collaboratively generate new interpretations. Through a creative workshop, the team synthesised results, producing five mid-range theories situated within the ecological framework of IPV (Figure 1). Across all levels, unequal gender power relations emerged as the underlying driver.

- **Societal level:** Communities reinforce traditional gender norms including the harmful belief that jealousy is synonymous with love. This underscores the importance of targeting community norms that condone violence.
- **Relational level:** Women sometimes expressed jealousy by subverting expected female roles, while men often used jealousy as a means of control. This points to the need for couples-based programmes that promote healthy ways of managing jealousy.
- **Individual level:** Jealousy and infidelity were often amplified by male alcohol consumption, women's economic dependence and poverty. Multi-sectoral programming should address these drivers, while monitoring the potential for interventions – particularly economic empowerment – to unintentionally increase IPV due to suspicions of infidelity.

This synthesis transformed fragmented local findings into a coherent, multi-level understanding of jealousy, infidelity and IPV. It generated actionable insights for prevention programmes, highlighting the need to challenge harmful norms, support healthy relationship skills, and integrate IPV risk monitoring into programming, in particular economic empowerment initiatives.

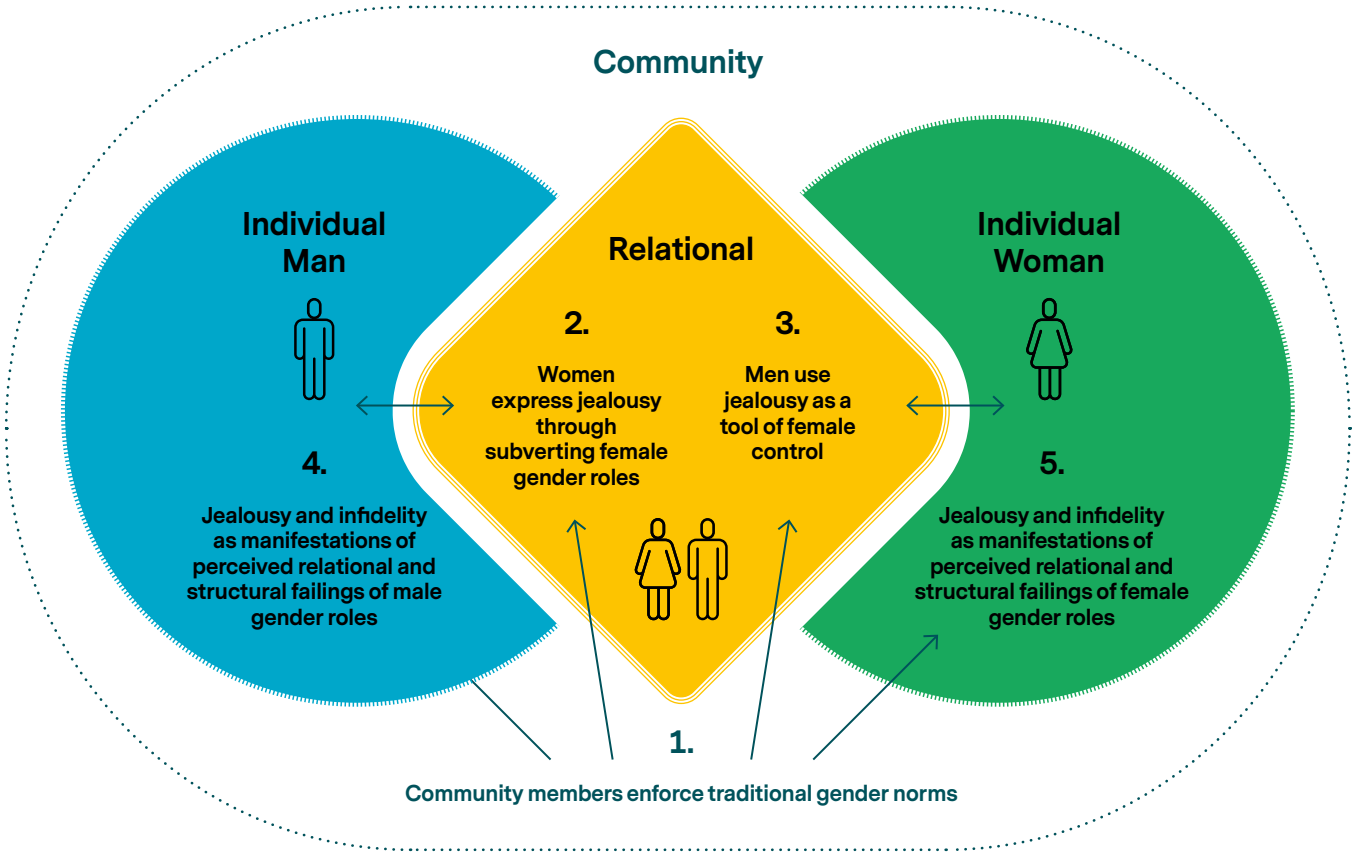


Figure 1: Resulting mid-range theories on romantic jealousy and infidelity mapped onto the ecological framework conceptualizing intimate partner violence (IPV) (adapted from Heise 2012).

Understanding pathways between agriculture, food systems, and nutrition: An evidence and gap map of tools, metrics and methods

The 2007-08 food price crisis exposed major weaknesses in both evidence and practice. It highlighted the absence of interdisciplinary, cross-sectoral methods that could have revealed system-level weaknesses earlier. This gave rise to a decade of investment and innovation in tools, methods and metrics to study how food systems translate into nutrition and health outcomes. We were asked to map these innovations in what became the first methods-focused Evidence and Gap Map (EGM). We mapped over 900 reports describing different types of innovative tools, metrics or methods applied to the food systems-nutrition-health nexus. These reports are also analysed and filterable by characteristics such as stage of development or geographic application, and themes such as dietary assessment, water footprints, markets, equity/power, or food loss/waste. Building on this, we later applied a similar rigorous approach to map methods used to study complex food systems. This produced another methods-focused analysis and accompanying EGM, further strengthening the evidence base for understanding how agriculture and food systems affect nutrition and health.

Inequalities in research on food environment policies: Using evidence and gap maps to synthesis policy evidence

This NIHR-funded project shows how evidence gap maps can be used to critically analyse evidence from a policy perspective, including the scientific evidence itself, the policy approaches employed, and equity implications. The EGM included 482 publications from 2010-20 that evaluated real-world policies promoting healthy food environments at the international, national and state level. The map highlighted strong inequities in the origin, design and scope of the evidence. For example, 81% of publications reported on only 12 countries, suggesting that research capacity and funding lie in the hands of a few expert teams worldwide. The map also questioned the evidence underlying the presentation of public-private partnerships (PPPs) as the gold standard in global health commitments, as only 32 (6.6%) publications were about PPPs, the majority of which were about the same two partnerships. Lastly, the map showed a need to consider impacts on equity more consistently as this was assessed in only 50% of policy effectiveness evaluations, and the proportion has decreased over time.

Psychosocial interventions to improve the mental health of survivors of human trafficking: A realist review

Over 50 million people globally are subjected to modern slavery and human trafficking. Adverse mental health consequences of extreme exploitation are prevalent and often severe. While many psychosocial interventions exist, it is unclear how they work across different contexts. We conducted a systematic and realist review of evaluations of psychosocial interventions for survivors of human trafficking. We sought to identify the influence of these interventions on the mental health and wellbeing of trafficked people and examine *how* they worked, for *which survivors,* and in *which contexts.* We began with a scoping review, which was used to develop hypothesised context-mechanism-outcome configurations and the conceptual model of the care pathways for post-trafficking interventions. We consulted a group of service providers working in UK-based NGOs and survivors connected to two other survivor NGOs on the suitability and relevance of the conceptual model. The resulting framework guided the subsequent stages of our review.

We searched eight databases for published evaluations of psychosocial interventions for survivors of human-trafficking. We followed a realist approach to analyse the data and report on the limitations of these studies. We identified four mechanisms of change triggered by different intervention activities: (1) awareness and understanding; (2) trust, safety, and security; (3) agency, autonomy, empowerment, and social connections; and (4) self-reflection, self-expression, and self-care. Improving mental health after traumatic events is an ongoing, nonlinear process. Intervention effectiveness and transferability would benefit from more transparent programme theories and clear articulation of assumptions on the pathways to change.

Effectiveness of remote interventions for adults in alcohol and drug treatment: A systematic review using qualitative comparative analysis

As part of a systematic review of the effectiveness of remote interventions for adults in alcohol and drug treatment, meta-analyses showed wide variation in the effect of individual interventions. To explore why some remote interventions were effective while others were not, we conducted Qualitative Comparative Analysis (QCA). QCA assumes that outcomes result from the interplay between intervention content, implementation and context. It recognises that there may be multiple routes to effectiveness, or ineffectiveness. The method combines a qualitative case study approach, with quantitative methods using set theory. It aims to identify combinations of features that are associated with effective, or ineffective, interventions.

We included 13 intervention evaluations from the meta-analyses in our QCA; eight 'most effective' and five 'least effective'. To identify features to incorporate in the QCA, we used Intervention Component Analysis (ICA), a theory-generating method, whereby intervention, implementation and contextual features were extracted from evaluation reports and articles, including from authors' reflections within discussion sections. This identified three overarching principles which we explored further in three QCAs, followed by a final QCA that consolidated the initial three QCAs findings. These principles were: 1) meeting people's treatment and recovery needs; 2) taking a person-centred approach; and 3) maximising service use.

The consolidated QCA (Figure 2) found that intervention evaluations which reflected at least one configuration for principle one, in addition to principle two and/or principle three, were likely to achieve better outcomes than those which do not. To be effective, it seems essential to meet people's treatment and recovery needs, but to increase the likelihood of positive outcomes, interventions should also take a person-centred approach and/or maximise service use. ICA and QCA enabled a more in-depth exploration of *how* remote interventions work than was possible through meta-analysis alone.

Figure 2: Consolidated QCA for effectiveness of RCTs of remote interventions for adults in alcohol and drug treatment.

Evidence Banks

There has been a notable increase in the use of evidence banks and repositories in recognition of the need to ensure findings are accessible to enhance evidence synthesis.

The Climate and Health Evidence Bank

The Climate and Health Evidence Bank (climatehealthevidence.org) was developed by the Pathfinder Initiative, a Wellcome-funded research project led by LSHTM that aims to provide evidence to inform policies and actions that deliver both mitigation of climate change and improvements to human health. As part of the Pathfinder Initiative's first phase of work, we conducted a comprehensive review of existing literature and put out a call for case studies of implemented climate actions that have demonstrated both greenhouse gas emissions reductions and measurable health benefits.

The Climate and Health Evidence Bank (Figure 3) was developed to showcase these solutions and to provide the best available scientific evidence to support transformative action on climate and health at global, regional, national and local levels. It consists of a wide range of interventions from across the world and sectors, including energy, transport, agriculture and land use, as well as nature-based solutions such as conservation and ecosystem restoration. Examples include a forest protection programme in Western Tanzania; urban road pricing schemes in London, Stockholm and Milan; the transition from coal and natural gas to renewable energy in the United States; and a bicycle-sharing scheme in Buenos Aires. Each case study demonstrates the scale of emission reductions, the impacts on health and wellbeing, and the feasibility and potential for scale-up. Our review found that most evidence on the health benefits of climate action is derived from modelling studies but we are continuing to collect real-world case studies.

Case Studies

Our case studies show that climate change mitigation actions implemented at global, national and local levels are contributing to greenhouse gas emissions reductions and bringing many benefits to people and the planet.

Explore the **Data**

Filter by: **Region** + **Scale** + **Sector** + **Health effects** + Apply View by:

Ethiopia
Local
AFOLU
Flood mitigation
Food security
Livelihood benefits

Poverty alleviation and environmental restoration in Humbo

The Humbo Community-based Natural Regeneration Project regenerates degraded forests and gives local communities the opportunity to benefit from carbon markets. **Read more** →

Tanzania
Local
AFOLU
Health and Education
Healthcare
Livelihood benefits
Other

Ntakata Mountains Forest Protection Programme

The Ntakata Mountains project protects around 216,000 ha of woodland in Western Tanzania and is improving the livelihoods of approximately 38,000 local people through carbon credits. **Read more** →

London, Stockholm, and Milan
City
Transport
Air quality

Urban road pricing schemes in London, Stockholm and Milan

Assessment of the urban road pricing schemes in London, Stockholm and Milan on congestion, air pollution, CO2 emissions, and traffic accidents. **Read more** →

New Taipei, Taiwan
City
Transport
Air quality

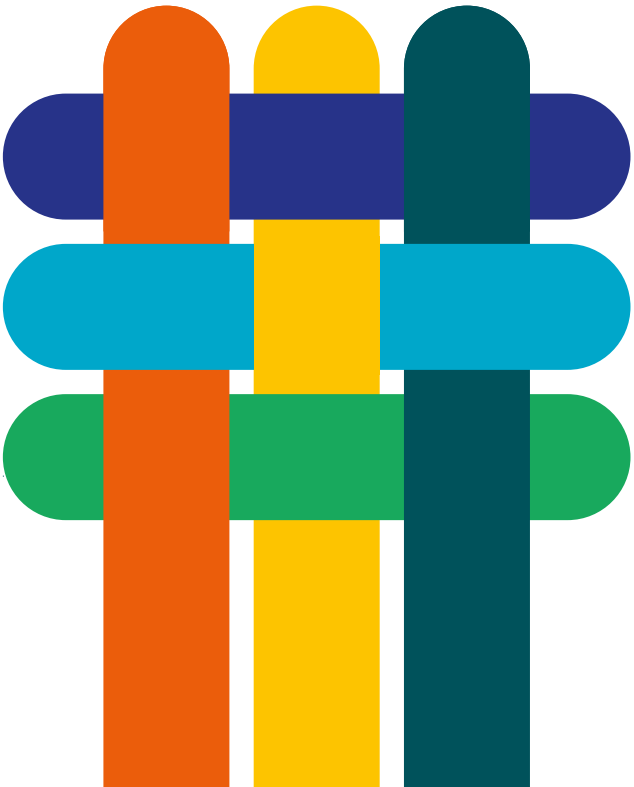
Developing sustainable urban transport in New Taipei

New Taipei, the most populous city in Taiwan, has introduced several actions to promote the use of public transport and active travel to reduce greenhouse gas emissions and air pollution from the transport sector. **Read more** →

Figure 3: Pathfinder Initiative Evidence Bank: case studies section.

