Human Organization, Vol. 67, No. 4, 2008

0018-7259/08/040454-15$2.00/1

Evaluating Appreciative Inquiry as an Organizational Transformation Tool: An Assessment from Nepal

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Two women's health projects in Nepal are examined for impacts from using Appreciative Inquiry (AI) as an organizational transformation and team building tool. This paper describes AI, and then looks at its use in Nepal to help improve access, quality of care, and utilization of essential obstetric care (EOC) by pregnant women. AI is ostensibly designed to assist hospital, health post, and health project staff improve their attitudes towards work and their service to clients. Typical accounts of AI impacts are told in "success stories," analogous to storytelling and mini-case studies in anthropology. The focus here, however, is on issues of evaluating AI, itself. Some AI practitioners eschew attempts at "rigorous" evaluation of their own work and maintain that AI is fundamentally "different" and not amenable to objective (especially quantitative) measurement. The results of the AI assessment on the two health projects are discussed in light of the ongoing debate about the nature of development in general, and the place of AI, the issue of evaluating AI, the use of logical frameworks ("log-frames"), "problem solving" approaches, and both quantitative and qualitative measures. The evaluation-of-AI literature (very scant) is reviewed, and one promising new methodology that combines AI with log-frame indicators is described.

Key words: appreciative inquiry, project evaluation, women's health, obstetric care, Nepal

Introduction

Appreciative Inquiry (AI) is a relatively new rapid development, research, and training tool that elicits success experiences from staff and builds upon "the positive" to affect transformational change within organizations, institutions, and communities. This participatory action tool has been used in organizational development (OD) since the 1980s in team building workshops for business corporations and institutions. Today, it is also allied tangentially with the "Positive Psychology" movement (Fredrickson 2000; Gillham 2000; Seligman 2002; Snyder and Lopez 2002). AI was initially designed by OD specialists for use in North America, and most of the AI literature reflects that focus.

For over a decade, AI has been adapted to international development on poverty reduction, public health and education projects, by sociologists, applied anthropologists, organizational developers, and others. It is used as a participatory tool for exploring local contexts and creating positive transformations and personal commitments for change and improvement. Practitioners generally describe AI as a tool for empowering local people to take control of their lives and jobs, to achieve agency, and to improve their roles and working conditions. Compared with other popular development strategies, like Participatory Rapid Appraisal (PRA) and Participatory Learning and Action (PLA) (IIED n.d.; Mukherjee 2004), AI practitioners consider AI to be even *more* participatory, positive, and proactive.

Like PRA and PLA, AI engages people in groups or teams to discuss, analyze, and plan specific activities and actions within their institutions (district hospitals and rural health posts in this study). AI practitioners strictly follow a highly formulaic phase-wise or cyclical structure that places an extraordinary emphasis on success stories. Storytelling is a means to raise awareness of past and current accomplishments that affirm one's own, a team's, or an organization's worth as the basis for constructing a better future. From an anthropological perspective, AI as applied to international development tends to deal with modern institutions and organizations recently embedded with traditional societies, with cross-cultural implications.

The positive approach of AI is grounded in a "theory of affirmation," which directs change agents away from preoccupation with the "root cause of *failure*" towards the "root

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cause of *success*"(Cooperrider 2000). It encourages imagination, innovation, and inspired positive actions in place of traditional approaches focused on *problem* solving. It relies on the discovery of rich and inspiring accounts, metaphors, and themes, told in a "new language" of development, through stories that highlight peak experiences, which then become the fuel for remarkable developmental change (Cooperrider et al. 2001; Odell 1998).

This paper focuses on the application of AI on two women's health projects implemented by the Government of Nepal with international donor assistance. One was the "Women's Health Project" (WHP), part of a regional "Women's Right to Life and Health" program funded by the Bill and Melinda Gates Foundation through Columbia University's Mailman School of Public Health with technical assistance from the United Nations Childrens Fund (UNICEF). The other was the "Nepal Safer Motherhood Project" (NSMP), supported by the United Kingdom Department for International Development (DFID) with technical assistance from Options Consultancy Services of London. Both projects were implemented by government staff assisted by local non-governmental organizations (LNGOs), through the Family Health Division of Nepal's Department of Health Services.

In 2004, the author led separate assessments of each project that dealt all or in part with the impacts of the AI approach. On WHP, the review team examined AI as a strategy for transforming hospitals and health posts into more efficient and effective public service institutions (Messerschmidt 2005). On NSMP, a different review team studied women's access to emergency obstetric care (EOC) services in largely rural areas of Nepal (Thomas et al. 2004), during which considerable understanding of the impacts of AI was also achieved. AI was considered an important tool for improving staff and institutional performance on both projects. The two review teams also looked tangentially at the quality and utilization of health services.

The present study combines the findings of both assessments. It begins with a brief overview of the history, philosophy, and methods of AI, then examines how it was applied on both projects.

One of our first observations from the global literature and the Nepal data was that many AI practitioners appear almost evangelical in their belief in the "positive affirmation" theory. (Similar evangelism has been observed within the "participatory development" movement; see Henkel and Stirrat 2001). Practitioners zealously elicit "success stories" to build upon for use in training project officers and local health practitioners. Another early observation was that there is an amazing lack of rigorous assessment of AI methodology or techniques, including a lack of self-evaluation by its own developers and practitioners. To be fair, there are examples of *self*-evaluation activities within some projects and programs using AI methodologies, and many examples of using AI techniques for evaluating *other* (non-AI) project work; but the former are not well documented (or exist primarily in project reports and other grey literature) and the latter are not the focus of this inquiry (see Preskill and Coghlan 2003; Rogers and Fraser 2003). Some AI practitioners believe that AI (itself) is fundamentally *un*measurable quantitatively. Both of these issues are examined. The paper concludes with a brief case study of a successful evaluation of AI, where AI itself was used as an evaluation tool.

Appreciative Inquiry: Origins, Methods, Cycles, and Principles

AI was created in the 1980s and perfected over two decades as an alternative to the mainstream "problem solving" approach in development. In 1987, two OD specialists, David Cooperrider and Suresh Srivastva, published the first article popularizing the AI concept. Their audience was other OD professionals working in business and industry primarily in North America. Since then, AI has gone international and the literature has increased from a few articles and "how to" booklets to hundreds of articles and numerous books and manuals (Bushe and Khamisa 2005; Tamang 2002).

While credit is generally given to David Cooperrider and his OD colleagues for popularizing AI as a transformational development tool (see Cooperrider and Srivastva 1987; Cooperrider et al. 2001; Cooperrider and Whitney 1998), it apparently has deeper and earlier roots. Furthermore, a number of studies of an "appreciative" and positive nature known by other names both predate and parallel AI's development (see Hirschman 1995; Messerschmidt 1988; Tendler 1997; Uphoff, Esman, and Krishna 1998). For example, the AI approach has been challenged, superseded, or combined in international development, at least, with such popular methods as Asset-Based Community Development (ABCD) and the Positive Deviance (PD) approach (Bhat 2000; Buscell 2005; Cunningham and Mathie 2002; Greene and Caracelli 1997; Kretzmann and McKnight 1997; Richardson 2004; Sternin 2003).

