

# Triple Approach to Program Evaluation and “Contextual Program Evaluation Model” Proposal

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## Abstract

Complexity, contextuality, and reflectivity have come to the forefront in almost every field, including education. In this paper, the program evaluation process is considered within the framework of a socially complex system. In this regard, a model proposal for program evaluation is developed: Contextual Program Evaluation Model (CPEM). The conceptual and theoretical frameworks on which the model is based are ‘complexity theory’, ‘contextual/reflective learning and evaluation’, and ‘social and ecological/environmental accountability’. Taking this triple framework into account, the four evaluation domains/components of CPEM are as follows: ‘agents’, ‘context-process’, ‘emergent outputs’, and ‘impact’. Considering the core concepts of the complexity system, ‘agents’ is preferred instead of ‘inputs’. Furthermore, since reflective process-orientedness is essential in education, and the experiences in the process are assumed to be ‘context-dependent’, ‘process-context’ is considered intertwined. Outputs are conceptualized as ‘emergent outputs’ because they are viewed as results that emerge through mutual interaction and transformation within existing patterns and attractors in context-dependent reflective processes. Finally, considering the accountability approach, impact (institutional/societal/ecological) was identified as the fourth domain of evaluation. By considering these factors, a program evaluation framework for the CPEM is developed. Then, a concrete example of program evaluation based on CPEM is presented. With this, an attempt has been made to provide users with a helpful guide containing steps.

## Keywords

Complexity, contextuality, reflectivity, social accountability, program evaluation

## 1. Introduction

Over time, many program evaluation models have been developed based on different approaches and theories, focusing on different domains of evaluation (input, process, context, activity, product, output, impact). Among these models, the Kirkpatrick Model is an “output” focused evaluation, whereas, in others, evaluation is carried out through multiple domains. Among these multiple-domain models, most of which can be considered within the framework of a complicated system approach with their different relational nature. For instance, the Logic Model has a linear process between domains (input, activities, product, and output), in contrast, the Context, Input, Process, Product (CIPP) Model has a non-linear dynamic relationship (Frye & Hemmer, 2012). Furthermore, these systems could be seen as models based on the input-(process)-output approach, built on more mechanistic metaphors.

Although Frye and Hemmer (2012) categorize the CIPP Model within complexity theory, it might be more appropriate to consider this model within the framework of the nonlinear complicated system approach (Gulpinar, 2021; Snowden et

al., 2007). There is no such a model developed within the framework of complex systems with many qualities other than nonlinear processes. This paper will present a program evaluation model proposed in this direction. This proposed model is the "Contextual Program Evaluation Model (CPEM)".

## 2. Conceptual and Theoretical Framework of CPEM

The CPEM is based on three approaches and theories. These approaches and their core concepts are presented below.

### 2.1 Complexity theory

In recent years, the direction of transformation in medical education has been debated. These discussions show a paradigm shift in education and healthcare processes. With this change, educational processes, including program evaluation, are being addressed based on "complexity theory" (Gulpinar, 2021; Holmboe & Batalden, 2015; Mennin, 2010a). In this framework, it is essential to re-evaluate the existing program evaluation models based on a mechanistic and deterministic approach, linear or non-linear input-(process)-output understanding, through complexity theory. In complexity theory, systems are considered as self-organizing context-dependent systems that are more flexible/dynamic, non-deterministic, and non-linear, with fuzzy boundaries, and more open to change through mutual interaction and transformation. It provides a more appropriate framework for addressing the "uncertainties" and the "wicked issues" encountered in educational processes (Mennin & Eoyang, 2022). The complex system focuses on "process" and "context". These two foci are also valid for the program evaluation system. In this system, where educational processes are seen as socio-cultural interaction and socialization processes, the quality of the interaction and the attractors affecting the interactions are the keystones to be focused on in the evaluation processes. Also, "inputs" in existing program evaluation models have evolved towards "agents" and outputs towards "emergent outputs". Outputs and impacts are defined as emergencies that emerge in the context/ecosystem in which they occur, in processes that occur through mutual interaction and transformation between agents and in line with a small number of simple rules and principles. With these process-oriented, collective, and contextual emergences, for example, curricula and program evaluation systems co-transform and co-develop. These transformations and developments are accompanied by the emergence of new emergences (new attractors, patterns, situations) as critical thresholds (complexity threshold, breaking/transformation threshold) are crossed. Therefore, changes are also addressed through attractors and critical thresholds in program evaluation processes. For example, assessing the attractors in an organization is essential for uncovering the facilitators and resistances to change. Finally, in contrast to the complicated system approach, plans for program evaluation practices are made in more flexible framework plans. In fact, in a complex system, the emphasis on planning and the practice of complicated systems is seen as "over-planning". Spontaneous emergent outputs replace planned and unplanned outputs.

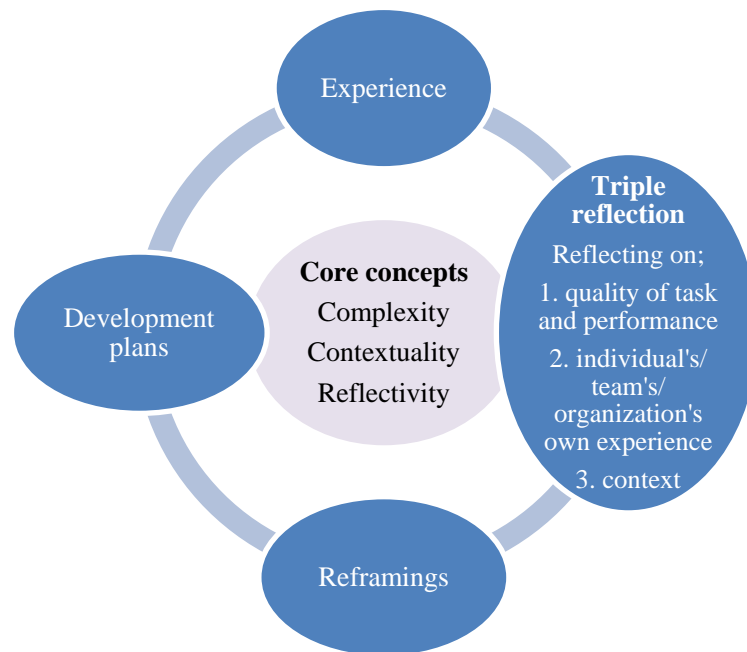
### 2.2 Contextual/reflective learning, curriculum, and program evaluation