Process Evaluation

The Centre promotes innovative qualitative, quantitative and mixed methods research in process evaluations. It also advances diverse approaches to developing, applying and testing programme theories that underpin intervention and programme design.



Organ Donation (Deemed Consent) Act 2019 in England: A policy process evaluation

This process evaluation explored how the Organ Donation (Deemed Consent) Act 2019, which introduced an 'opt-out' system for organ and tissue donation, was implemented in England, particularly within the context of the COVID-19 pandemic. We adopted a mixed-methods, multi-component design to assess its implementation fidelity, contextual influences, and mechanisms of impact. The evaluation included extensive patient and public involvement, ensuring that people's lived experience shaped both our analysis and final recommendations.

Key methods included:

- Media analysis of over 280 UK news articles and thousands of reader comments to explore public messaging, and the public's perceptions and understanding of the purpose of the law change.
- Parliamentary debate review to trace evolving policy narratives and politicians' rationales for proposing the law change.
- Quantitative analysis of National Health Service (NHS) Blood and Transplant audit and registry data to assess trends in consent and donation rates as context for the process evaluation.
- Online structured surveys and qualitative one-to-one interviews with healthcare professionals (n>1,000) to understand frontline staff experiences, training needs, and how the law influenced their practice.
- In-depth interviews with bereaved family members (n=103), including complex decision-making cases under the new legislation and in-depth interviews with members of the public with a focus on people from minority ethnic and faith backgrounds (n=30).

- Comparative policy analysis of the Spanish opt-out system to contextualise England's deceased donation processes and their implications for the implementation of the new law.

The law aimed to simplify 'consent' by removing the burden of decision making from acutely bereaved families, instead emphasising the deceased's wishes in life. But its implementation coincided with a global pandemic, severe staffing pressures, limited public understanding, and a somewhat risk-averse organ donation system resistant to cultural and procedural change. As a result, presumed (deemed) consent—as envisioned by policymakers—was never fully realised in practice.

Our findings have informed national policy debates and recommendations for clearer communication with the public, improved support for families at the bedside, stronger systems for recording people's donation wishes and investment in a sustainable, well-resourced organ donation workforce.

CHIEDZA data collector team.

CHIEDZA trial: Qualitative process evaluation of a community-based intervention to improve HIV outcomes in youth

CHIEDZA community hubs.

CHIEDZA was a cluster randomised trial that investigated the impact of community-based integrated HIV and sexual and reproductive health services for young people in Zimbabwe on HIV and other health outcomes. The process evaluation of the CHIEDZA trial aimed to assess acceptability of the intervention, fidelity, feasibility and adaptations during implementation, document the impact of contextual changes on the implementation, and provide explanations as to uptake of specific components of the intervention, for example HIV self-testing and menstrual hygiene.

CHIEDZA community mobilizers in Bulawayo.

We conducted qualitative research that included: non-participant observations of intervention delivery; interviews with healthcare providers, youth mobilisers, and clients; focus group discussions with youth and adults from both intervention and control communities; and a review of implementation team meeting minutes.

Key results from the process evaluation demonstrated the intervention had high acceptability and showed the importance of young people being offered multiple services in one consultation and the value of non-judgemental healthcare professionals on acceptability and service uptake.

Campaign for Female Education (CAMFED): Process evaluation of the Transitions and Agriculture Guide programme

The CAMFED Transitions and Agriculture Guide programme aims to support young female school graduates to start businesses, seek employment and access further education. The multi-component intervention includes financial literacy training, business planning and advice, reproductive health and well-being information, leadership training, and climate-smart agriculture training. LSHTM, The Health Research Unit Zimbabwe and EDI Global are evaluating the delivery and impact of the CAMFED Transitions and Agriculture Guide. The outcomes being evaluated were selected by young women in the programme and include wellbeing, leadership, and sexual and reproductive health.

We are conducting repeat in-depth interviews with young women enrolled on the programme in Tanzania and Zimbabwe, observations of programme delivery, and a survey at three timepoints. Through this evaluation we will understand the programme delivery, acceptability, and mechanisms of impact. The Health Research Units' youth researcher academy is training and mentoring six young women from the CAMFED Transitions and Agriculture Guide Programme to design and implement small sub-studies within this evaluation. This evaluation will provide key evidence to understand the implementation, mechanisms of impact, context, and acceptability of the programme.

The Safe Inhalation Pipe Provision (SIPP): Process evaluation of a harm-reduction intervention

Crack cocaine use is increasing in England with smoking the most common method of administration. International evidence shows that providing stimulant inhalation equipment has public health benefits and increases engagement with services. However, in the UK, only injection equipment is legally permitted to distribute. With the support of local police, LSHTM and community partners, which included people with lived experience of crack use, developed, implemented, and evaluated the **Safe Inhalation Pipe Provision** (SIPP) intervention. The intervention includes providing a smoking equipment kit and e-training about crack harm reduction. SIPP aimed to reduce crack-related health harms and generate robust UK-specific evidence to inform legislative review.

For the process evaluation we monitored completion of the e-training by staff and the provision of SIPP kits, including uptake, coverage and reasons for requesting new pipe. We collected qualitative data to explore SIPP's implementation, mechanisms, and influence of local contexts, which included interviews and focus groups with providers, clients and other people who use crack who were not engaged with the services, as well as ethnographic observations.

Evidence from the process evaluation was critical to enhance implementation and interpret findings to support future SIPP delivery:

- *Amending the intervention to enhance acceptability:* problems were identified with the smoking kit case, filters, and pipe length/width. A shorter pipe was introduced during the intervention and, longer-term, we collaborated with our social enterprise partner to develop an improved kit.
- *Understanding survey findings:* qualitative data helped link high respiratory burden identified in the survey, itself impacting usability of SIPP pipes, with pre-intervention smoking equipment and practices.
- *Intervention component interactions:* staff played a critical role supporting clients requesting SIPP kits. E-training increased practical crack-related knowledge among staff, which was often low pre-intervention, improving confidence to instigate conversations and ultimately better support clients using crack.
- *Influence of context on engagement:* we identified that services with a stronger abstinence-focused recovery culture were more resistant to SIPP, lessening the impact of training, but increased presentations and disclosure of crack use by clients resulted in staff seeing the benefit of the intervention and supporting SIPP.
- *Identifying unanticipated practices:* qualitative data uncovered that existing clients disclosed crack use for the first time because of SIPP and some people used other drugs with the pipe; neither of these practices were anticipated in our logic model.

SIPP as a harm-reduction intervention has received unexpectedly high interest, with the possibility of a legislative review soon. Justifying changes in law require evidence of impact, but policy makers and providers have specifically requested evidence from the process evaluation on 'why' and 'how' SIPP reduced harm. This evidence has influenced some providers to start local implementation, and the evidence will be important to optimise potential future national rollout.

Optimising the Health Extension Program: Process evaluation of a care-seeking strategy

The "Optimising the Health Extension Program" strategy (OHEP) was a three-year intervention implemented across four Ethiopian regions to improve care-seeking for common childhood illnesses through community engagement, capacity building of health extension workers, and stronger district-level accountability. We conducted a mixed methods process evaluation, which included monitoring data and qualitative interviews, alongside a plausibility study in 52 districts (26 intervention, 26 comparison).

Quantitative fidelity assessments showed that only 6 of 31 planned activities (19%) were implemented, with high fidelity in the initial phase. Qualitative interviews with implementers and district health managers helped to explain the low implementation fidelity. Challenges included the intervention's complexity, weak administrative capacity, limited resources, and bureaucratic delays. Competing district priorities, such as responses to outbreaks, often diverted attention away from OHEP. We also found that supervision of health extension workers was inconsistent as many felt under-supported, and community engagement was uneven across sites, reducing the program's reach.

Based on the process evaluation we concluded that the lack of measurable impact was due to multiple implementation challenges. We recommended that future programmes should prioritise stronger integration with routine systems, improved supervision and support structures, and sufficient time for multisectoral implementation.

Mobile Men trial in Uganda and South Africa: Rapid ethnographic assessments

The Mobile Men trial is a mixed method, open-label randomized controlled trial of Pre-Exposure Prophylaxis (PrEP) implementation. We are working in three fishing communities and one urban setting in Uganda (Masaka district) and in transport hubs and a construction site in South Africa (Eastern Cape and KwaZulu-Natal). Men aged 18 years and above are randomized to receive either oral tenofovir disoproxil/emtricitabine PrEP (on-demand or daily) or long-acting injectable cabotegravir for nine months and then offered the option to switch to their preferred method of PrEP.

We are conducting rapid ethnographic assessments at the beginning, middle and end of the trial to gather detailed information on the geographical and social context of each site, and to track change over time within both the community and among trial participants. Each assessment lasts 15 consecutive days within each community and employs a range of participatory research methods including transect/spiral walks, ethnographic observations, and informal conversations, as well as in-depth interviews and group discussions, with community members, health service providers, and mobile men.

Findings from the first formative rapid assessment informed the selection of trial sites, the location of clinics, and the design of recruitment strategies. The second round of assessments aim to explore local issues affecting recruitment and retention, community perceptions of oral and injectable PrEP and the impact of changes in international funding on the availability of HIV prevention methods and information.

The final assessment will investigate social changes in each place as well as in the HIV prevention landscape, the availability of and reported uptake of PrEP by men who are mobile for work, and others in each setting, and people's views of the trial.

Fish landing site in Uganda.

Add-Vacc HPV vaccine trial: An electronic rumours tracking tool

Add-Vacc is a cluster-randomised trial in rural northwest Tanzania assessing the addition of male HPV vaccination to female HPV vaccination offered through the national vaccination programme on community HPV prevalence. Recognising that vaccine-related rumours can undermine vaccine uptake, we developed and piloted an electronic rumours (eRumours) tracking tool. Using tablets, staff captured information that was reported to them or that they heard in real time, entering the report date/time, location, category and rumour source. Informed by previous research, vaccine-rumour categories included: 1) effects on fertility; 2) general vaccination concerns; 3) COVID-19 (and the trial vaccine); 4) Freemasonry beliefs; 5) samples [collection and use]; and 6) other, with sub-theme and free-text options. We reviewed daily summaries from the trial database and flagged new and sensitive rumours for immediate discussion. We recorded 266 rumours which showed geographic and temporal patterns associated with historical and current events.

The e-Rumours tool promptly raised trial team awareness of rumours influencing vaccination implementation and uptake, including concerns the vaccine was injected into the penis, it was really COVID-19 vaccine, or it caused homosexuality. Real-time rumour reporting, analysis and feedback (Figure 4) facilitated enhanced trial team communication and rapid rumour response, including dynamic and ongoing trial community engagement.

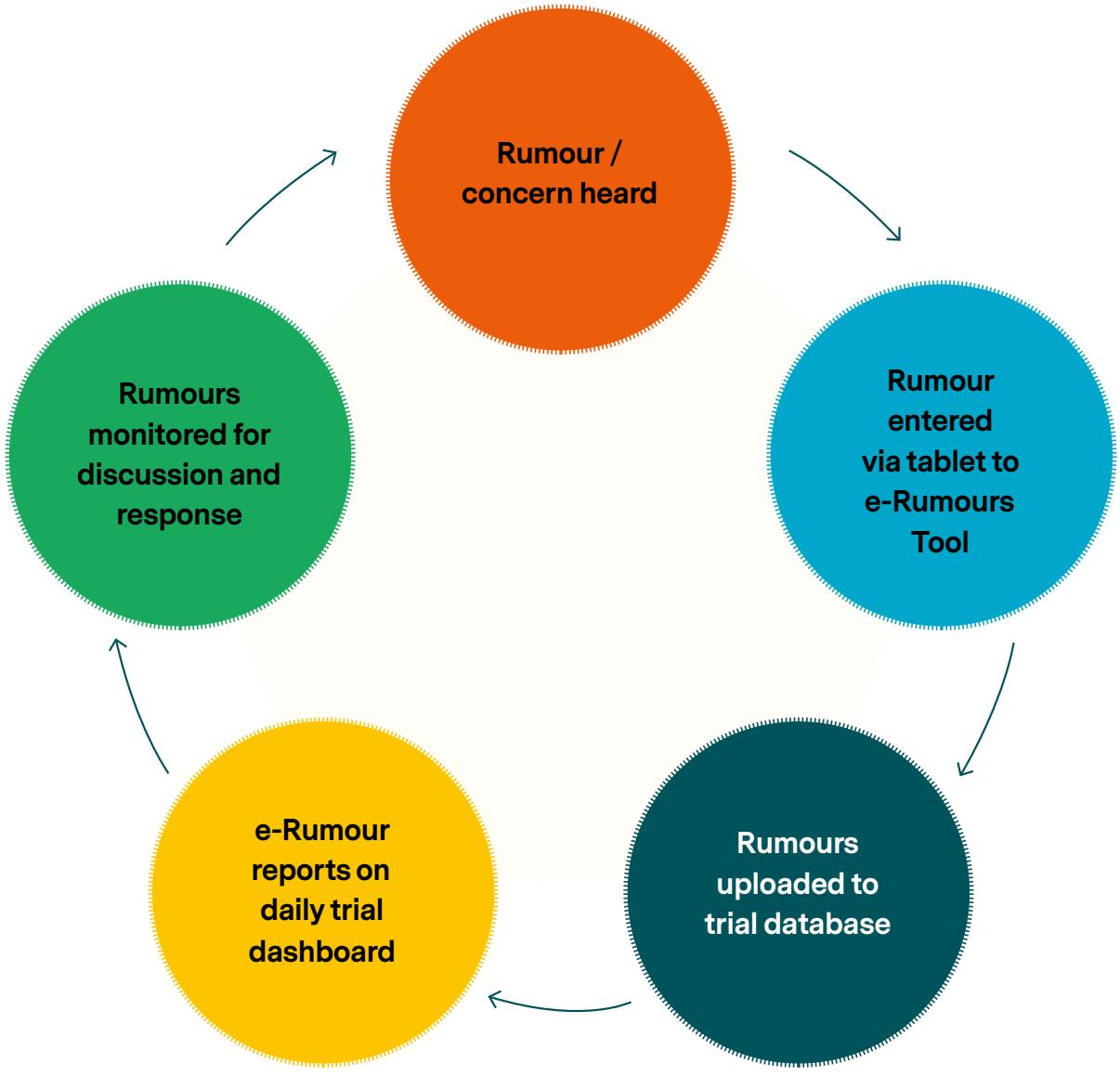


Figure 4: eRumour Reporting and Action Cycle.