A key point in understanding the popularity of Appreciative Inquiry in development is the disdain of many of its practitioners with the common preoccupation with "problems" around which both planning and evaluation often focus. On the one hand, they say, a singular focus on problem solving is limiting and tends to de-energize and cast a dispiriting effect on organization staff, administrators, and other stakeholders. They see problem solving approach as limiting and negative, as it typically begins with identifying key problems/concerns/issues, then analyzing their causes, designing solutions, and developing action plans. In other words, "The basic assumption of problem solving seems to be that 'organizing-is-a-problem-to-be-solved'..." (Afful 2001:7). Though both seek "solution[s] to be embraced" (Ryan et al. 1999), problem solvers typically ask: *What are we doing wrong?* and *How can it be repaired?* while AI practitioners typically sidestep (or ignore) problems and ask: *What have we done well?* and *What more can be done?* See Table 1. Put another way, the AI approach seeks to "flip" problems into their "positive

Table 1. Problem Solving and Appreciative Inquiry Compared

The 'Problem-Solving' Approach (seeking 'the root cause of failure')	The 'Appreciative Inquiry' Approach (seeking 'the root cause of success')
Basic Assumption:	Basic Assumption:
An organization is 'a problem to be solved' (from the outside)	An organization is 'a mystery to be embraced' (from the inside)
Actions:	Actions:
identifying the problem ('felt need')	appreciating and valuing the best of 'what is'
analyzing the cause(s)	envisioning 'what might be'
determining possible solutions	dialoguing 'what should be'
planning and action	innovating 'what will be'

opposites" by focusing attention on the *exceptions to the problems*, then search for and build upon the "root causes" of those exceptional successes.

The existence of "problems," development "breakdowns," and "failure" is not denied in AI but is interpreted and handled differently. As one practitioner told us during the studies: "We turn 'breakdowns' into 'breakthroughs.'" AI practitioners point out that the entrenched problem solving approach to development is based *almost entirely* on the notion that systems under consideration are in trouble: "broken, not working, not functioning, not having, not existing, not living, not happening"...; i.e., as "injured system[s]" in need of fixing (Tamang 2002:48). Typical problem solvers, they say, perceive reality as fragmented pieces, thus as "failure," to which development agents step in with "solutions" (Korten 1990:143). The problem is that looking only for what is *wrong* within a system tends to create *dependencies* and perpetuate *inferiority* relationships, they point out. (The dichotomy, of course, is too simplistic.)

By contrast, AI practitioners elicit "success" stories and experiences, personal and group narratives often around the opposite or exceptions to the problem; i.e., narratives that *energize* and *provide positive focus and feedback*, and which *do not deprecate*. They seek indigenous knowledge and traditional responses to societal and institutional needs from which to encourage participation and create empowerment. (We agree with these goals but find them one-sided.)

To determine the positive, to discover success, and to encourage local solutions to pressing institutions issues, AI practitioners have developed several innovative strategies and tools. The most popular is the highly structured and formulaic "4-D Cycle." It consists of four steps: "Discovery," "Dream," "Design," and "Destiny" (or "Delivery") (Bushe and Khamisa 2005; Cooperrider and Srivastva 1987; Whitney and Cooperrider 2000). See Figure 1.

Each phase in the 4-D Cycle is broadly defined as follows:

> (1) During *Discovery,* participants interview each other in pairs, seeking high-point experiences around one mutually agreed upon topic (e.g., a professional activity, staff attitude, company challenge, institutional growth, or community development initiative), which are then described in plenary to the larger group. This establishes the "positive core" (topical focus) of the workshop.
> (2) During the *Dream* phase, the whole group orders the discovery experiences into patterns and themes that are further amplified through discussion and negotiation. Some AI moderators ask participants to go beyond their Discovery experiences, to build on them to imagine a future full of such experiences where their Dreams have been achieved. Eventually, consensus is reached about creating a vision of what is better or new vis-á-vis the topic. The participation of leaders along with staff and other stakeholders is strongly encouraged, so as to involve all members of the whole organization in the process. The AI facilitator prompts group members to articulate their "dreams," sometimes through pictures (visions of the future), analyze them, then seek positive "breakthrough" behaviors with which to proceed.
> (3) In the *Design* phase, participants translate their dreams into action plans. They may refer to particular policies, processes, structures, cultural norms, physical conditions, and/or social and professional relationships or attitudes that need specific attention. This phase culminates in propositions about how these sorts of "organizational factors" can be used and transformed to realize the dreams.
> (4) In the *Destiny* (or *Delivery)* phase, participants identify specific activity areas where they wish to make change. AI facilitators assist them to focus on the core areas of concern by creating "breakthrough teams" to develop actions plans or mini-projects by which to proceed and "succeed."[1]

At the main AI workshop, participants proceed step-wise through each phase of the cycle. The facilitator encourages them to focus on the *positive*, produce *stories* of life-giving forces, locate and select *themes* that arise for further inquiry, generate shared *images* of a preferred future,

then find *innovative ways* to create that future on the job (Burke 2001:7). The facilitator also encourages the leaders of the institution, organization, or community where AI is being introduced to allow time for participants to accomplish their Destiny goals and, in the process, the local leadership becomes (hopefully) convinced that the process is good and the anticipated outcomes realistic, wanted, needed, and achievable.

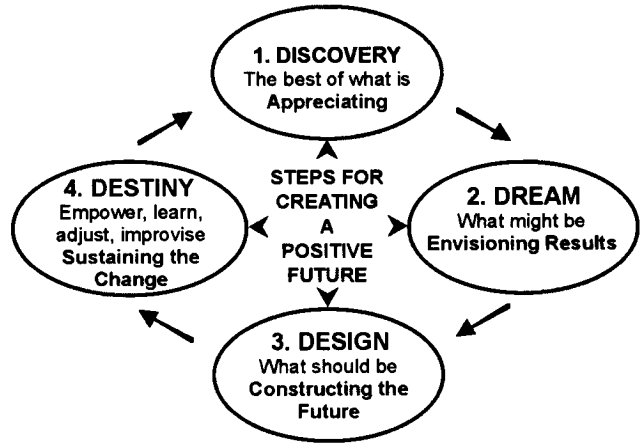
The underlying philosophy of AI is expressed through four core principles: *Appreciation, Application, Provocation,* and *Collaboration*. Underlying each is the Positive Principle (*Affirmation*). Together they imply that building and sustaining momentum for change requires large amounts of social bonding and positive outlook, combining hope, excitement, inspiration, caring, camaraderie, a sense of urgent purpose, and sheer joy in creating something meaningful together. The fundamental belief is that the more positive the questions asked and dreams and plans created, the more long lasting and successful change will be (Burke 2001; Bushe and Khamisa 2005; Cooperrider and Srivastva 1987; Cooperrider and Whitney 1998).

A great deal of AI is also imbued with a spiritual dimension, sometimes combined with a "whole organization" approach to development. In Nepal, the spiritual is often equated with moral precepts in Hinduism and Buddhism. On the two health projects, positive "wholeness" was translated into a "whole hospital" approach, involving hospital managers and staff, community stakeholders, and the health projects' officers. Alternatively, the whole organization approach may encompass a company, school, neighborhood or community, etc.

Many AI practitioners are especially attracted to the notions of spirituality and wholeness espoused by the popular American philosopher Ken Wilber. In his book, *The Marriage of Sense and Soul* (1998), Wilber tries to reconcile the historic disjunction between the scientific and the spiritual by unifying or "marrying" them. His approach is sometimes referred to as a new "paradigm" for development, one that cannot be easily approached scientifically, thus cannot be "measured" or "counted."[2] Instead, it involves emotive social-behavioral dimensions that embody spiritual strengths (thus, qualitative/non-quantifiable, subjective/non-objective) strengths. Wilber contrasts science's objective quest for *truth* with the subjective spiritual search for *meaning*. It is the latter that AI practitioners seek. Wilber's "sense and soul" may be interpreted as the difference between rational thought *vs.* emotional intelligence or science *vs.* art.

Regarding the spiritual, there is a tendency for some AI practitioners to act like "true believers" (Hoffer 1951), exhibiting an almost religious fervor and dedication to AI as a cause or movement. For them, the notion of carrying out an objective (in the sense of mechanically quantitative in contrast to subjectively qualitative) examination of processes and results of AI is anathema, a misfit between what they "know" and "believe." Empirical, positivistic science, says Pradhan (2003), is "limited to the world of objectivity as measured by

Figure 1. 4-D Cycle



Adapted from Mohr and Watkins, 2001.

our senses and corollary instruments. [It] rejects the world of interiors and subjectivity because such phenomena or worlds cannot be validated within the existing paradigms of science. Increasingly, serious thinkers are calling for a broader science that includes subjective ways of knowing," as in AI.

The approaches of AI "Believers" and "Doubters" have been discussed by Thatchenkery (1999) as two kinds of games. In the "Doubting Game," consultants, developers, researchers, or other actors (usually from the problem solving camp) cast a suspicious (some say negative) eye on things. In the "Believing Game," by contrast, AI practitioners focus more positively on understanding the organizational (system) dynamics from the participants' point of view. For them, explanations and interpretations are affirmations of what organizations are all about rather than what they are not.

This dichotomy, too, seems overly simplistic, for there is certainly a third category of "Healthy Skeptics" (my term), who are neither true believers nor doubters, but are, instead, relatively neutral observers who seek to be well informed and analytical, striving to find and explore valid, reliable, and verifiable evidence of what works (and what doesn't), and why, wherever, and however it is found. Good development researchers, administrators, facilitators, and evaluators should *always* display a healthy and informed skepticism (avoiding overt negativism), otherwise they risk becoming obstinately aligned for or against whatever new "truth," fad, movement, or cause has achieved popular orthodoxy.

The Two Projects: An Open Field for AI

In Nepal, AI has been used on UNICEF's Women's Health Project since 2000, in four districts (Messerschmidt 2005) and on the Nepal Safer Motherhood Project from 1997 to 2004 in nine districts (Thomas et al. 2004). On the

NSMP, the practice of AI was called by other names, both the "Artistry of the Invisible" and "Foundation for Change" (Hodgson et al. 2003). Staff on both projects were engaged in joint staff/community stakeholder workshops for initial training, then formed AI "breakthrough teams" to design action plans for positive, productive, and sustainable institutional change or transformation. Both projects relied on the same Nepalese consultancy firm to facilitate AI. The goal was to change attitudes and improve the accountability of health professionals, encourage greater involvement of community stakeholders, and increase access and utilization of reproductive health care services by pregnant women. The ultimate goal of both projects was to reduce Nepal's high rates of maternal mortality and morbidity.

Nepal's maternal mortality ratio (MMR) is one of the world's highest, estimated at 539 per 100,000 live births (GoN 1997).[3] In Asia, it is second only to Afghanistan's MMR of 1,900 (WHO 2005). Most maternal deaths in Nepal are an unnecessary, avoidable outrage (Messerschmidt et al. n.d.), and the mitigation of that outrage was the ultimate goal of both projects.

Nepal's high MMR and the context of health care in general reflect a complex combination of institutional, social and political factors, and public perceptions:

- *Institutional factors*: Women are frequently ignored in public and institutional settings, including hospitals; access to/delivery of affordable, reachable, efficient, well-managed, client-oriented health services, which women and their families trust, has traditionally been grossly inadequate.
- *Social factors*: High fertility and parity are played out against the low status of women, through early marriage (early child bearing and short birth intervals), poor nutrition, low female literacy, lack of awareness, poor reproductive health, high unmet demand for family planning, and societal norms that deny women voice and inclusion. Women tend to be disempowered and are often outside of family decision-making processes (Messerschmidt et al. n.d.).
- *Political factors*: Weak government in Nepal has been compounded since 1996 by a devastating Maoist insurgency in the countryside. The insurgency has had both negative and positive impacts in the health sector (Delfabbro, Pettigrew, and Sharma 2003). While not directly addressed through AI, there are indications that AI trainings and workshops have helped project staff deal more positively and constructively with it (Odell 2007).
- *Public perceptions* about health care (all negative and problematic) include: (1) the poor condition of health facilities, (2) lack of medicines, and (3) a poor attitude towards work by health staff (GoN 1998).

The social problems affecting the status of women were uppermost in each project's plans. Both projects addressed public perceptions 1 and 2 through a combination of service-oriented, supply-side technical, bio-medical, and infrastructural inputs, and perceptions 1 and 3 (and attitudes towards women generally) through AI workshops and trainings.

Reviewing the Project Approach to Appreciative Inquiry

During the fieldwork and analysis, we sought to determine if AI had contributed to the achievement of project goals, and if so: *why* and *how*. We specifically examined each project's:

- consistency with project vision;
- process for harnessing the energy of group cooperation;
- encouragement of innovation and new ideas;
- ability to foster continual learning;
- ability to involve all stakeholders in the development and improvement of EOC services and facilities;
- ways of initiating change in the attitudes and behaviors of health service staff and community stakeholders;
- goal of training local AI facilitators for its long-term sustainability;
- effect on participation and empowerment of lower level staff, including those from disadvantaged castes or ethnic groups;
- role in improving staff and organizational accountability; and
- overall impact on the goal of increasing access to EOC and providing support to health systems, health workers, and local government officials.

Findings

Prevailing Situation

Prior to 2000, health facilities assisted under the WHP were locally described as "remote islands isolated from the communities they were expected to serve" (from fieldnotes). This was reflected in the low "met need" (utilization) of 2.5 percent documented during project planning. (Achieving "met need" is a key indicator of lowering a country's MMR.) By December 2004, the combined "met need" at the four WHP-supported hospitals reportedly rose to 16.05 percent (Messerschmidt 2005:59, Table 5). The change under the NSMP was comparable (IoM/DCMFH 2004). Nonetheless, "met need" remains far behind *true* need. It is generally thought, and our findings suggest, that the training of health care staff and community members in AI has contributed to positive change, though it is not known how effective it has been in lowering Nepal's MMR, nor how sustainable. AI is only one of several contributing factors. It is also the most difficult to assess, and *it should not be assessed in isolation.*

One pre-requisite to providing quality EOC services is the establishment of strong dedicated teamwork and positive attitudes among health facilities staff. The poor quality of health care has been due in past to a combination of inadequate training, insufficient equipment and supplies, weak infrastructure, and bad attitude, compounded by poor interpersonal relations among and between health staff and the general public. Furthermore, local health workers complain that they have little or no voice in decisions about health facility functions and that they lack the power to influence health care outcomes (GoN 1998).