Measuring Context

Assessing the ways in which contextual factors affect, and are affected by, implementation, intervention mechanisms and outcomes is a critical part of process evaluation. However, measuring contextual factors can be challenging.

Context Tracker: measuring and interpreting context

A major challenge in process evaluations is meaningfully measuring and interpreting the influence of "context"—the local conditions, relationships, and events affecting how a programme is delivered and received. Many studies struggle to do this in a consistent and meaningful way, partly because they lack practical tools to do so.

We developed a tool called the **Context Tracker** to guide qualitative data collection and analysis within evaluations of complex health interventions. It was first used in Zimbabwe (Figure 5) and later adapted for a study in the UK. Both projects were testing harm reduction approaches to increase healthcare engagement among marginalised communities (female sex workers in Zimbabwe and people who use crack cocaine in the UK).

The Context Tracker uses a simple table to track five key domains of context drawn from implementation science frameworks: physical, social, economic, policy/legal and epidemiological. At regular intervals (monthly in Zimbabwe and quarterly in the UK), researchers populated the table with data from observations, field notes, and interviews, listing factors within the key domains that seemed to help or hinder programme delivery or engagement differently across time and location. For example, during the SARS-CoV-2 pandemic, variations in how restrictions on mobility were policed in different Zimbabwean towns meant some sex workers had greater difficulty reaching programme clinics or peer educators compared to others. In the UK, we found that the level of social connection and trust between people who use crack affected their willingness to participate in intervention activities.

The tool is designed to be structured yet flexible. It enhances the richness and rigour of process evaluations by offering a systematic way to document and compare context across different settings and over the course of the study. Before conducting the process evaluation, the Context Tracker Template can be used to reflect on the five key domains (physical, social, economic, policy/legal, and epidemiological) across three contextual levels (micro, meso, and macro), identifying likely influencing factors for each cell by drawing on existing literature and local knowledge, while adding factors that emerge during implementation. These factors then guide the topics to be covered in regular qualitative data collection. The tool supports a deeper understanding of how contextual factors influence implementation and helps explain why an intervention might only work well in certain places.

Context Domains & Levels	Micro (individual/peer group)	Meso (Community)	Macro (National/Cultural)
Physical	· Location of sex work (street, brothel, entertainment venue)	· Distribution of illegal activity (drug purchase & consumption & sex work "hot spots")	· Climate/Seasonality
Social	· Peer norms regarding drug use/sex work and related risk (alcohol use)	· Social cohesion/support among target population	· Political stability, fragility and/or conflict
Economic	· Charging for sex acts (e.g., higher price for non-use of condoms)	· Local tourism/other industries driving sex work	· Donor/Funding environment
Policy/Legal	· Experience of arrest/harassment by police or other authorities	· Cooperation between services and policies/authorities · Existence of 'victim friendly' units for legal redress	· Laws criminalising or regulating drug use/purchase and sale of sex · National strategy or targets re: health equity
Epidemiological	· Risk behaviour	· Background prevalence rate of HIV, HCV, STI, etc.	· National prevalence rates · Underlying population health

Figure 5: Context Tracker Template: example of factors identified for a Harm Reduction Intervention among sex workers in Zimbabwe.

Impact evaluation

Experimental Designs

The Centre promotes the use of a wide range of experimental and randomised designs to produce strong, reliable evidence on the causal impact of public health interventions, programmes and policies.

Coordinated Care for Alcohol Problems: An individually randomised control trial

Globally, problem drinking is one of the leading risk factors for morbidity and premature mortality. Problem drinking includes three categories – hazardous, harmful and dependent – based on the severity of drinking and associated harm. In many health systems, available treatments primarily focus on the most severe form of dependent drinking and are often limited to hospital-based services, making access difficult for most people.

Coordinated Care for Alcohol Problems (CCAP) is a coordinated package of treatments targeting the entire spectrum of problem drinking in Goa, India. We will use a parallel arm, individually randomised controlled trial (RCT) to evaluate the effectiveness and cost-effectiveness of CCAP. The parent RCT comprises three sub-trials (within each randomisation stratum) which will evaluate CCAP interventions specific to the different categories of problem drinking compared to Enhanced Usual Care. The intervention will be delivered to adult men with drinking problems by trained, non-specialist health workers at the primary care level. Patients will be stratified by the severity of their problem drinking (hazardous, harmful and dependent) and individually randomised into the intervention or control arm.

For hazardous drinking, we will test the effectiveness of Mobile-based Brief Intervention Treatment (M-BIT), a digital intervention, compared to brief intervention leaflets in improving drinking outcomes. For harmful drinking, we will test whether the Counselling for Alcohol Problems Plus (CAP+) treatment will lead to better treatment engagement compared to Counselling for Alcohol Problems (CAP), an evidence-based brief psychological treatment. For dependent drinking, we will assess the effectiveness of home-based detoxification and brief counselling (CONTAD) compared to hospital-based detoxification

(Hosp Detox) in improving drinking outcomes. Finally, for the parent trial we will test the effectiveness of CCAP in improving drinking (combining all severities) and related outcomes compared to Enhanced Usual Care. The randomisation is illustrated in Figure 6.

The CCAP trial will provide evidence for a scalable and consolidated care package for the entire spectrum of Alcohol Use Disorders. Its findings could inform national and global health policies, supporting a shift from hospital-based treatment to integration within primary health care systems.

CCAP Trial

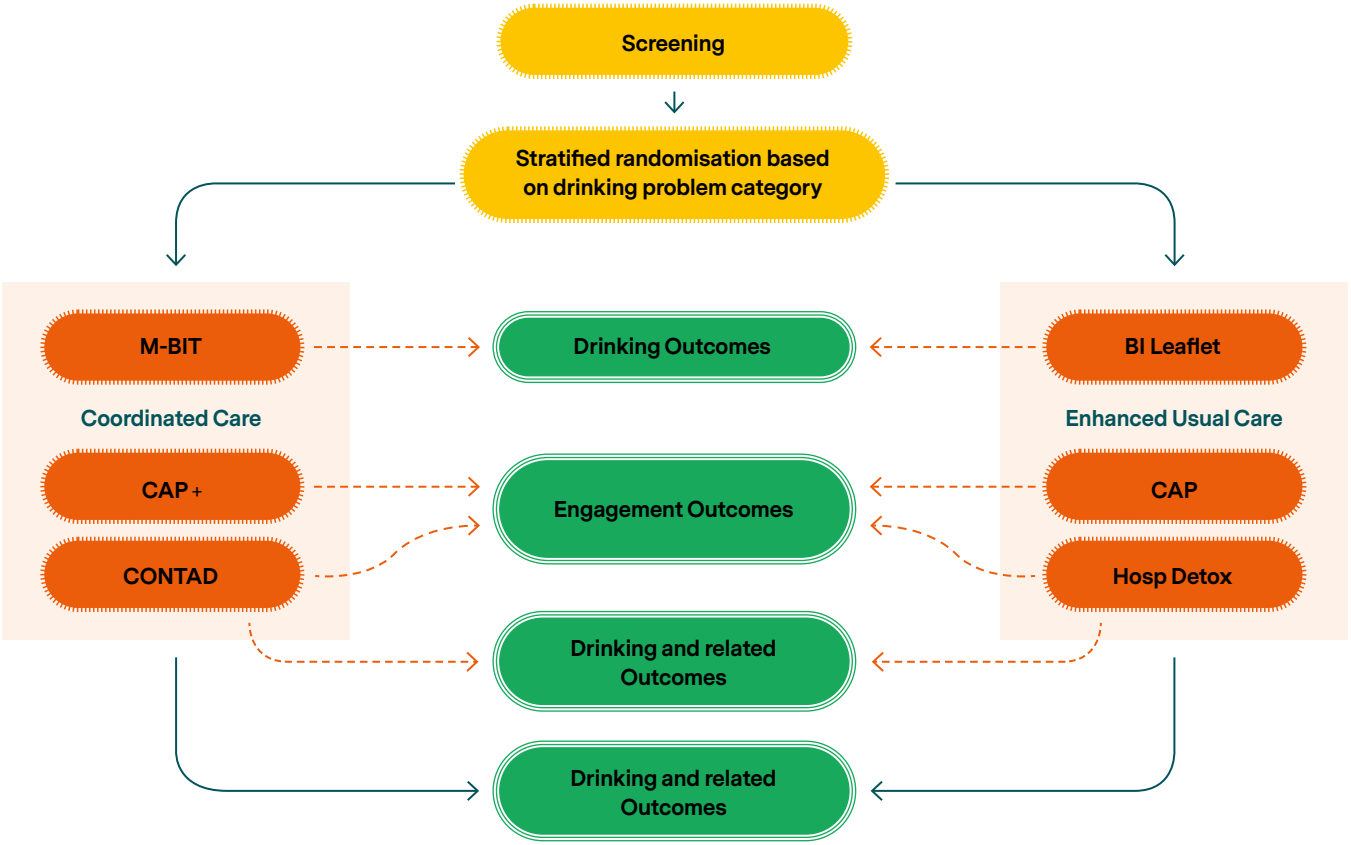
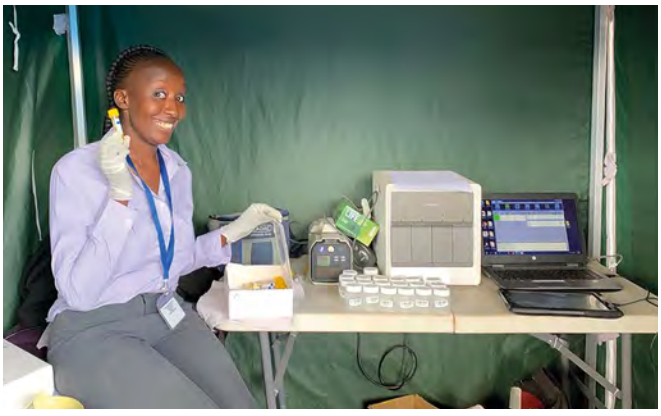


Figure 6: Coordinated Care for Alcohol Problems Randomised Control Trial Design.

STIs in CHIEDZA (STICH): A cluster randomised control trial

Young people are at particularly high risk of sexually transmitted infections (STIs). There is limited evidence of the effectiveness of screening interventions in this group, especially in low-income settings where syndromic management is often the standard of care. Nested within the larger CHIEDZA trial, the STICH (STIs in CHIEDZA) trial was a cluster-randomised controlled trial investigating the impact of a community-based sexual and reproductive health intervention offering STI screening and treatment to young people, compared to the standard of care, on population-level prevalence of STIs in Zimbabwe.

The primary outcome was population prevalence of any of three STIs: *Neisseria gonorrhoeae, Chlamydia trachomatis,* or *Trichomonas vaginalis,* assessed through



STICH Trial Community Based Testing by community health worker, Fadzanayi Hove.

a population-level survey immediately after the intervention period. The trial found high population prevalence of curable STIs as well as high uptake of STI screening among youth who attended intervention sites. Overall community-based STI screening reduced population-level prevalence of *Neisseria gonorrhoeae* but not of *Chlamydia trachomatis* or *Trichomonas vaginalis.*

The process evaluation was critical for interpretation of the trial results, suggesting many young people found it difficult to engage across the STI care cascade of screening, treatment, and accepting partner notification slips. The qualitative data found that healthcare providers attitudes, including friendliness and a non-judgemental and factual approach, was key to encouraging young people to take up screening and partner notification slips for those who returned for their results and treatment.

The trial served as a proof-of-concept of the feasibility and acceptability of population-based STI screening among youth. These findings will inform research and practice for future STI screening interventions.

Clean Frontline: A stepped-wedged cluster randomised trial

Healthcare-associated infections affect around one in ten patients admitted to hospitals in low- and middle-income countries (LMIC). Contaminated surfaces are a major route of transmission, yet hospital cleaners often receive little or no training in environmental hygiene. This was the first trial to test an intervention to improve hospital surface cleanliness in a low-resource setting.

Our stepped-wedge, cluster-randomised trial in 13 Cambodian referral hospitals evaluated a low-cost, training-of-trainers package based on the WHO environmental cleaning guidelines for LMIC health facilities. A stepped wedge design, through which we can capture time trends, was chosen because of the fluctuating nature of the outcome which varies with seasons and associated weather conditions. In addition, this design most closely simulates a real implementation scenario.

'Cleaning champions' were mentored to train ward cleaners, and microbiological cleanliness was assessed monthly by sampling near-patient surfaces. We observed a positive effect of the intervention on cleanliness in the surface analysis. Qualitative findings from the process evaluation showed high acceptability and improvements in cleaners' knowledge, prioritisation of high-risk areas, and cleaning technique, but also highlighted supervision challenges and severe resource constraints, including low staffing levels which limited the opportunity to increase cleaning frequency.

The trial further revealed high variability in levels of surface contamination, making sample size estimation for future trials challenging. At an average cost of US$5,600 per hospital, the approach proved feasible, scalable and has informed plans for national roll-out of this training intervention.

Deep cleaning hospital beds at Sreytouch Vong hospital, Cambodia.

INCLUSIVE: A realist trial

The INCLUSIVE trial evaluated the Learning Together intervention, which took a whole-school approach to preventing bullying and promoting health in English secondary schools. In the Learning Together intervention, schools used restorative practice to address conflict and other behaviour problems. This aims not to merely punish perpetrators but to repair relationships and avoid recurrences. Schools also brought staff and students together into 'action groups' to review data on student needs, and to plan and implement local actions to increase student engagement and belonging, thereby reducing bullying and improving health.

We used realist trial methods to assess impacts, understand intervention mechanisms and how these work in different places and subgroups to produce different impacts. These methods involve proposing initial context-mechanism-outcome configurations (CMOCs), theorising how context and mechanisms interact to generate outcomes, and then refining these CMOCs based on qualitative research nested within the trial. Statistical methods such as moderated-mediation analysis are then applied to data from both arms of the trial to test these CMOCs.

The trial reported that Learning Together prevented bullying and promoted mental wellbeing and health-related quality of life, as well as reduced psychological difficulties, smoking, drinking, drug use and police contact. An independent evaluation commissioned by the Education Endowment Foundation found that the intervention also improved GCSE attainment. Realist analyses suggested that, in schools with strong baseline capacity and relatively low levels of conflict, action groups generating belonging were key to improving outcomes. In schools with less capacity and experiencing more conflict, the key mechanism involved restorative practice curtailing conflict.

Defining Clusters

Defining clusters for a cluster randomised trial is a critical step that can significantly influence the validity, feasibility, and interpretability of the evaluation.

Leveraging GIS to Inform the Design of a Cluster RCT

The IMPRESS study (Implementation of evidence-based facility and community interventions to reduce the treatment gap for depression) was conceptualised to answer two questions in the field of global mental health: can an evidence-based counselling programme for depression be scaled up via the primary health care system in an entire state in India? Can community volunteers be trained to improve demand for, and adherence to, the counselling programme?

The formative phase of this Hybrid Type II cluster randomised controlled trial aimed to study service utilisation of all primary health centres in Goa using a Geographic Information System (GIS). An administrative map of Goa was uploaded into QGIS, and coordinates of 30 health centres were mapped using Google Maps. Data on attendees' areas of residence were gathered through a three-month retrospective review of clinic registers and a brief questionnaire administered to a convenience sample at primary health centres. Finally, we used QGIS to analyse this consolidated health centre data, creating maps of the specific administrative units served by each health centre.

We found that the official structure of India's primary health care system was not reflected in reality. While the system has been designed to prioritise geographical accessibility by providing comprehensive care closest to people's home, we found that only 17% of the attendees attended the primary health care facility corresponding to their catchment area over the 13-week data collection period. During this time, most people accessed 5-15 different primary health care facilities for their varied health care needs.

This prompted us to reimagine the definition of a 'cluster' for our study. We used GIS mapping to define clusters as mutually exclusive groups of villages where more than 70% of the residents exclusively accessed a single health centre. 28 of the 30 PHCs in our sampling frame served our newly defined clusters and were included in our randomization process. More importantly, by using GIS to map healthcare utilisation patterns we were able to avoid potential contamination of the community-based intervention by establishing mutually exclusive clusters.

Our key takeaway from this study was that GIS mapping can be used to support trial design as administrative boundaries set by the health system do not necessarily determine healthcare seeking, especially in low-resource settings wherein contextual factors such as transport routes, prevalent stigma, and lack of support from the family, often prompt people to seek care at healthcare facilities which might not be geographically closest to where they live.

Quasi-Experimental Designs

The Centre supports members in pragmatically applying and combining quasi-experimental methods to enhance impact evaluations, recognising that random allocation is not always feasible, ethical, practical or preferable.

Adolescents 360: Using quasi-experimental methods to evaluate a reproductive health intervention for adolescent girls

Figure 7: A360 multi-component external evaluation.

Adolescents 360 (A360) aimed to increase voluntary modern contraceptive use (mCPR) and reduce unplanned pregnancy among girls aged 15-19 years in Ethiopia, Tanzania and Nigeria. The innovative A360 intervention design approach combined human-centered design with social marketing, developmental neuroscience, sociocultural anthropology and youth engagement. LSHTM led the external outcome evaluation of this programmatic intervention (included in Figure 7).

The human-centered design involved an extended intervention development process which meant that details of the intervention were not fully defined by the time we had to design the evaluation study. Randomisation of intervention delivery was not possible, and we needed to evaluate the intervention in all three countries. We used the resources available to conduct two different types of studies. In two states in Nigeria, we used a quasi-experimental approach conducting repeat cross-sectional surveys (pre-post evaluation) in intervention and matched comparison communities. The primary analysis was an estimation of difference in differences in mCPR within each state. In Tanzania and Ethiopia, due to resource constraints, we conducted repeat cross-sectional surveys (pre-post evaluation) in intervention communities only. We also captured secondary outcomes mapped onto a theory of change which allowed us to observe whether changes occurred as expected along the causal pathway. Interpretation was aided by a process evaluation led by Itad along with secular mCPR trends and self-reported A360 exposure data. There was also an external cost effectiveness assessment led by Avenir Health.

Approximately 23,500 girls were interviewed at baseline in 2017 and a similar number in 2020/21. A360 did not lead to increased use of modern contraceptives from adolescents at a population level, except in Oromia, Ethiopia. The process evaluation found that self-reported exposure to A360 was low, ranging from 5–24%, and in three settings was positively associated with contraceptive use.

100 Million Brazilian Cohort: Using regression discontinuity designs and propensity score methods to evaluate the effect of Bolsa Familia conditional cash transfers on health outcomes

The 100 Million Brazilian Cohort links the records of individuals and families who have applied to the Bolsa Familia Programme, the largest conditional cash transfer scheme worldwide, with several morbidity and mortality health records. The cohort includes over 140 million people who applied for social protection from 2001 with data for approximately two-thirds of Brazils' population. We developed the cohort in collaboration with the Center for Data and Knowledge Integration for Health from Fundacao Oswaldo Cruz (Cidacs/Fiocruz).

Evaluation of Bolsa Familia relies on observational data. Therefore, we applied quasi-experimental designs to estimate the programme's effects on health while controlling for differences in the target population and comparing outcomes of people who received or did not receive the programme. In designing the evaluation, we took advantage of the delays in programme implementation and the availability of extensive socioeconomic and demographic data coming from the cohort baseline. This allowed us to incorporate regression discontinuity designs using income thresholds, and propensity score-based methods using socioeconomic and demographic data. The latter includes propensity score and kernel matching, propensity score weighting, and marginal structure models to assess the effects of the programme on different health outcomes.

As of July 2025, the data platform has provided evidence on the intended and unintended effects of Bolsa Familia on improving health outcomes. This includes birth outcomes, child mortality, leprosy, tuberculosis and HIV incidence and treatment outcomes, suicide, all-cause and cardiovascular disease mortality. The cohort is ongoing and is now including geocoded data, longitudinal socioeconomic updates and linking climate and environmental data to investigate the role of social protection policies as adaptation strategies to climate change.

Figure 8: Logo for the 100 Million Brazilian Cohort.

Police Stop and Search practices: Using interrupted time series and difference in difference methods to evaluate the impact on crime and mental health outcomes

The evidence for the effectiveness of stop and search practices (SAS) conducted by police forces is limited and suggests the strategy has small, if any, impacts on reducing violent crime among adolescents. Negative impacts in targeted communities on their mental health outcomes, and disproportionality in targeting by race, ethnicity or socioeconomic status have been used as arguments for intermittent curtailment of police SAS powers. However, SAS practices are highly valued by forces who argue for their deterrent effects.

A key issue in measuring effectiveness is the difficulty in designing robust evaluations of SAS given the practice is usually applied in ways that bias causal conclusions (i.e., a focus on high crime areas, and/or the combination of SAS with other policing strategies). Randomised trials of SAS are rarely possible given issues with removal of what are perceived as core police powers. This project in London and Manchester will therefore exploit a natural experiment to conduct two quasi experimental evaluations: a rapid fall in UK SAS rates in 2014-16 due to a change in government Home Office SAS legislation, and a subsequent rapid rise in 2018-20 following a change in Home Secretary and reversal of legislation.

The first is an interrupted time series analysis comparing rates of violent crime in children and young people over the period of the mandate changes, using aggregated crime data from Greater Manchester Police and London Metropolitan Police. The second is a granular analysis matching small areas with high and low rates of SAS but similar crime rates over the same periods to conduct a pooled difference in difference analysis. This will be accompanied by a descriptive study of ethnic disproportionality in SAS practices, and participatory modelling – a qualitative analysis approach to understand causes and mechanisms by which SAS leads to negative mental health outcomes in targeted youth populations.

Selective Licensing schemes for private rented housing in England: A mixed method natural experiment

Over four million households in England rent homes from private landlords, accounting for 19% of all households. The private rental housing sector (PRS) has doubled over the last two decades. The social housing sector has been shrinking since the 1980s while the global financial crisis has made it harder to buy a home. The proportion of homes failing to meet the criteria of the Decent Homes Standard in 2019 was 23% in PRS compared to just 12% in the social rented sector and 16% for owner occupied homes. The costs to the NHS of dealing with health problems caused by poor housing conditions in the sector is estimated to be £340 million per year. Since 2006, local authorities have had discretionary powers to implement so-called Selective Licensing (SL) schemes for periods of five years at a time. Private landlords operating in the designated zones must register, pay a fee, and allow health and safety inspections.

We are currently undertaking a mixed methods evaluation of the Selective Licensing in England to establish whether the schemes improve the sector and lead to health and social benefits for residents. The project is led by LSHTM with funding from NIHR and involves a team of researchers from five different universities. Selective Licensing is an area-based intervention, and the impact evaluation is designed as a natural experiment. A range of health, social and economic outcomes will be studied pre/post implementation and compared to matched control areas. The matching used socio-demographic data for small areas (Census and Indices of Multiple Deprivation). The process evaluation involves stakeholder interviews with tenants, landlords, local authority implementers, and third sector representatives across England.

Y-Check: A hybrid implementation-effectiveness study using a mixed-methods pre-post design

In low- and middle-income countries, improving access to preventive interventions for adolescents (10-19 years) is critical in the context of high morbidity and mortality from communicable and non-communicable diseases. Schools offer an important opportunity to reach adolescents with health services and offer the potential to provide routine health check-ups ('well-care visits'). To address the gap in evidence on the feasibility, acceptability, and effectiveness of 'well-care visits', WHO is coordinating the Y-Check Research Programme in cities in Zimbabwe, Tanzania and Ghana. The Y-Check intervention was implemented between 2022-24 among 10–19-year-olds. The intervention involved well-care visits in schools and community venues, providing health promotion as well as screening, treating and referring adolescents for common conditions. We used self-administered digital questionnaires, clinical tests, and nurse/physician assistant reviews to screen for 20-25 conditions/behaviours, including mental health, nutrition, and HIV/STIs (HIV/STI screening was only conducted among older adolescents in the community settings, not in schools).

We are evaluating the implementation and short-term effects of Y-Check through a hybrid implementation-effectiveness study incorporating a mixed-methods pre-post design. The primary outcome is the proportion of those screening positive for ≥1 health issue who receive appropriate on-the-spot care and/or complete documented referral(s) for all identified issues. Implementation outcomes, including acceptability, adoption, appropriateness, feasibility and fidelity, are being assessed through a mixed-methods process evaluation. Data from observations, in-depth interviews and participatory workshops will be analysed thematically. Secondary effectiveness outcomes such as changes in behaviours will be measured through pre-post surveys. A full-cost economic evaluation will be undertaken from the provider perspective to estimate the total cost of setting up and implementing the intervention.

Y-check intervention team, Zimbabwe.

Y-check tablets to collect self-administered questionnaires.

Great Green Wall (GGW) of Africa: Using a natural experiment to understand the health implications of large scale environmental restoration

The Great Green Wall (GGW) is an ambitious African-led initiative that seeks to combat climate change, restore biodiversity, and improve livelihoods in dryland regions. Spanning the width of the Sahel, it aims to restore 100 million hectares of degraded land by 2030.

While environmental and socio-economic benefits of GGW interventions are well documented, the health impacts of the GGW – and restoration in general – remain underexplored. Emerging evidence suggests both positive outcomes, such as improved nutrition and mental health, but also potential risks, including exposure to infectious diseases.