The result has been a generally low team spirit among health care workers and avoidance of local health facilities and services by community members, except under dire circumstances. Nepalese women prefer home births attended by relatives and/or traditional birth attendants. An estimated 89 percent of all childbirths in Nepal are home deliveries (GoN 2001).[4] Where health facilities have been improved and public awareness raised, and as women have been empowered with self confidence, voice and agency, more pregnant women are seeking health care services.

Project Response

The factors and perceptions noted above all affect how and why locals utilize EOC services or not. Project planners felt that if public access and utilization were to be improved, then systems of accountability, participation of stakeholders in management, staff commitment to teamwork, good attitudes, and positive results required immediate attention. Recognizing this, both projects contracted AI facilitators from the private sector to run AI workshops at all project-supported health facilities, with the goal of achieving positive transformation of the EOC services system, including staff attitudes and skills. The facilitators followed the standard 4-D Cycle in workshops, to: (1) develop a process and vision for staff of participating health facilities and other stakeholders; (2) create breakthrough teams and action plans; (3) introduce innovative methods to manage change, facilitate group activities, and promote a more positive, holistic view of people, processes, and systems; and (4) train local coaches and trainers to sustain the effort.

The effectiveness of all project inputs including AI was judged against standard logical framework indicators such as: (1) increased utilization of EOC services by women with obstetric complications; (2) more positive provider-client-stakeholder relationships realized; (3) breakthroughs generated to improve facilities management, quality of care and service, technical inputs, a rights-based approach, team spirit and effectiveness, inter-departmental cooperation and collaboration, and individual and group learning; (4) problems addressed and dealt with proactively, demonstrating positive ways of working, good morale, establishment of an "appreciative culture," accountability, commitment, motivation, ownership, creativity, and sense of pride; (5) improved interpersonal communication and relationship-building skills; and (6) improved relations between hospital staff and community support groups.

Stories About Change

Stories are part of the way group members see themselves, and stories about AI activities are indicative of AI's impacts and results. Stories (or mini-case studies) are used to create histories and justify actions (hence, are qualitative but only mildly evaluative). "Stories are an old way of organizing knowledge" that, "when used as strategic tools,... confront denial by encouraging—in fact, requiring—the willing suspension of disbelief" (Wack 1984). When done carefully and well, story analysis is a useful anthropological tool, and is frequently borrowed by non-anthropologists (who think it is easy to use).

A key objective of AI's 4-D Cycle is development of an institutional "vision statement," which reflects stories about change accomplished and looks forward to change intended. Then, if change happens, success stories will emerge. An institutional vision includes short and long-term timelines and a range of objectives and goals for both health care staff and communities to strive for. "Shared vision" is also expressed through stories that exude group pride, team spirit, and mutual commitment towards a "cause" or agreed-upon goal. Virtually all medical, nursing, and paramedical staff persons involved with the projects, and community members on hospital and health post support committees, have shared these sentiments and frequently expressed them through positive stories. But, while such vision statements are readily articulated by staff and exist as oral histories and sometimes in writing, when carefully examined the sustained efforts necessary to continue the transformation appeared weak. The authors of an earlier review of NSMP noted that after only a few years of AI's "Foundation for Change" approach (despite follow-up workshops) there were already "indications that the changes will not be sustained at their present level" (Hodgson et al. 2003:25-26). Our findings are similar.

At one government hospital, a group of nurses was asked to name the "best" hospital in the region. They replied emphatically, in one voice: "Ours, of course!" though it was well known that a nearby government hospital was larger, more popular, better equipped, had more staff and medical specialties with broader technical capabilities, and greater funding. When asked to explain themselves, they told anecdotes and stories that expressed a corporate "pride of place," a collective belief in their own institution, its aims and objectives, and in the individuals working there, regardless of other factors. They attributed their altruism to AI training.

At another facility where AI was also popular, a recently assigned senior medical officer (untrained in AI) said that on arriving he found a remarkable group spirit and teamwork among staff. It was unlike anything he had experienced previously in non-project supported hospitals. It was AI, he said.

Improved teamwork is one key to AI success. During early AI workshops on each project, breakthrough teams were formed to create and pursue action plans as part of the Design and Destiny steps in the 4-D Cycle. On both projects they reflected existing institutional groupings, in the form of functional teams that looked after emergency obstetric and antenatal care services, infection prevention and sanitation, laboratory management, outdoor grounds maintenance (sometimes called Sweeper Teams, typically employing female members of the erstwhile "untouchable," or Dalit, caste of Sweepers), institutional management support, and community relations. (The number and names of functional teams varies between hospitals.)

One often heard story describes how AI has contributed to breaking down social exclusion based on caste status. It describes good working relationships and mutual respect on functional teams with mixed caste and ethnic membership, often including the socially privileged along with so-called "untouchable" Dalit service castes. Within each facility, the intensity of expressions of relative equality and non-discrimination varied slightly, but the overall impression was one of increased social inclusion to a degree unusual in the broader society. From our observations, restricted to work situations, we were unable to observe social relations among staff members in the wider communities where social conservatism and exclusion are more commonplace. (For a broader assessment of social inclusion in Nepal, see DFID and WB 2005, and Biggs, Gurung, and Messerschmidt 2005.)

As the story goes, after AI training and inculcation of the theory of affirmation, men and women of the Dalit Sweeper caste are now working well on both the breakthrough teams and functional teams alongside their more privileged caste colleagues (doctors, nurses, and technicians of ostensibly "higher" or "elite" castes).[5] We found that the so-called "lower" caste team members are typically among the most exuberant "believers" in AI. The leader of one hospital's so-called "Peon and Sweeper Team" proudly assured us that his team meets weekly to discuss duties, current needs, solutions to problems, and success stories. He described his team as strong, viable, and sustainable, and he exuded great personal pride, enthusiasm, and self-confidence, which he attributed to AI. He and his Dalit team members clearly have the most to gain and the least to lose by practicing socially affirmative precepts.

Breakthrough teams and functional work teams are often coterminous. Breakthrough teams usually take up one-off tasks, some of which are never completed, or when done leave the team members without focus, incentive, or ability to create a new one. We found that while the functional teams continued to work at their various institutional jobs, most of the "breakthrough" work teams established within them had not met in many months, and that members were typically not sure if their team's breakthrough action plans were being carried out or would continue in the future. It is questionable if the breakthrough teamwork on either of the two projects can be sustained over the long term despite follow-up training and given their dependence on help from outside AI facilitators whose contracts are, in turn, project-dependent.

In the presence of outsiders, especially of central government or funding agency officials and persons identified as "evaluators" (as we were), health facility staff tend to speak glowingly and tell stories highlighting the positive impacts of AI on both the institution and themselves. However, as one informant said (no surprise): "When the evaluators are here AI works; when they're not here it doesn't." When respondents on both projects spoke well of AI (often), they described such "positive" characteristics as: (1) benefits of teamwork; (2) improved cleanliness of facilities; (3) better social relationships on teams; (4) increased respect shown to patients regardless of caste or class; and (5) positive personal effects on themselves and their families.

When we asked hospital administrators to "*show us* visual evidence" of AI's positive influence, we were inevitably taken on a tour of buildings and grounds, introduced to members of the functional teams, and assailed with remarkable "Before-and-After" stories. For example, we often heard that "before-AI" the general health facility environment was dirty, with cows, goats, pigs, and dogs wandering in and out; garbage and hospital wastes routinely dumped out of sight in a back field; public toilets stopped up and filthy; access roads mired in mud during the rainy season; and a generally unsightly and unpleasantly odoriferous atmosphere. Our guides then singled out and complemented the Sweeper team, and proudly showed us the currently prevailing "after-AI" conditions: hospital grounds cleaner and less cluttered, stray animals barred from entering (except the ubiquitous pi-dogs), garbage picked up and hospital waste hygienically incinerated, public toilets relatively more clean, access roads drained and repaired, and trees and flowers planted. In one hospital, the nurses placed flowers in the wards (with an assurance that it was not done just to impress us).

Changes such as these stories and observations show, however, are *relative*. There is no doubt that some facilities "after-AI" *are* cleaner, an admittedly difficult task under subtropical conditions and high utilization by a public largely unfamiliar with modern sanitation or the causes of infection and disease. Nonetheless, many government hospitals and health posts in South Asia, even those positively affected by AI, have a long way to go to meet international standards of hygiene. By comparison, private and other non-government run hospitals are much better in this regard, partly (or perhaps largely) due to better funding (and typically without AI). This raises a question that needs further examination: Does AI training of staff at substandard facilities make up in any way for poor funding and lack of resources?

AI researchers generally seek, and AI believers and participants tend to tell, stories rich in imagery and generative metaphor, describing in the "new language" how positive transformations within organizations, on teams, and among individuals and their families have occurred, echoing the movement's affirmative goals and philosophy (Bushe and Khamisa 2005). Our fieldnotes are replete with such accounts and, while the success stories are generally consistent, they do not indicate total consensus. This distinction is important. *Consistency* indicates general trends, with the very real possibility of significant and sometimes innovative distinctions arising (i.e., different creative ways of doing similar things). *Pure consensus*, by comparison, quickly sounds pre-packaged and rehearsed, lacks conviction, and is unconvincing. And, unfortunately, AI (unlike anthropology, for example) does not substantially address in its storytelling a necessary understanding of social relationships, nor social conflict, nor does it do well in contextualizing attempts at positive transformation with broader sociocultural, historical, political, and economic contexts.

Nevertheless, the "new language" that we heard was replete with positive imagery, such as:

- "Changed behavior" and "new commitment" to the affirmative principles of AI in the workplace and family, especially among younger adults.
- New "listening skills," leading to more "affirmative relations" and "recognition" of the basic humanity, worth, and potential of teammates and the public.
- Increased "social equality," in contradistinction to the marginalizing and discriminatory tendencies of traditional casteism and social exclusion. One informant declared that nowadays "we recognize only two 'castes'—no longer *thulo* and *sano* [big and small; i.e., "higher" and "lower"], but only *purus* [male] and *mahila* [female]."
- More respect towards women, with some men describing their female staff counterparts as "softer" and "more receptive," "less ego-centric," "more committed" to their work, and "more willing to admit and fix mistakes," compared to most men.
- Increased "self-confidence," especially with adoption of social "negotiation skills." One informant said that AI had strengthened his abilities to speak with gun-toting members of the Maoist insurgency who have threatened life and work in rural Nepal, and another said she had gained self confidence enough to marry out of caste, for love, contrary to tradition, and against parental choice.
- Increase in nurses taking the initiative to "save lives" in instances where doctors are not available and where, previously, a doctor had to be present before complicated cases were taken up.
- Increased feelings of ownership towards "our hospital" and of committed "service to the public."
- The importance of "social mobilization" for the "upliftment" of marginalized peoples and disadvantaged groups.
- "More trust," "better quality service," "improved staff behavior," and more emphasis on facility "cleanliness," with frequent reference to Sweeper caste teams as the "backbone" of hospital operations.

At one hospital, however, we also heard an unusually negative story, still carefully phrased in AI language. Both staff and community members described the poor leadership qualities of the resident medical superintendent. He was consistently referred to, unflatteringly, as having "poor management skills," a polite euphemism (we were told) for "lack of compassion," "bad attitude" or "misbehavior," despite his participation in AI workshops and trainings. When we interviewed the doctor, he emphatically (but unconvincingly) declared: "In *my* hospital *all* improvements are AI!" then took us on a tour of the facility.

By contrast, the medical superintendent at another hospital was the focus of a positive AI testimonial that has been acclaimed widely among Nepalese health practitioners. Prior to AI, the story goes, this doctor demonstrated little sympathy for the plight of the poor, discouraged community involvement in hospital affairs, and expressed little enthusiasm for the "new fad" called Appreciative Inquiry. At the first AI workshop in his hospital, he refused to allow his staff members to meet together with community participants. Only after the AI facilitators organized a combined meeting on the last day where experiences and visions of both groups were shared and compared did he begin to show appreciation for AI. Upon hearing almost identical vision statements from both sides he reportedly experienced an epiphany of sorts, became an enthusiastic supporter of community involvement in hospital affairs, and supported creation of a community-based hospital development committee. After determining that the collective "dream" to provide free or low-cost services to the ultra-poor was important and achievable, he agreed to implement a long-neglected policy stipulating that a proportion of hospital earnings be used as a "poor fund" to cover the costs of the poorest patients. He proudly declared, "that no person will die in my hospital for want of medicine" (though evidence of how the poor fund is used is fuzzy).

This particular doctor is frequently called upon to talk to other medical professionals and community leaders about his remarkable personal transformation, and that of his hospital team under AI. Thus, he has become what is often referred to in community development literature as a "champion" or "local hero," a special class of individuals "who've found effective ways to build their communities, fix what's broken, and make them better" (AAFC 2002; Garr 1998). In analyzing his changed behavior, he is also considered a "positive deviant;" hence, a role model to be emulated (Biggs, Gurung, and Messerschmidt 2005).

Strengths and Weaknesses Observed

The use of AI on the project has had mixed results, both positive and weak, and it is on this basis that internal evaluation of AI initiatives seems all the more imperative. Here is a list of *positive results* that we documented; but are they "sustainable" without reinforcement and support (like medical science and practice)?:

- AI is compatible with the ethos of public service professionals, like health service professionals (and educators);
- AI promotes positive thought and affirmative action in local practitioners' professional lives and work environments, and in the personal lives and families of staff members;
- AI has a spirit-raising effect among those who take it to heart, enhancing the institutional cultures of project-supported health facilities, hospital support committees, and community safe motherhood groups, in ways that reflect and "fit" the moral principles of the two dominant religions of Nepal, Hinduism and Buddhism; and
- AI is attractive to outsiders (untrained in its application) who observe it from a distance. There is a strong conviction among AI facilitators, followers and outside observers, alike, that "it works" to achieve "remarkable results." It is highly popular among most of those trained in it, and it is envied by outside observers who have heard convincing stories told by its "true believers."