A key challenge is our inability to control the intervention for epidemiological investigation is that the restoration activities are already taking place and we cannot fully randomise people to treatment or control groups. As such, we are using mixed methods and a quasi-experiment to investigate the health impacts that can be linked to the activities. We are combining literature review, secondary data analysis, qualitative and quantitative surveys, and a non-randomisable prospective cohort study focusing on nutrition and infection indicators across three study countries: The Gambia, Senegal and Burkina Faso. Findings will be integrated into a systems model, linking environmental restoration to health impacts and costs.

Residential area in the GGW beneficiary village of Tambana (The Gambia).

A domestic stable with a horse for farm work in the GGW beneficiary village of Jaba (The Gambia).

Research team during an interview with a female local mayor in the village of Jufureh (The Gambia).

Cross-Cutting Topics

Group of women in meeting discussing health impacts of a Polio vaccination (Credit: Louis Leeson).

Decolonial & Equitable Approaches

Within the field of evaluation, there is a growing movement to advance methods, theory, and practice through the application of evaluation approaches that are decolonial and equitable. This movement draws predominately on indigenous scholarship from the Global South. The Centre aims to synthesis these learnings and promote decolonial methodologies and equitable practices in evaluation among its members and the wider LSHTM community.

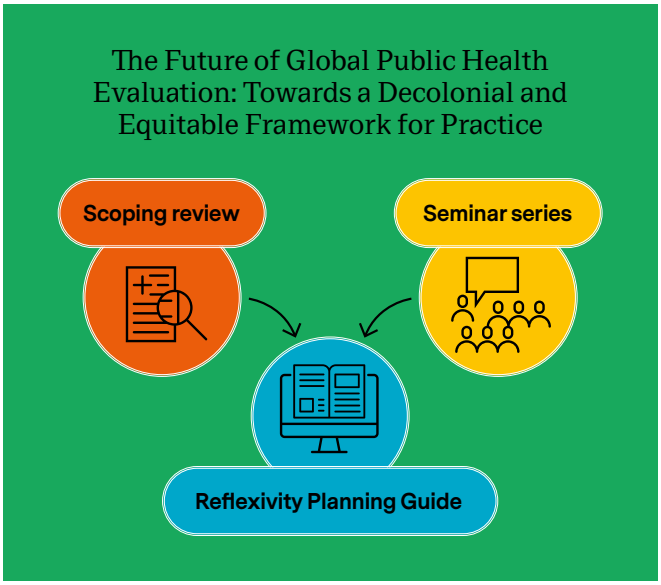


Figure 9: Review of decolonial and equitable approaches to evaluation.

Scoping review of decolonial and equitable approaches to evaluation

To better understand the growing movement to decolonise evaluation, the Centre for Evaluation conducted a scoping review of existing literature (illustrated as part of Figure 9). The review synthesised 54 key sources from global health and development evaluation methods to map the conceptual and practical guidance available for evaluators seeking to move beyond Eurocentric norms.

The analysis identified four distinct but overlapping clusters of approaches: 1) Indigenous frameworks that centre relationality and community-driven processes; 2) decolonial and anticolonial approaches that explicitly analyse and disrupt power structures; 3) culturally responsive evaluation that aligns methods with local values; and 4) participatory approaches that champion community ownership and empowerment.

This synthesis provides a valuable map for evaluators and researchers, showing a rich ecosystem of under-used paradigms and frameworks. However, the review also highlighted critical gaps in the evidence. The field is still debating how to integrate these diverse frameworks, and there is a notable lack of empirical studies demonstrating their effectiveness in practice. Key questions also remain around evaluator positionality and the feasibility of embedding these methods within traditional evaluation projects.

Building on the review, we have developed a reflexivity planning guide that represents the starting point for collective reflexivity, fostering deeper discussions on ethical, contextually relevant, and justice-oriented evaluation practices across the Centre for Evaluation members. This guide is structured around the health evaluation cycle, encompassing the following phases: idea development; project development; implementation;

post-data collection and analysis; and project completion and review. Each phase includes a set of reflexive questions, evidence from the literature on best practice, and key considerations related to evaluation types, methodologies, and contextual factors, where applicable. Over the coming years we will continue to evaluate and review the use of the guide and aim to enhance decolonial and equitable practices in all evaluation involving LSHTM researchers. In addition to this internal resource, to take this discussion to the wider academic community, we wrote a viewpoint in the Lancet Global Health (in press) that advances the argument for approaching implementation science through a decolonial lens, contending that methodological pluralism, epistemic justice, and the redistribution of power are essential to strengthening scientific rigour.

EquiPar: Piloting a tool to strengthen the equity of research partnerships

A recent addition to LSHTM's decolonisation strategies is EquiPar – a practical tool to support fairness and equity at the level of individual research projects (Figure 10). Recognising persistent inequities in research partnerships rooted in colonial legacies, power imbalances, and knowledge hierarchies, a group of researchers at LSHTM have developed EquiPar to encourage research teams to reflect critically on key dimensions of partnership, including people and relationships, research activities, and resource management. The tool was piloted in 2023 across six LSHTM and low- and middle-income country collaborations, using a mixed methods approach including a survey, in-depth interviews, and workshops involving both LSHTM and partner institutions.

Findings showed widespread engagement with the tool and positive perceptions amongst all the teams. Respondents appreciated EquiPar's structured yet flexible approach, which helped facilitate open dialogue, promote inclusive practices, and raise awareness of equity-related issues, including gender and professional hierarchies. It also supported more thoughtful planning, clearer roles, and more collaborative authorship. While some challenges were noted, such as time constraints and institutional and structural barriers beyond individual projects, most participants found the tool valuable, with many planning to use it in future work and recommending it to others.

EquiPar reflects LSHTM's broader commitment to decolonising research and advancing equity through meaningful partnerships. Our next steps include refining the tool, creating a user-friendly digital version, and embedding its use across LSHTM's research ecosystem and also more widely, to support a broader shift towards equity and justice in global health research partnerships.

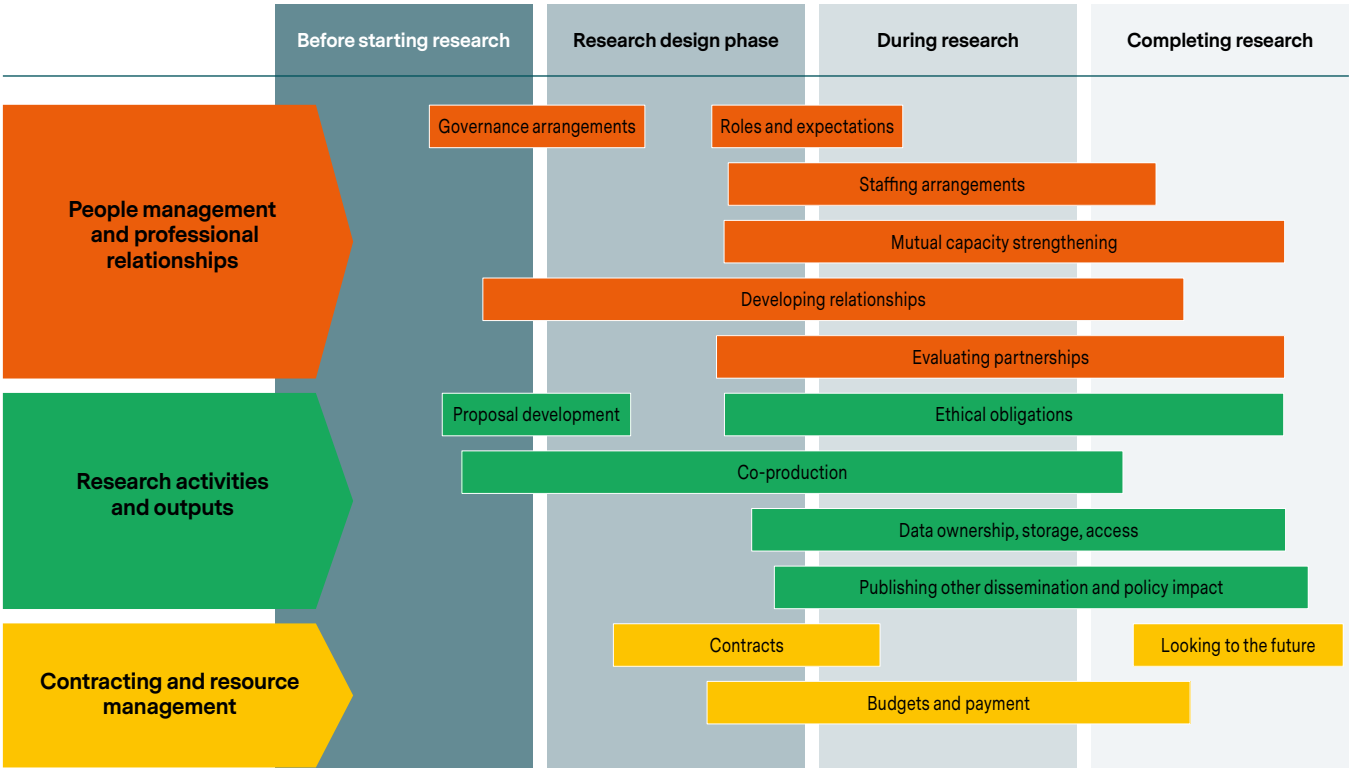


Figure 10: Domains across the three themes in the EquiPar Tool.

An equitable partnerships approach to evaluation

Uneven power dynamics are common in the evaluation of complex health interventions where a range of stakeholders are involved. An equitable partnerships approach to evaluation can help build trust and space for resolving conflicts for ensuring successful intervention and evaluation outcomes. To guide them through their partnership work, The MRC International Statistics & Epidemiology Partnership (ISEP), through its working group, has developed an Equitable Partnerships Framework, which draws on a range of guidance tools such as LSHTM's EquiPar tool. The framework is purposefully integrated within ISEP's monitoring and evaluation (M&E) framework to ensure continuous assessment and improvement of its practices for achieving its goal of being fully African-led by 2028. It is built on equitable partnership principles tailored to ISEP's objectives, e.g., 'Principle 3 – Our work will be: multiculturally valid and oriented towards Africa partner ownership'.

The framework also contains two adaptable annual assessment tools: (1) joint assessment tool; (2) self-survey. The joint assessment tool is for co-investigators to discuss how well the partnership is doing against a set of equitable partnership criteria and to agree collectively on how best to move forward. The self-survey is for the wider ISEP community and has a broader focus; it asks questions against each outcome in the partnership's Theory of Change, with a section dedicated to equitable partnerships. The decision to have a section instead of a whole tool is deliberate, for upholding ISEP's principle of respect for people's time and conflicting priorities. Having the framework and associated assessment tools integrated into M&E allows ISEP members to hold themselves accountable to each other and monitor whether fluctuations in power affect the partnership's other outcomes and goals.

Participants putting their hands in a circle to show that partnerships are a core element of Global Health research.

Participatory Practices

The Centre for Evaluation aims to promote effective stakeholder involvement in evaluation, support the use of robust and critical approaches that ensure stakeholders have decision-making roles and assess the impact of various participatory practices.

Figure 11: DEPTH approach, reproduced with permission. Marston C, et al.

Co-production of a mixed-method quasi-experimental evaluation of National Ugly Mugs services

Sex workers and services have developed ways to prevent violence and support survivors, but we don't know enough about what works best to improve sex workers' safety and mental health. The *Sex Workers Evaluate Reporting Violence* (SWERV) project is led by researchers at LSHTM, National Ugly Mugs (NUM) and Brunel University.
NUM is a UK-wide charity working with sex workers and their core violence prevention and support services include the processing of reports of harm against sex workers; provision of victim support services; and dissemination of alerts to warn sex workers of dangerous people and conditions that pose a threat to their safety. NUM curates the national database of violence and harms against sex workers known as the 'NUMChecker'. This tool allows sex workers to screen potential clients using email addresses, phone numbers, profile names and vehicle registrations, to determine if there is a match to a submitted report.

With sex workers and sex worker organisations central to the process, we have designed a mixed-method quasi-experimental design informed by realist principles, to evaluate how NUM's services affect sex workers' safety and mental health.

The participatory methodology is framed by the DEPTH (Dialogue, Evidence, Participation and Translation for Health) approach (Figure 11), which uses dialogues with communities and practitioners to co-produce action-oriented health research. The DEPTH approach involves: mapping to identify key groups and evidence; first dialogue

workshops to co-design the research with key groups; data generation and preliminary analysis; second dialogue workshops to co-create final analysis and ideas for action; and research into action, working together to change policy and practice. We have also recruited a group of community co-researchers and advisors with diverse lived experiences of sex work onto the study team and advisory group, to co-design, deliver (data collection, analysis and write-up), steer and disseminate the findings and recommendations of the research.

The evaluation itself will include a qualitative and quantitative process evaluation; a pre and post cohort study with non-equivalent comparison group to estimate impact; and an economic evaluation comprising costing of interventions and cost-effectiveness analysis.

Experience-based co-design of integrated HIV and SRH services in Zimbabwe

In Zimbabwe, HIV and Sexual and Reproductive Health (SRH) services remain fragmented despite overlapping needs, leading to missed opportunities for comprehensive, person-centred care. The TSIME study (Integrating Sexual and Reproductive Health into clinic-based HIV services in Zimbabwe) aims to develop and test an integrated model of HIV and SRH care for people living with HIV (PLWHIV) in public health settings. The study used Experience-Based Co-Design (EBCD) as a participatory evaluation and intervention design approach to centre the experiences of patients and frontline health workers (Figure 12).