Two *main weaknesses* are these (but are they "killer" failings?):

- On *cost*: Running AI workshops and trainings can be both costly and time consuming, particularly if the initiative

remains largely project-dependent, requiring periodic coaching and refresher inputs by AI facilitators contracted from outside as we found in the projects under study. Although a rigorous cost-benefit analysis was not feasible (there is little that can be reliably counted or measured from which to formulate valid and unassailable statistical outputs), it was nonetheless apparent that the costs of contracting professional facilitators were high compared to its observable results. (On the other hand, compared to the cost of failed systems operating without such innovative strategies as AI, and the cost of medical operations, which are not comparable, some might consider AI innovations to be comparatively inexpensive.)

- On *sustainability*: Those who received AI training seem reluctant to "pass it on" to newcomers in the workplace. The sought for "champions" and the long-term positive roles of local trainers failed to arise in most cases examined. Continuous learning is so important for the sustainability of AI impacts, its precepts, and the changes it inspires, that new staff and trainees need both to be taught its philosophy and convincingly shown its operating principles by mentors previously trained in AI, without which sustainability is doubtful. This issue is further highlighted by the fact that very few senior level health administrators are trained in AI. It has very few advocates in central positions of authority, it is not taught in Nepalese medical schools where doctors and nurses are trained and, therefore, higher level administrative support systems do not exist in Nepal.

Without question, AI workshops and trainings have taught hospital staff a great deal about looking positively at the world around them, their workplace, and their personal lives. They have failed, however, to impress upon participants the importance of passing AI learnings on to others not involved in the workshops. Rather, local practitioners have remained dependent on facilitators contracted from outside to periodically refresh and renew the AI message. At one hospital supported by WHP, for example, when staff members were asked if they had conducted any follow-up activities to continue highlighting AI in the workplace or in their personal lives, they said "no." When asked if new staff (doctors, nurses, and auxiliary personnel) or volunteers (student nurses and interns) were briefed on the "meaning" and practice of AI, they said "no." When asked if they were aware of an active nation-wide AI support network, they said, "We know nothing about it." The Nepal Appreciative Inquiry National Network (NAINN) boasts a national membership with regional chapters, but neither the national network leaders, nor project staff or local health professionals trained in AI by the two projects under study had approached or been contacted by NAINN about participating in its meetings and activities. The only conclusion is that AI lessons and good practices are not passed on to others, nor shared beyond the institution. The result is significant lost opportunity.

There is also a broader, more generic problem with AI that derives from over-reliance on stories alongside a dearth of other sources of data. In our review of AI on both projects, we attempted to be as objective as possible by accessing all relevant documents, and all project inputs, along with field observations and stories. One obvious problem arising from the stories is the chance of being deceived by *the fallacy of misplaced causation*. The simple recitation of direct cause-effect correlations, in the form of dichotomous "before/after" stories and "input/output" anecdotes, yielded some evocative accounts of change. Logic suggests that when health care staff consciously and attentively engage in affirmative behavior, inculcated through AI training, their attitudes and actions are likely to improve. But caution is advised both in relying too heavily on "stories" and in assuming a too simplistic 1:1 causation. The facts and attributions are complex and relative.

Causation implies a strong correlation between one set of circumstances or happenings and another. Correlations are helpful, of course; but, they are just *correlations* and no more. It is certainly plausible that AI has enhanced hospital and health post operations, but we have no *unassailable* proof. For one thing, other important project interventions have also had significant effect on facilities, staff incentives, and service improvements. They include a generous supply of medical equipment, medicines, and technical training. It is virtually impossible to accurately *measure* the effects of each input on overall organization transformation or improvements in health care services, and no single input can be said to predominate in seeking causal connections with organizational change.

This does not mean, of course, that the stories or other evidence should be ignored. As Costello, Osrin, and Manandhar (2004) remind us, "Absence of evidence of effect is not evidence of absence of effect." Some correlations are indicative, of course, and social scientists often rely on less than well-measured objective proof, often through correlations in the form of "case studies." The success story, as a kind of mini-case study, has a special place in AI, just as it does in anthropology, where it is often used to powerful effect. We agree with Anne Radford (2005:30) that "through storytelling, circulating praise, images of hope, and a sense of wholeness" AI has the power to bring staff and managers together and "to deliver results in a new way." But can it be proven? (Does it *need* to be proven?)

Sometimes stories about the transformational impacts of AI go on to achieve almost mythical proportions and significance. Stories-become-myths that describe dramatic changes and remarkable successes are commonplace in the AI literature, reinforcing the goal of mobilizing positive myths for positive outcomes. Anthropologists, too, consider myths to be good to "think with" (Standing 2004:82), for they reveal underlying truths and help the analyst grasp unmeasurable meanings and intents that are sometimes hidden from direct observation. But, a myth is a type of story about something that is not directly verifiable, and myths are often given uncritical acceptance by members of a group in support of particular practices, beliefs, or institutions. They often resonate with an accepted ideology or orthodoxy, embodying a visionary ideal that becomes believed and is expressed through a collective zeal. The result may then become a fable, a type of myth that tells about a highly marvelous happening, i.e., a "fabulous" account or exaggerated explanation. When myths become fables, and the fables are then used to provide irrefutable "evidence" of transformational change, the relativity of change becomes obscured, and both reliability and validity are rapidly lost.

On Evaluating AI (or: The Amazing Lack of Self-Evaluation)

As part of our assessment, we conducted an intensive literature review, seeking examples of rigorous evaluation of process and long-range impacts of AI. There is considerable writing on the process of *doing* AI, especially of the 4-D Cycle, but little on *results* over the long term. We agree with Bushe and Khamisa (2005), who have conducted one of the few AI impact reviews that "there is an almost complete lack of published research...examining it." Kotellos, Rockey, and Tahmassebio (2005:16) point out that no evaluator (except themselves) "has applied an appreciative evaluation methodology to study the impact of a full Appreciative Inquiry process [itself] in the context of an organization and community." There is, however, a growing interest in AI as an evaluation tool (see Preskill and Coghlan 2003; Webb, Preskill, and Coghlan 2005).

The dearth of AI *self*-evaluation comes as no surprise. Lack of objectivity and distance by the serious practitioners of popular movements like AI and other entrenched development orthodoxies is not new. Rather, it reflects the inherent skepticism of critical reflection on new methods by most true believers (Biggs and Smith 1998). The lack of self-evaluation is part of the AI "mystique."

Our literature review was limited to descriptive and largely non-evaluative agency documents and journal articles about its power to transform organizations and individuals. Because AI is a subject that some dedicated practitioners consider to be unmeasurable, it is rarely subjected to rigorous assessment. As one observer of OD studies has noted, "Ninety-seven percent of what matters in an organization can't be measured" (Johnson 1999:296, quoting statistician W. Edwards Deming; see also Ion 1995). True enough, perhaps. Thus, hard evidence of AI's results and impacts (beyond show-and-tell) is lacking, which reflects the inherent difficulty in grasping its soft, "emergent," positive qualities. In addition, much of what *is* written about AI lacks rigor and appears extemporaneous.

Besides using AI tools to evaluate other projects, and other tools to evaluate AI activities, a third possibility also suggests itself, i.e., merging the two, using AI techniques to evaluate AI results. Although AI is an increasingly popular organizational and community change methodology, amazingly few attempts have been made to evaluate its long-term effectiveness and impacts using any sort of rigorous methodology. (There are lots of reports of all the "good" and "positive" things AI has done, but virtually no evaluations of its long-term effectiveness and results.)

In 2001 there were an estimated 200 articles specific to AI in the international literature (Burke 2001). By now there are probably well over 500 (our estimate), but few writings attempt to assess AI *results* or *effects* in transforming organizations. Articles by Bushe and Coetzer (1995), Jones (1998), and Kotellos, Rockey, and Tahmassebio (2005) illustrate only tentative attempts at evaluating AI. Too many AI practitioners state outright that evaluating AI is a fruitless venture, since most (if not all) standard evaluation techniques are inconsistent with AI assumptions and contradictory to the transformational change process. We find it interesting that, with few exceptions, no dedicated practitioners (nor their critics) have suggested ways to respond to the inherent contradictions. Instead, they have turned it into an *either/or* discussion, which is not helpful. This is not to say that there is no evidence of positive transformation from AI in organizations or individuals. It happens, as our findings indicate; but, with few exceptions, AI practitioners have avoided rigorously evaluating their own AI methodology.

Most of the few exceptions are focused on AI as used in business and public or private institutional settings in North America. Few look at AI as used in international development. The scant international literature is exceedingly "grey," limited to obscure project reports. We found only two reports relevant to our needs, one on NSMP's "Foundation for Change" (Hodgson et al. 2003), and one from a UNICEF project in Uganda (Rudolph 2003), with an associated memo.[6] The report from Uganda is a technical review buried in the UN agency files. The memo about it, by a senior advisor (Ford 2003), criticizes its lack of quantitative analysis. Ford sums up the dilemma that development agencies face in attempting to assess the impacts of AI:

> The Technical Review [by Rudolph] makes a powerful positive impression on development practitioners who already believe in Appreciative Inquiry. But it will fail to convince practitioners who use logical framework analysis to guide their work or donor agencies that employ results-based management (RBM) to determine funding levels, because it makes no attempt to prove that the appreciative methodology leads to better [results]... than current "expert-driven" approaches...and [it] fails to capitalize on an important opportunity.

The implication is that standard log-frames for planning and evaluating development projects tend to highlight *only* the quantitative dimensions, though this need not be the case (see Kotellos, Rockey, and Tahmassebio 2005). It also implies that one can "prove" only by objective and (so-called) "rigorous" quantitative analysis that an event has happened and has had specific results. At best, such claims are probabilistic, not absolute. Meanwhile, it is unlikely that AI as a highly qualitative activity will supplant the predominantly quantitative, linear, log-frame based problem-solving approach favored by international development agencies any time soon, though some marriage of approaches is inevitable.

Biggs and Matsaert (1999) have addressed a major weakness of the log-frame for planning, monitoring, and evaluation. It becomes "overly preoccupied with easily quantifiable, physical, and short-term outputs such as number of vehicles, numbers of trained staff, and with technical indicators such as trial results," they say, "rather than with...[the] processes and capabilities involved.... Failure to develop context-specific indicators, based on qualitative analysis...can lead to the

development of highly abstract and meaningless indicators... [ignoring, for example,] the nature of social interactions." They conclude that "...we need to move away from the measurement of outputs and to look instead at impacts, a shift which is hindered by the inflexible structure of traditional monitoring processes..." (Ibid.). Therefore, mixing a qualitative approach like AI with a quantitatively biased log-frame approach may have promise. We found only one evaluation of AI that incorporates log-frame analysis, the short but innovative piece by Kotellos, Rockey, and Tahmassebio (2005) described below.

In conclusion, the vast bulk of the literature on AI is written by "Believers" and is, therefore, limited in outlook. We have found nothing of a serious critical/analytical nature by AI "Doubters," nor by "Healthy Skeptics," and they are at fault by ignoring it.

On Measuring AI or Not: A Specious Argument

As noted, AI practitioners tend to assume that it cannot be "measured" in any objective manner and that, by implication, it is exceedingly difficult to evaluate in *any* rigorous manner. It is, AI practitioners say, a fundamentally and qualitatively different phenomenon. "People inform one another not through numbers, but through stories..." they say (Johnson 1999:297).

In our opinion, the black/white dichotomy between qualitative/quantitative analyses is a specious one, unhelpful in analyzing the impacts of AI on organizations and individuals. An entire section of one of the most popular books on organizational development, *The Dance of Change* by Senge et al. (1999), addresses the issue. The idea of measuring AI is also raised in some other OD and AI handbooks and manuals. As a heuristic device, to sort out distinctions between types of data, statistical measurement of phenomena is useful, but declaring that one kind of study or methodology applied to AI is best and another is not is problematic. Good analysis should utilize *both* qualitative analysis and quantitative measures, depending on subject matter and purpose; not one *or* the other.

Rather than arguing *either* qualitative *or* quantitative analysis, what is ultimately needed and potentially most useful are analyses that ask: *What works? What is useful and effective? Why? When? How often?* etc., then apply whatever methods of "measurement" work best and are most demonstrable and convincing. For example, in reviewing AI's impact on Nepal's health sector development, one must first ask *what, if anything, is countable* about personal commitment, teamwork among competing and sometimes jealous professionals, or the spirit and pride that appears to have developed by breakthrough team members (of different social standing). The spirit of some team members is especially remarkable in the face of severely impoverished physical conditions, poor financial support to essential infrastructure, and lack of adequate reward systems and other incentives. But is any of it "measurable" in any statistical fashion? We agree with Meador who says that it is probably not: because "some 'soft' results are almost impossible to quantify.... [H]ow can we measure diversity, employee satisfaction, or personal change—the most important factors in predicting organizational change?" (Senge et al. 1999:311). But unmeasurable does not mean it cannot be successfully evaluated by other means.

In a chapter entitled "Cracking the 'Black Box' of a Learning Initiative Assessment," Roth (Senge et al. 1999:303-311) presents an overview of the critical issues confronting measurement of organizational change, but he is not encouraging about their resolution. In fact, the discussion is rather negative, providing little help to the prospect of evaluating organizational transformation by *any* means. Nowhere in Senge's entire book are there any solid suggestions regarding the difficulties of evaluating any aspects of organizational change in any manner.

Nonetheless, evaluation of AI is beginning to draw attention, though slowly and with apparent reluctance. It is as if the practitioners of AI are so wedded to the notion that AI *cannot* be objectively evaluated by any means that in our experience they appear largely unwilling to try. Are they unaware of the strong traditions of anthropology, history, and law, for example, which rely upon qualitatively-based assessments of social reality, providing believable results?

Using AI to Evaluate AI

We conclude by highlighting the work of Kotellos, Rockey, and Tahmassebio (2005) who describe using an appreciative evaluation methodology to study the impact of a full AI process implemented at a community holistic health center in America. Analogies to our own review of AI in Nepal are obvious (but, unfortunately, we learned of this innovative application of AI evaluation to AI practice too late to incorporate it into our review).