Our objectives were to: i) understand how people experience fragmented care pathways; ii) identify user-defined priorities for integration and iii) co-design and test context-sensitive improvements to service delivery.

The participatory evaluation involved five key stages:

- **Narrative interviews** with PLWHIV and providers
- **Feedback events** to identify emotionally significant moments in care
- **Joint workshops** bringing together users and providers to prioritise changes
- **Prototype development** of integrated care practices (e.g., improved waiting times, targeted counselling, simplified workflows)
- **Clinic-level implementation** of selected changes, with ongoing feedback

Notably, the co-design process began with qualitative research in the form of narrative interviews with key informants, including healthcare providers, managers and people living with HIV. These same participants were then engaged as stakeholders in subsequent feedback events and workshops, ensuring continuity between early data collection and collaborative design of the intervention.

This approach enabled service users and providers to become co-evaluators and co-creators, defining what 'successful integration' means from their perspective. It also strengthened local ownership and alignment with Ministry of Health priorities. In resource-limited settings, participatory and co-production approaches such as EBCD help ensure evaluations are grounded in lived experience, responsive to context, and more likely to inform sustainable change.

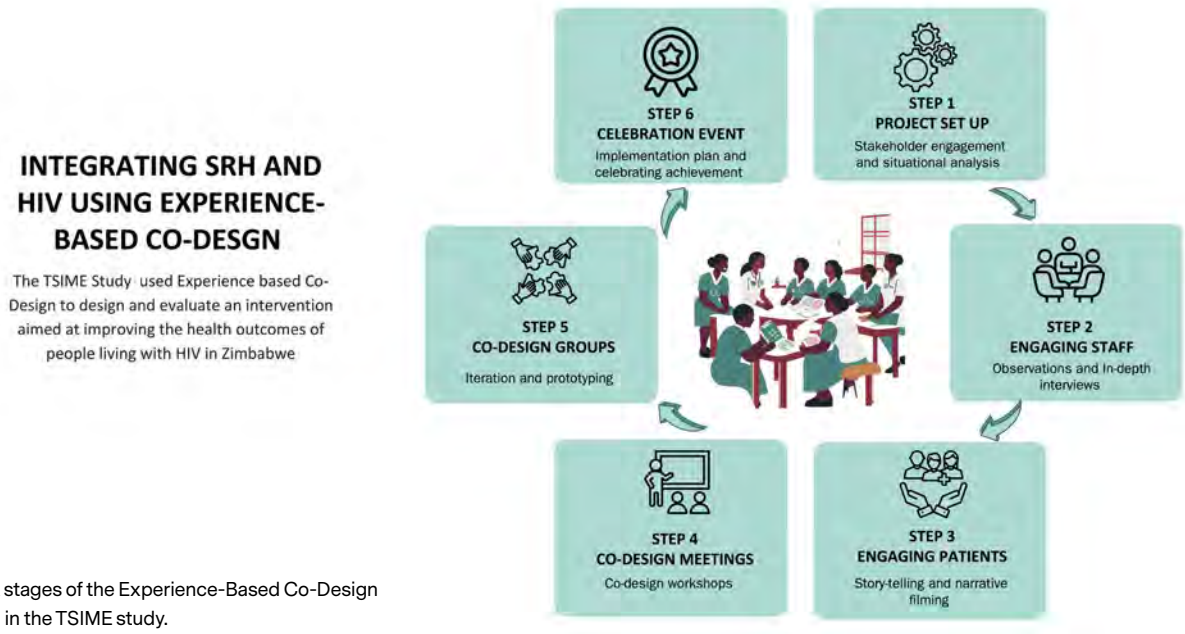


Figure 12: Six stages of the Experience-Based Co-Design process applied in the TSIME study.

Disability Inclusive Youth (DIY) research: Including children and youth with disabilities in defining disability inclusive research

'Disability Inclusive Youth (DIY) research' is an innovative and co-creative programme which aims to improve inclusion of children and youth with disabilities in health research in East Africa', funded by the Wellcome Trust. The DIY programme uses a participatory approach to include children and youth with disabilities in health research in Kenya, Rwanda and Uganda. Youth with disabilities receive a two-week research training and undergo internships at the MRC/UVRI & LSHTM Uganda Research Unit, University of Nairobi and University of Rwanda.

They then explore the barriers and facilitators to disability inclusive health research by conducting qualitative interviews with leading health researchers, key health stakeholders, government and research organisations, and health service providers. In addition, the youth researchers use qualitative research methods including journalling, drawings, photo voice and participatory video to document experiences of children and youth with disabilities and their caregivers in health research. Through participatory workshops, recommendations are designed to make health research in the region disability inclusive.

The DIY study has an advisory board consisting of academic representatives from British and African universities and national disability council and union members from Kenya, Rwanda and Uganda. In addition, each country has a Youth Advisory Group consisting of youth with different impairments, which advises the research teams on the cultural acceptability and inclusivity of the design, implementation and evaluation of the study activities.

The DIY training and mentorship programme was designed and piloted in Uganda in 2023, in collaboration with the THRU Zim unit, Makerere University and National Council for Persons with Disabilities, funded by the Arts and Humanities Research Council. The first cohort of youth researchers made a participatory film about their experiences.

Involving young people and professional stakeholders in a qualitative systematic review and meta-ethnography synthesis of youth violence in the UK

We conducted a qualitative systematic review and meta-ethnography synthesis to explore children and young people's accounts of their involvement in serious youth violence in the UK. We conducted public involvement with two key groups: young people and professional stakeholders representing those in youth work, academia and voluntary organisations. The aims of the consultations were to: (1) foster a dialogue between the researchers, the young people and stakeholders; and (2) share details of the proposed review, method and findings and consider their dissemination and real-life implications.

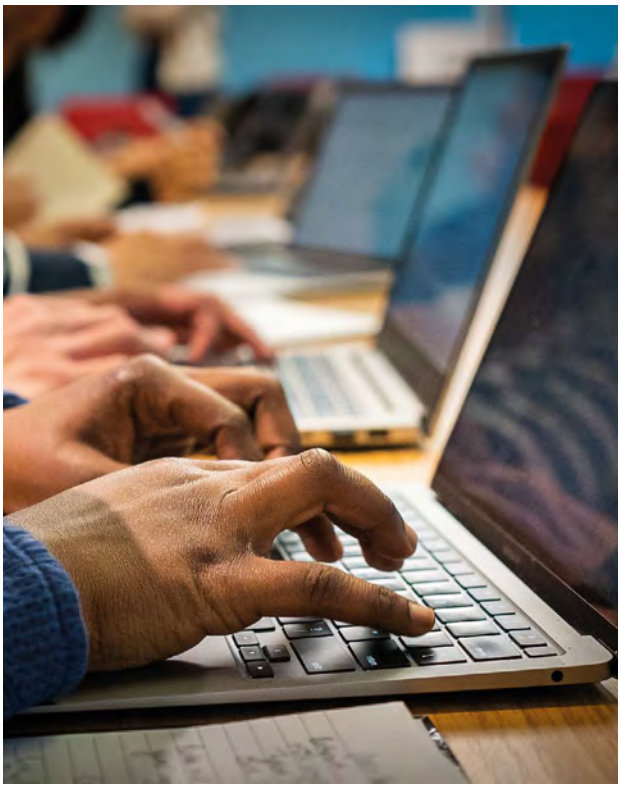
We sought feedback on our conceptual model; how they define the key concepts including serious youth violence, at risk youth; as well as exploring differences in experiences across gender, ethnicity and geography, both in terms of entry into or exit from violence. Young people were consulted at two-time points: once at the beginning of the review process and once after we completed the initial analysis.

The feedback from the public involvement sessions included young people's perspectives of the concept of violence, particularly, the importance of structural violence and the impact of structural inequities. They reflected on the challenges and contributions of mental health issues.

Professional stakeholders welcomed the focus of qualitative evidence to challenge the over-reliance of quantitative evidence. However, they also queried the feasibility of having a complete picture through qualitative data, particularly capturing environmental or structural influences, as some thought qualitative research may more readily reflect individual or interpersonal dynamics rather than structural. At the follow-up session, young people proposed disseminating findings in formats that are visually engaging and accessible, especially for use in settings like youth clubs, advocating for low-text, user-friendly materials that young people can easily relate to and engage with.

Artificial Intelligence

The Centre has begun exploring the role of Artificial intelligence (AI) in evaluating complex public health interventions, with particular attention to its implications for decolonising evaluation and strengthening participatory practices.



MSc Students working in study space (Credit: LSHTM).

Expert workshop on role of AI in evaluation

Artificial intelligence (AI) is increasingly being used in the health sector to improve service delivery. However, there has been limited attention to the role of AI in evaluating public health interventions. To address this gap, in December 2024 we convened an expert workshop with 60 participants from 12 organisations. The workshop reviewed existing evidence on the use of AI in evaluating complex public health interventions and explored how approaches from other areas of health could be transferred into evaluation design.

In the opening session senior LSHTM staff shared updates on the development of an AI strategy for education, research and operations, while a representative from the World Health Organization (WHO) spoke about their guidance on the ethics and governance of AI in health.

The evidence synthesis session featured sessions on: guidance for the responsible use of AI in evidence synthesis; using AI to automate descriptive mapping; and developing and using machine learning systems for extraction and prediction. Most speakers in this session were colleagues from the UCL Evidence for Policy and Practice (EPPI) Centre who are focusing on the role of AI in evidence synthesis to enhance policy and practice decision-making. In collaboration with the EPPI centre, we host the 'London Systematic Reviews and Research Use Seminars' and through this series, we will continue to host seminars on the use of AI in evidence synthesise.

In the impact evaluation session, colleagues presented on: using AI to design interventions, enhance recruitment and retention, and maximise sample size (e.g., with 'digital twins' as control groups); using computational methods to measure the impact of expenditure on development outcomes; applications of AI in genomic surveillance; and the importance of understanding the 'black box' of machine learning tools. These discussions highlighted the extensive use of AI in statistical analysis and the need to identify opportunities for sharing good practice.

In the process evaluation section, we heard about the value of AI in: processing images for object detection and classification; scanning, processing and summarising quantitative data; transcribing, translating, coding and even collecting and analysing qualitative data. These discussions revealed substantial methodological gaps in the application of AI to process evaluation, but also highlighted the potential to adopt or adapt existing AI methods to measure implementation, mechanisms of impact and contextual factors. This is an area of methodological research where the Centre for Evaluation is well placed to contribute.

Looking ahead, we will continue to explore the opportunities and challenges that AI presents for evaluating complex public health interventions, while also considering its implications for our commitment to decolonising evaluation and strengthening participatory practices.

Using human-AI collaboration to map public health policy options

Synthesising evidence for policy options becomes challenging as evaluations of public health interventions (EPHIs) rapidly proliferate worldwide. Our Mapping Public Health Policy Options project mapped out research topics and EPHIs in The Trials Register of Promoting Health Interventions (TRoPHI) database. Utilising an innovative human-artificial intelligence (AI) collaboration, we conducted bibliometric analyses of TRoPHI records published from 1995 to 2024. Intervention functions were classified manually, whereas health topics were synthesised into ten categories by human and automatic AI coding (GPT-4-omni, version February 2024).

Of 17,279 eligible EPHIs, 16,774 (97%) were analysed for both health topics and intervention functions. The majority of evaluations (52%) focused on lifestyle behaviours (e.g., healthy eating, parenting). Regarding intervention function, capability-based interventions (e.g., education, information provision) and individual-level interventions (including therapeutic/motivational approaches) were employed by most EPHIs with a persistent dominance throughout three decades. Fifty-nine percent of evaluations involved both capability-based and non-capability-based interventions. Among non-capability-based EPHIs, structural interventions (changing policies, laws or environments) were the least utilised (7%).

EPHIs over the past three decades focused on the individual level and most targeted lifestyle behaviours, with continued neglect of broader determinants of health. Future evaluations should address under-represented topics to mitigate inequities in evidence synthesis. Generating evidence on broader health determinants is urgent for making real progress in public health.

Digital Evidence Synthesis Tool INnovation for Yielding improvements in climate & health (DESTINY)

Rigorous evidence about what works and why, is urgently needed to address the climate emergency. The development of artificial intelligence (AI) and machine learning (ML) offers great opportunities to improve the efficiency with which reviews are completed. However, AI needs to be used responsibly to ensure that rigorous and transparent processes are followed to reach conclusions. LSHTM Planetary Health Group researchers are leading a programme of impact cases for a new £10 million Wellcome-funded project, **D**igital **E**vidence **S**ynthesis **T**ool **IN**novation for **Y**ielding Improvements in Climate & Health (DESTINY).

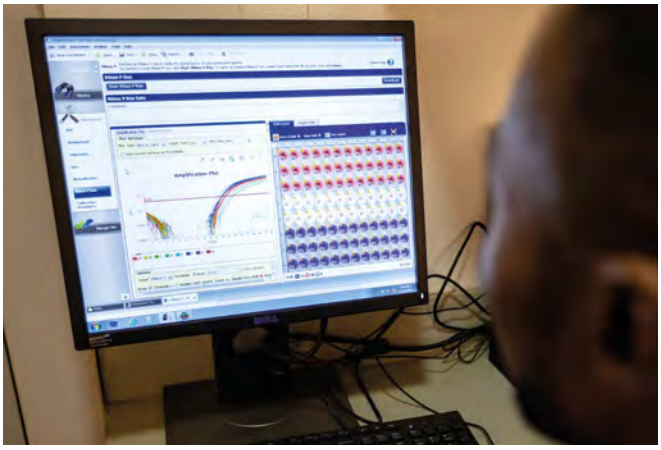
DESTINY is developing methods to automate various aspects of the review process, to generate living evidence syntheses on a number of climate change topics. This includes evidence maps of mitigation and adaptation interventions, and systematic reviews of interventions to improve air quality and food systems. One aspect of the project is to automate the extraction of effect sizes, which estimate the magnitude of the reduction in mortality and ill-health outcomes due to the intervention. For example, the LSHTM team is using AI to provide systematic estimates of the impacts of climate change mitigation and adaption interventions on mortality, on topics where mortality represents most of the global infectious disease burden. The team completed a proof-of-concept for the water, sanitation and hygiene (WASH) sector, providing the first systematic estimates of the impacts of WASH interventions on mortality.

An approach for combining clinical judgment with machine learning to inform medical decision-making

Machine Learning (ML) methods can identify complex patterns of treatment effect heterogeneity. However, before ML can help to personalise decision-making, transparent approaches must be developed that draw on clinical judgement. We developed an approach that combines clinical judgment with ML to generate appropriate comparative effectiveness evidence for informing decision-making.

We motivate this approach in evaluating the effectiveness of 'non-emergency surgery' strategies, such as antibiotic therapy, for people with acute appendicitis who have multiple long-term conditions, compared to emergency surgery. Our four-stage approach: i) draws on clinical judgement about which patient characteristics modify the relative effectiveness of non-emergency surgery; ii) selects additional covariates from a high-dimensional covariate space by applying an ML approach (Least Absolute Shrinkage and Selection Operator) to large-scale administrative data; iii) generates estimates of comparative effectiveness for relevant subgroups and, iv) presents evidence in a suitable form for decision-making.

We find that the ML approach is helpful in assessing heterogeneity in comparative effectiveness across subgroups. Our interactive tool for visualising ML output allows findings to be customised according to the specific needs of the clinical decision-maker. We conclude that a principled approach of combining clinical judgement with a ML approach can improve trust, relevance and usefulness of the evidence generated for clinical decision-making.



Lab scientist at the Kuchigoro Primary Health Centre's small laboratory prepares a blood sample for testing, Kuchigoro, Abuja (Credit: Louis Leeson).

Technical working group for Cerebral Spinal Meningitis meeting (Credit: Louis Leeson).

MSc Students working in study space.

Teaching

Students on the Sexual Health module visiting the Vagina Museum in London.

Teaching

Improving the design and conduct of public health evaluations through teaching and capacity building is a core role of the Centre for Evaluation. Our members contribute to MSc modules, short courses, and external training programmes, and provide support to research degree students and early career researchers through regular drop-in sessions.

Evaluation of Public Health Interventions module

Members of the Centre for Evaluation developed and run the Evaluation of Public Health Interventions (EPHI) module, offered both face-to-face and via distance learning. The face-to-face module combines lectures, practicals, groupwork and panel discussions to cover impact and process evaluations of complex public health interventions. It runs for five weeks in February-March and typically attracts around 60 students.

The Distance Learning module is self-directed and accessible from October to June, giving professionals flexibility to study at their own pace. Its content largely mirrors the face-to-face module and is delivered via recorded lectures, online exercises and readings, supported by discussion forums for interaction with peers and tutors. Students can also join live webinars with tutors, which are recorded for those unable to attend in real time.

Both EPHI modules are also available as stand-alone courses for people not enrolled in a Master's programme at LSHTM.

Photo of YEF hybrid training.

Evaluation-led training initiative in quasi-experimental designs to support decision-making in a UK Government What Works Centre

In 2019, the UK Government contributed £200 million to establish the Youth Endowment Fund (YEF). Operating as a 'What Works' Centre, the YEF has a 10-year mandate from the Home Office to lead and fund research on strategies to reduce violence affecting children and young people in England and Wales.

In early 2024, the YEF invited proposals to design a package of training sessions on quasi-experimental and observational study designs (QEDs) for its staff. The aim was to equip them with the skills to review and critique non-randomised impact evaluations. The Centre for Evaluation submitted a successful bid, and from mid-2024 worked closely with the YEF to define the level and pitch of the training material for a largely non-academic audience incorporating motivating examples from YEF priority areas.

A team of 10 experts delivered the final sessions at the YEF offices or online in late 2024. The team included Dr Melissa Neuman, Dr Daniel Carter, Dr William Rudgard (University of Oxford) Dr Julia Pescarini, Professor Ruth Keogh, Dr Stephen O'Neill, Dr Thiago Cerqueira Silva, Professor Tim Powell-Jackson, Dr Shay Soremekun, and Professor Mitzy Gafos. The training built on the Evaluation of Public Health Interventions MSc module and covered causal inference, statistics, and a range of QEDs including interrupted time series, synthetic controls, regression discontinuity, propensity scores and matching, instrumental variables, target trial emulation, and difference-in difference designs. This collaboration provided a valuable opportunity for the Centre to directly engage with policymakers.

Evaluating Public Health Interventions textbook

Spring 2026 will see the release of a new textbook titled 'Evaluating Public Health Interventions', edited by Tim Colbourn (UCL) and James Hargreaves (LSHTM), jointly published by UCL Press and LSHTM Press. The book has been developed over several years and many chapter authors are from LSHTM and teach on the Evaluation of Public Health Interventions module. Over 20 chapters and five sections, the book covers many aspects of evaluating public health interventions, programmes and policies in real world settings. It takes in process, impact and economic evaluation methods, and includes chapters on realist trials, stakeholder involvement in evaluation and approaches to assessing the transferability of interventions from one setting to the other. The book and associated exercises, including statistical package-based questions, will be available free to download from a book website. Physical copies will be available by covering the printing costs.

CREATE PhD Fellowships

The CREATE Fellowship is a partnership led by LSHTM, in collaboration with four other UK universities and six African partner institutions. This Wellcome Trust-funded programme supports fellowships based in the UK, Zimbabwe, Zambia, Ethiopia, The Gambia and Uganda. It is open to early-career healthcare professionals who are committed to improving health and wellbeing in Africa. The programme aims to support health professionals undertaking PhD-level research training, which includes building capacity in evaluation.

Tinashe Mwaturura is evaluating a new blood culture workflow for identifying neonatal sepsis in a tertiary hospital in Zimbabwe. The workflow integrates an automated molecular platform with streamlined phenotypic methods, such as Gram staining, organism identification, and direct antimicrobial susceptibility testing, combined with rapid communication of results to clinical teams. The goal of her PhD is to evaluate staff experiences with the improved workflow, the practical challenges encountered, and the perceived impact on patient care, particularly in facilitating timely, sensitivity-guided antimicrobial therapy.

Data collection will involve semi-structured interviews and workshops with laboratory staff, clinicians, and training facilitators and observational studies of the blood culture process. Findings from this evaluation will inform the feasibility and sustainability of introducing rapid diagnostics into routine neonatal sepsis management in similar settings.

> "The CREATE PhD fellowship at LSHTM has equipped me with rigorous training in evaluation methodologies, including mixed methods, implementation science, and health systems research."

Tinashe Mwaturura
PhD student

Maureen Tshuma's PhD focuses on developing, implementing and evaluating a community-based assessment and intervention to support cognitive and psychological health among older adults living in urban Zimbabwe. The intervention, known as Healthy Minds community-based peer-to-peer support groups (CHAPS), is part of a wider study called KOSHESAI. It was co-developed with older adults to address the challenges of ageing. Each group runs for 16 weeks and are led by two non-specialist, trained community 'champions' – an older adult volunteer paired with a younger volunteer.

Maureen's research includes a mixed-methods process evaluation to investigate intervention delivery, with attention to acceptability, adoption, appropriateness, feasibility, fidelity, intervention impact, as well as quantifying out-of-pocket costs for accessing the intervention. Data collection methods include observations and real-time feedback, a quantitative survey, interviews, participatory workshops and focus group discussions. Participants include older adults, caregivers, community leaders, CHAPS group members, healthcare professionals, and key stakeholders, across multiple community-based settings and timepoints. Findings from the research will guide the co-development of a Healthy-Ageing Intervention Toolkit and inform potential future implementation of sustainable and scalable models by health care providers.

> "Being a CREATE PhD fellow has significantly enhanced my capacity in evaluation by providing access to interdisciplinary training and expert mentorship, which are crucial for developing robust, community-based assessment and intervention strategies."

Maureen Tshuma
PhD student

Trained community facilitators/'champions' holding the Healthy-Minds CHAPS intervention manual which we co-developed and designed with older adults and other stakeholders.

Student Liaison Officers

The work of the Centre is supported by Student Liaison Officers (SLO) who serve as the interface between the Centre and the student body. SLOs organise student facing events and ensure we respond to requests from the student body. We are supported by research degree students representing the three faculties and MSc students enrolled in various programmes each year.

Research Degree Student Liaison Officer: Jonna Messina Mosoff

I decided to join the Centre specifically as a Research Degree Student Liaison Officer as I'd worked in monitoring and evaluation after my MSc and when I returned to the School for my PhD, I knew evaluation would be involved. I was interested to learn about different evaluation types and methods being used across the faculties and departments. My PhD uses data from an impact evaluation, which is itself one of multiple evaluations within a larger project. I wanted to ensure that even as I dove into my specific research, I would have the opportunity to learn how methods could be applied in novel ways to different diseases. Additionally, I recalled that my first exposure to evaluation was only in term 2 of my MSc and I hoped that as an RD SLO I could help ensure that MSc students had early and constant access to information and resources about evaluation. Now, every year the Centre for Evaluation hosts an event titled 'demystifying evaluation' which was developed by the SLOs and is aimed at MSc students who've perhaps heard the word evaluation before but aren't sure of what it means. It's been great fun to organise each year with a different group of MSc SLOs, and to see the students start to engage with evaluation early in their degrees.

Jonna Messina Mosoff
PhD candidate in the Department of Disease Control

MSc Student Liaison Officer: Khadija Diatta

I became a Student Liaison Officer with the Centre for Evaluation because I wanted to understand what evaluation means in public health, the day to day work of designing, delivering, and learning from complex interventions. I also hoped to meet people who do this for a living. The SLO role delivered both.

The highlight has been regular conversations with seasoned colleagues at the Centre for Evaluation. Our SLO meetings with the co-director were especially valuable: our ideas were genuinely invited, which boosted my confidence and nudged me to contribute more actively in seminars and events. That openness made the Centre feel like a community I could belong to, not just observe.

I also took the Evaluating Public Health Interventions module and would recommend it to anyone curious about how evaluation works in practice. We built logic models, mapped processes, and explored both process and impact evaluation. The hands on work strengthened skills I'll carry forward: turning a theory of change into measurable indicators, thinking through implementation fidelity, considering equity from the outset, and collaborating in multidisciplinary teams under time pressure.

When I first arrived at LSHTM, working in health evaluation wasn't on my radar. Through the SLO role and EPHI, it now is. The experience has opened doors, showing me a career path where rigorous methods and real-world impact meet and given me the confidence and tools to walk through them.

Khadija Diatta
MSc student on the Public Health for Development programme

Collaborations

Centre for Evaluation Retreat, 2023.

Collaborations to enhance evaluation

The diverse methodologies, thematic areas, and geographic contexts that the Centre works in reflects the diversity and complexity of global health challenges. As such, we work closely with a broad range of groups internal and external to LSHTM, and serve on a range of committees, to enhance our impact on improving the design and implementation of evaluations.

Evaluating humanitarian responses: Working closely with the UK Public Health Rapid Support Team

Evaluation within the context of public health emergencies in low- and middle-income countries (LMICs) seeks to understand, test, and improve how interventions are deployed under crisis conditions. However, such evaluations face unique contextual, methodological, ethical, and operational challenges due to the urgent, unpredictable, and resource-constrained nature of crisis settings. While it is essential to continue building a strong evidence base to determine what interventions effectively support populations in crises, evaluations also need to extend beyond effectiveness studies to guide decision-making and improve impact, scalability, sustainability, and equity. This requires advancing evaluation frameworks that consider the dynamic macro- and micro-level factors unique to humanitarian contexts, increasing the use of innovative designs, testing key implementation strategies, adopting methodological innovations from other disciplines, and strengthening the training and leadership of researchers, practitioners, and affected communities.

The UK Public Health Rapid Support Team, a partnership between LSHTM and the UK Health Security Agency, is investing in evaluation research within several LMICs in Africa, Southeast Asia and South America to conduct innovative evaluations of public health interventions deployed during epidemic response. This support is essential for bridging the gap between research on effectiveness and practical implementation, helping to strengthen accountability and improve outcomes for populations impacted by public health emergencies, conflicts, and disasters.

The International Centre for Evidence in Disability: Evaluating programmes for evidence to inform disability action

People with disabilities comprise about 16% of the global population and experience many barriers such as poorer health access and increased poverty. Yet, little is known about what works to address these disparities because of a paucity of robust evaluative evidence. The Programme for Evidence to Inform Disability Action (PENDA) is a flagship research programme that builds upon this evidence base. PENDA is led by the International Centre for Evidence in Disability at LSHTM and funded by the Foreign, Commonwealth and Development Office. The project comprises 13 evaluations conducted in 13 countries in sub-Saharan Africa and Asia. Twelve of these are impact evaluations, most of which have an integrated process evaluation. The interventions PENDA evaluates encompass diverse complex interventions, each of which possess multiple components and differ in terms of target population within the disability community (e.g., women with disabilities, children with disabilities).