Among the most innovative aspect of what Kotellos and colleagues have accomplished is the use of log-frame analysis incorporating qualitative indicators. Their evaluation was both appreciative and participatory. It engaged board members of the organization along with community stakeholders and holistic health practitioners. The evaluation was conducted after a decade of AI experience at the center. They document various impacts of AI to date, and discuss ways the organization's leadership could more effectively expand and contribute to developing a healthier community over the next five to 10 years. These objectives are not unlike those we worked with in Nepal.

Their evaluation proceeded in five steps and provides a useful model for future AI process evaluations. First, the AI evaluators held two forums on the subject of healthy communities. One was a "summit" defining a "Vibrant Community," followed by a workshop on how to create and sustain a "Vibrant Community Initiative." Thus, they somewhat loosely followed AI's standard "4-D Cycle," with the summit meeting

analogous to the Discovery and Dream phases, followed in the workshop by Design and Delivery activities.

Second, the evaluators set out to determine the health center's goals and objectives. The evaluation was designed "to measure changes in perception, knowledge, and behavior among individual participants, the organization, and the greater community since the AI process began." They immediately noted a lack of "clearly defined objectives" and "actionable items" to evaluate, and concluded that a standard log-frame development exercise would have been appropriate at the time the center was created a decade earlier. Reflecting on this need, they determined that it was not too late to create one. The focal point of this step was drawing up a *retrospective* log-frame to establish the goals, purposes, outputs, activities, and connecting assumptions of *both* the center's decade long activities and the subsequent evaluation, along with indicators linked to means of verification. The outputs of this activity guided them in determining which data sources to use to collect relevant information.

Third, Kotellos et al. prepared a set of AI evaluation questions based on the log-frame indicators that they and leaders and participants from the center designed.

Fourth, they conducted fieldwork to answer the questions generated, using key informant interviews and focus group discussions. Participants in this holistic process included the target organization's board members, practitioners, members and donors, organizational partners, and community groups. Representatives of the local health department, hospital, schools, human services centers, and churches were also included.

Finally, the team analyzed the data and wrote up the results. The analytical process was closely guided by the log-frame and resulted in a set of themes describing the organization's work in AI language. For example:

> (1) the holistic health center "remained true to its core values that focused on community, integrity, learning, acceptance, love, and spirit;"
> (2) its leaders and practitioners more "carefully listened to the stakeholders and members" needs and wishes regarding the center's role in the community," thus focusing attention on stakeholder concerns, and
> (3) the center's credibility in the community increased as it became "more recognized as a viable partner by the established health care community, and increasingly by the greater community." About the latter, one respondent made this analogy: "It's like the difference between being on the bleachers and being in the game. We're in the game now" (Kotellos, Rockey, and Tahmassebio 2005:18).

The evaluation team also documented the various challenges and lessons learned during their work. At the beginning of the article, they point out that their use of AI to evaluate an AI process is the first of its kind (Ibid. 16; though perhaps the first of its kind *to be so carefully documented* would be a more believable claim). Ultimately, however, they accomplished much more. They were innovative in adopting standard evaluation procedures combined with the retrospective log-frame and indicators. As noted earlier, the use of log-frames is considered to be an older, more conservative, mainstream "problem solving" approach to planning and evaluation, one that many AI practitioners consider fundamentally contrary and inimical to AI (Ryan et al. 1999; Tamang 2002). It is refreshing, therefore, that Kotellos and her colleagues returned to the log-frame approach with creative modifications to accommodate the uniqueness of AI. If used by future AI evaluators, it will undoubtedly help donor agency planners and decision-makers to feel more comfortable with AI processes and evaluation results.

Kotellos and her colleagues conclude with two recommendations, with which we fully agree:

- every project evaluator should include AI processes among his/her set of tools, and
- evaluation should be a part of every AI process, from the beginning.

To their conclusions I now repeat our own—that to avoid becoming obstinately aligned for or against a new "truth," fad, or movement, the safest approach to *any* development orthodoxy is to maintain a healthy and informed skepticism.

Notes

[1]This abbreviated description of the cycle is adapted from Ashridge Consulting (AC) (2005). Definitions of the phases and steps vary across the AI literature. For example, Mohr and Watkins (2001) promote a "5-D Phase Cycle" beginning with "Define" (to set the stage), followed by the other four (see also Martinetz 2002). Coghlan, Preskill, and Catsambas (2003) have created a "4-I Model" by which participants Initiate, Inquire, Imagine, and Innovate. Odell (2001) has created a "7-D Model," which he feels is more culturally compatible in some countries (including Nepal). After completing the 4-D Cycle he adds: Do It Now!, Dialogue/Discussion/Reflection, and Dance and Drum.

[2]Wilber eschews calling it a new "paradigm," noting that "paradigm" has been misinterpreted from the original landmark essay on the subject by Thomas Kuhn (1996; see Wilber 1998). The term "paradigm" as used here, however, simply implies a pattern of thought.

[3]Some international observers put Nepal's MMR even higher, from 740 (WHO 2005), to 1,500 (UNICEF/CDC, in IRINnews 2004). By comparison, the United States MMR is 14. In 2007, a lower official figure of 281 MMR was announced in Nepal, but some experts do not trust it (nor do we) because of the methods and analysis used to calculate it.

[4]Only 13 percent of home births are assisted by trained health workers (traditional practitioners and health professionals trained in Western medical practice). Another 23 percent are attended by traditional birth attendants (untrained). More than 50 percent of births are assisted by relatives, friends, or other non-health personnel, and 10 percent are not assisted at all. Only 8 percent of all health professionals in Nepal are fully-qualified "doctors;" the vast majority are nurses, auxiliary nurse midwives, heath assistants, auxiliary health workers, maternal and child health workers, and village health workers (GoN 2001).

[5]In distinguishing socioeconomic and ritual caste status we prefer the terms "privileged" and "less-" or "under-privileged" in place of the more popular but archaic and socially discriminatory "upper" or "elite" *vs.* "lower" or "untouchable" castes.

[6]As part of our search, an announcement was circulated on the Internet among AI practitioners. Several responded with drafts of recent and forthcoming articles. Three of the articles talk of using AI in urban North American settings (Reed et al. 2002; Ryan et al. 1999; Walker and Carr-Stewart 2004), each of which is only mildly or tangentially evaluative. All are weak on objective results, and none use quantitative analysis, with a small exception in Ryan et al. (1999). We take exception to Ryan et al. on other grounds, however, when they refer to their work an example of the "ethnographic method." Little of an ethnographic nature guides or informs their analysis, and none of the authors is an anthropologist. Each of these articles lacks the objective rigor necessary to convince many quantitatively-biased, non-AI oriented development decision-makers of their value. We did, however, find one relevant discussion in the February 2005 issue of the *AI Practitioner*, edited by Webb, Preskill, and Coghlan, entitled: "Bridging Two Disciplines: Applying Appreciative Inquiry to Evaluation Practice." See also Preskill and Coghlan 2003, including Rogers and Fraser in the same volume.

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