An ambition of PENDA is to build and test scientific theory about disability, inclusion, and the design and delivery of interventions. Theoretically, the view taken of interventions in PENDA is aligned to a realist perspective of evaluations. This emphasises the contextually contingent nature of the mechanisms by which interventions work and their consequent influence on intended (and unintended) outcomes. PENDA strongly emphasises 'context', including evaluations of the same intervention in different setting (e.g., evaluations of the same disability-inclusive Poverty Graduation Programme in Bangladesh and Uganda). PENDA also aims to produce 'learning for next time', which is informative for both policymakers and scientific enterprise.

Economic evaluations of public health interventions: Working closely with the Global Health ECOnomic (GHECO) Centre

The Global Health Economic Centre (GHECO) works closely with the Centre for Evaluation to conduct economic evaluations of public health interventions, considering how to get the most benefit from limited resources. Resources can include the time and skills of individuals, equipment, buildings, or energy, required to achieve a given action. An action could be how best to prevent malaria infections, treat heart disease, or mitigate the effects of global warming on health.

Resources are always insufficient to action everything we would like to achieve, and that means we need to make choices about how best to use the resources we have. Health care decision makers need to consider not only the benefits and harms of interventions but also their impact on the use of resources and the associated costs. The combination of these two pieces of information allows decision makers to assess efficiency. The need for evidence on both effectiveness and efficiency are closely aligned in health decision making. For these reasons, incorporating economics into evaluations, to produce evidence on cost-effectiveness to accompany the evidence on beneficial and adverse effects, can make the findings of the evaluation more useful for decision making. To do this well, it is often essential to work with a health economist from very early in the design of an evaluation.

GHECO is one of the largest groups of health economists at a single institution anywhere in the world and is rare amongst health economics groups for the breadth and scale of its work. Their research on economic evaluation spans applied and methodological research in the UK, and globally. GHECO are experts in the economic evaluation of malaria, TB, and neglected tropical diseases and have a strong track record across non-communicable diseases like cancers, heart disease, and diabetes as well as across maternal, neonatal, adolescent, reproductive, and sexual health (including HIV) in low- and middle-income countries. In addition, their work on economic evaluation brings together expertise in measuring and valuing health, quality of life and wellbeing, and assessing preferences using techniques like contingent valuation and discrete choice experiments. There is also considerable expertise in different methods of evidence synthesis (including different forms of meta-analysis) and the design of experimental and quasi-experimental studies.

Youth Endowment Fund: Serving on the Grants and Evaluation Committee

Shay Soremekun sits on the Grants and Evaluation Committee of the Youth Endowment Fund (YEF), a UK-government What Works Centre. The YEF has a 10-year mandate from the Home Office to identify and fund evaluations of promising programmes and interventions that may reduce the involvement of children and youth in violence in England and Wales. The Grants and Evaluation Committee reviews and makes recommendations about the YEF grant and evaluation strategy to the YEF Governance Committee, including decisions on which interventions to evaluate. The committee ensures YEF are appropriately managing funded work with the highest rigour.

Gavi, The Vaccine Alliance: Chairing the Evaluation Advisory Committee

James Hargraves has chaired the Gavi Evaluation Advisory Committee (EAC) since 2021. Gavi, the Vaccine Alliance, a global health initiative, has supported the vaccination of over one billion children since 2000, preventing over 18 million deaths in 78 lower-income countries. The EAC is a majority independent committee, and its main formal role is to approve the Gavi independent evaluation work plan. Members provide technical advice to specific evaluations, as well as broader evaluation advice at Gavi. It has a devolved responsibility to do this work on behalf of the Gavi board. In 2023, the chairs and evaluation leads at Gavi, the Global fund and the World Bank Global Financing Facility published a piece in the WHO Bulletin on 'Evaluating global health initiatives to improve health equity'.

UK Government Evaluation Task Force: Serving on the Evaluation and Trial Advice Panel (ETAP)

Shay Soremekun and Aoife Doyle sit on the Evaluation and Trial Advice Panel of the UK Government Evaluation Task Force. The ETAP convenes evaluation experts from across government, academia and other organisations to advise on, and support the design of, evaluations of government policies across its remit. Members review key evaluation documents, attend surgery-style workshops with government departments and answer specific evaluation questions. As such, the ETAP contributes to a cross-government programme to increase the use of high-quality evaluation in the design and delivery of policies and programmes, aiming to provide real impact on public spending.

Brochure Directory

Case Studies	Representatives	Links
Evidence Synthesis		
Exploring the role of infidelity, romantic jealousy and intimate partner violence against women: Using meta-ethnography	Marjorie Pichon and Ana Maria Buller	https://www.lshtm.ac.uk/research/centres-projects-groups/jealousy-ipv-collaboration
Understanding pathways between agriculture, food systems, and nutrition: An evidence and gap map of tools, metrics and methods	Thalia Sparling	https://www.sciencedirect.com/science/article/pii/S216183132200134X?via%3Dihub
Inequalities in research on food environment policies: Using evidence and gap maps to synthesis policy evidence	Laurence Blanchard	https://www.sciencedirect.com/science/article/pii/S2161831324001406?via%3Dihub
Psychosocial interventions to improve the mental health of survivors of human trafficking: A realist review	Joelle Mak	https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(23)00105-0/fulltext
Effectiveness of remote interventions for adults in alcohol/drug treatment: A systematic review using qualitative comparative analysis	Helen Burchett and Wendy Macdowall	
The Climate and Health Evidence Bank	Blanca Anton and Rosemary Green	https://climatehealthevidence.org
Process Evaluation		
Organ Donation (Deemed Consent) Act 2019 in England: A policy process evaluation	Nicholas Mays and Leah McLaughin	https://piru.ac.uk/research/previous-programmes/organ-donation-legislation-evaluation.html
CHIEDZA trial: Qualitative process evaluation of a community-based intervention to improve HIV outcomes in youth	Constance Mackworth-Young	https://www.chiedza.co.zw/the-program
Campaign for Female Education (CAMFED): Process evaluation of the Transitions and Agriculture Guide programme	Meghna Ranganathan and Constance Mackworth-Young	https://www.thruzim.org/adolescent-health-1/camfed
The Safe Inhalation Pipe Provision (SIPP): Process evaluation of a harm-reduction intervention	Casey Sharpe and Magdalena Harris	https://www.lshtm.ac.uk/research/centres-projects-groups/sipp
Optimising the Health Extension Program: Process evaluation of a care-seeking strategy	Yemisrach Okwaraji and Joanna Schellenberg	https://pmc.ncbi.nlm.nih.gov/articles/PMC7459764/
Mobile Men trial in Uganda and South Africa: Rapid ethnographic assessments	Martin Mbonye	https://doi.org/10.1371/journal.pgph.0005213
Add-Vacc HPV vaccine trial: An electronic rumours tracking tool	Susan Kelly and Shelley Lees	https://mitu.or.tz/gaining-insights-into-the-understanding-and-acceptability-of-gender-neutral-human-papillomavirus-hpv-vaccination-in-northwest-tanzania-social-sciences-in-the-add-vacc-trial/
Context Tracker: Measuring and interpreting context	Joanna Busza	https://pubmed.ncbi.nlm.nih.gov/39558424/

Case Studies	Representatives	Links
Impact Evaluations: experimental designs		
Coordinated Care for Alcohol Problems: An individually randomised control trial	Abhijit Nadkarni and Jaya Katiyar	https://www.centreforglobalmentalhealth.org/coordinated-care-for-alcohol-problems-ccap
STIs in CHIEDZA (STICH): A cluster randomised control trial	Chido Dziva Chikwari	https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(24)00373-5/fulltext
Clean Frontline: A stepped-wedged cluster randomised trial	Giorgia Gon	https://clinicaltrials.gov/study/NCT05540886?locStr=Cambodia&country=Cambodia&page=2&rank=17
INCLUSIVE: A realist trial *The study is described in more detail in the book titled: 'Realist Trials and Systematic Reviews' by Chris Bonell, G.J. Melendez-Torres and Emily Warren.*	Chris Bonell	https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31782-3/fulltext
Leveraging GIS to Inform the Design of a Cluster RCT	Abhijit Nadkarni and Yashi Gandhi	https://www.sangath.in/projects/impress
Impact Evaluations: quasi experimental designs		
Adolescents 360: Using quasi-experimental methods to evaluate a reproductive health intervention for adolescent girls	Aoife Doyle	https://doi.org/10.1371/journal.pgph.0002347
100 Million Brazilian Cohort: Using regression discontinuity designs and propensity score methods to evaluate the effect of Bolsa Familia conditional cash transfers on health outcomes	Julia Pescarini	https://cidacs.bahia.fiocruz.br/inovacao/coorte-de-100-milhoes-de-brasileiros-2/
Police Stop and Search practices: Using interrupted time series and difference in difference methods to evaluate the impact on crime and mental health outcomes	Shay Soremekun	https://youthendowmentfund.org.uk/grants/secondary-data-analysis/
Selective Licensing schemes for private rented housing in England: A mixed method natural experiment	Matt Egan and Jakob Petersen	https://www.lshtm.ac.uk/research/centres-projects-groups/selective-licensing-evaluation
Y-Check: A hybrid implementation-effectiveness study using a mixed-methods pre-post design	Aoife Doyle	https://pubmed.ncbi.nlm.nih.gov/38908843/
Great Green Wall (GGW) of Africa: Using a natural experiment to understand the health implications of large scale environmental restoration	Kris Murray	
Decolonial and Equitable Approaches		
Scoping review of decolonial and equitable approaches to evaluation	Sali Hafez and Ruth Ponsford	
EquiPar: Piloting a tool to strengthen the equity of research partnerships	Meenakshi Gautham and Catherine Goodman	https://www.lshtm.ac.uk/research/centres-projects-groups/equipar-pilot-evaluation#welcome
An equitable partnerships approach to evaluation	ISEP Equitable Partnerships Working Group	https://www.lshtm.ac.uk/research/centres-projects-groups/mrc-international-statistics-and-epidemiology-partnership

Case Studies	Representatives	Links
Participatory Practices		
Co-production of a mixed-method quasi-experimental evaluation of National Ugly Mugs services *This case study builds on the methodological work of the DEPTH research group (Prof Cicely Marston et al)*	Lucy Platt and Claire Broad	https://www.lshtm.ac.uk/research/centres-projects-groups/swerv https://researchonline.lshtm.ac.uk/id/eprint/4669580/1/Routes%20final%20report%20January%202023.pdf
Experience-based co-design of integrated HIV and SRH services in Zimbabwe	Rumbi Gumbie	https://www.thruzim.org/hiv-srh-1/tsime
Disability Inclusive Youth (DIY) research: Including children and youth with disabilities in defining disability inclusive research	Femke Bannink Mbazzi	https://vimeo.com/951856897?fl=pl&fe=vl
Involving young people and professional stakeholders in a qualitative systematic review and meta-ethnography synthesis of youth violence in the UK	Joelle Mak and Rhiannon Barker	https://youthendowmentfund.org.uk/reports/systematic-review-serious-youth-violence-and-meta-ethnography/
Artificial Intelligence		
Expert workshop on role of AI in evaluation	Mitzy Gafos	
Using human-AI collaboration to map public health policy options	Isaac Chu	https://researchonline.lshtm.ac.uk/id/eprint/4675715/1/Chu-etal-2024-Mapping-Public-Health-Policy-Options-Report.pdf
Digital Evidence Synthesis Tool Innovation for Yielding Improvements in Climate & Health	Hugh Sharma Waddington	https://destiny-evidence.github.io/website/
An approach for combining clinical judgment with machine learning to inform medical decision-making	Richard Grieves	https://journals.sagepub.com/doi/10.1177/0272989X241289336
Teaching		
Evaluation of Public Health Interventions Module	Mustafa Al-Haboub, Farhana Haque, Fiona Majorin, and Emma Radovich	Intensive: https://www.lshtm.ac.uk/study/courses/modules/intensive-modules/evaluation-public-health-interventions DL: https://www.lshtm.ac.uk/media/91081
Evaluation-led training initiative in quasi-experimental designs to support decision-making in a UK Government What Works Centre	Shay Soremekun	https://www.lshtm.ac.uk/research/centres/centre-evaluation/news/452476/lshtm-training-supports-major-uk-government-fund-evaluate-violence-prevention
Evaluating Public Health Interventions Textbook	James Hargreaves	
CREATE PhD Fellowships	Tinashe Mwaturura and Maureen Tshuma	https://www.create-phd.org/fellows
Student Liaison Officers	Jonna Messina Mosoff and Khadija Diatta	

Case Studies	Representatives	Links
Collaborations to enhance evaluation		
Evaluating humanitarian responses: Working closely with the UK Public Health Rapid Support Team	Farhana Haque	https://www.lshtm.ac.uk/research/centres-projects-groups/uk-phrst#research
The International Centre for Evidence in Disability: Evaluating programmes for evidence to inform disability action	Hannah Kuper and Mark Carew	https://www.lshtm.ac.uk/research/centres-projects-groups/penda
Economic evaluations of public health interventions: Working closely with the Global Health ECOnomic Centre	Timothy Powell-Jackson and Luke Vale	https://www.lshtm.ac.uk/research/centres/global-health-economics-centre
Youth Endowment Fund: Serving on the Grants and Evaluation Committee	Shay Soremekun	https://youthendowmentfund.org.uk/our-governance/
Gavi, The Vaccine Alliance: Chairing the Evaluation Advisory Committee	James Hargreaves	https://www.gavi.org/governance/gavi-board/committees/evaluation-advisory-committee
UK Government Evaluation Task Force: Serving on the Evaluation and Trial Advice Panel (ETAP)	Shay Soremekun and Aoife Doyle	https://www.gov.uk/government/publications/cross-government-trial-advice-panel-role-and-membership

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