Along with "complexity", the other two core concepts of CPEM are "contextuality" and "reflectivity". As socially complex systems, curriculum, assessment, and program evaluation systems are context-dependent and the processes experienced in all these systems are reflective. Each of these reflective processes is structured, gains meaning, and transforms according to the individual, institutional, social, national, and global contexts (sociocultural environment, institutional culture, climate, ecosystem, emotional climate, managerial climate, professionalism, physical-material environment and health/educational technologies, system, discourse, ideology, paradigm, etc.) in which it takes place. At the same time, experiences in processes reinforce or transform the emerging context (Gulpinar, 2021; Mennin, 2010b; Sandars, 2009). Therefore, it is crucial to think of contextuality and reflective process orientationality (mutual interaction and transformation, social relations and socialization) together. The interactions between agents in the process, the interactions between agents and the environment, the ecosystem, and the interactions between agents and context will be decisive for what emerges.

In medical education, contextuality is addressed more concretely in areas such as "situated/ contextual learning", "contextual decision making (clinical, ethical, managerial)" and "contextual curriculum" (Durning & Artino, 2011; Hawks et al., 2023; Schrewe et al., 2018; Watsjold et al., 2022). In pre-clinical and clinical education processes, it is essential to consider the interactions between agents, from learners and trainers to educational practices, from patients to health care systems, from physical environment to climate and culture. It is also essential to consider what are the different contextual patterns that emerge and how they work. On the one hand, the context of medical education emerges through dynamic interactions and transformations between these components (learners, educators, administrators, education and health care practices, patients, places, organizational culture/ecosystem, and society), (Schrewe et al., 2018), whilst at the same time, the emerging contexts will transform the agents and processes and determine the outcomes through these transformations.

At the same time, it is important to consider program evaluation as a reflective practice and to conduct the evaluation

process through triple reflection (Figure 1). In the triple reflection defined by Glpinar (2021), organizations/teams/individuals reflect on the following components: (a) reflecting on the quality of the task and their own performance in the process, (b) reflecting on their experience in the process, and (c) reflecting on the context (system, culture, learning or work environment/climate, etc.) in which the experience took place. Reflection on these three components is also complemented, in the second and third steps, by 'reframing' and setting further development plans in line with these reframes. In the specific case of program evaluation, a reflective/contextual program evaluation process is a process in which the organization/teams/parties reflect on (a) the nature of the program evaluation task, (b) their experiences in this process, and (c) the context (system, organizational culture, team environment/climate, emotional/relational climate) in which the evaluation process takes place. In this way, through the reflective program evaluation process, the culture of continuous renewal and development becomes an organizational culture.



**Figure 1. Reflective practice with triple reflection.**

As stated above, this contextual and reflective framework also concerns to assessment and program evaluation system. Evaluation can be carried out by considering the contextual learning, assessment, and evaluation matrices formed based on "contextual patterns" that emerge through the interaction of agents and processes. So, the main concern of this paper is contextual/reflective program evaluation.

### 2.3 Social and ecological/environmental accountability

The third core concept of the CPEM is "social and ecological accountability". Recently, the sociocultural approach and approach concerning the ecosystem have become prominent in medical education, including learning and clinical decision-making (Durning & Artino, 2011; Watsjold et al., 2022). This development has addressed the program evaluation system within the "social and ecological accountability" conceptual framework.

In this context, medical education programs and healthcare processes focus on community health-related conditions (social determinants of health, vulnerable, underserved populations and health, health equity) and contextualized social care (Sandhu et al., 2023). In recent years, new ones have been added in the context of social relevance, social responsiveness, social responsibility, and social accountability in relation to community health needs and health priorities (Boelen et al., 2016; Rourke, 2018). Health and healthcare processes have evolved towards a holistic approach with social, economic, cultural, and environmental determinants. Environmental issues such as environmental health, climate change and health care processes, decarbonizing health care facilities, environmental injustices, and environmental sustainability have started to be covered in programs (Philipsborn et al., 2021; Sullivan et al., 2022). Therefore, in line with social accountability and ecological accountability approaches, the dimensions of the program related to community and environmental health; and its impacts on community health and the environment/ecosystem have become essential in evaluating educational programs (Barber et al., 2020).

### 3. Contextual Program Evaluation Model

In program evaluation models, evaluation is based on data collected from different evaluation domains (input, context, process, activities, product, output, and/or impact). In CPEM, evaluation domains were first identified based on the three basic approaches and core concepts listed above. Then, evaluation levels were determined in order to give profoundness to the data collected from each domain. In this way, it is aimed to develop an evaluation model based on more comprehensive and in-depth data.

#### 3.1 Levels of evaluation

In CPEM, the following four levels are defined to provide depth to the evaluation data to be collected from different domains:

- Level 1: evaluating partner views
- Level 2: evaluating learners' achievements, competence levels
- Level 3: On-the-job observation and assessment, assessment in simulated settings, products, records, reports, portfolios, research, data/statistics, etc.; evaluating the level of transfer
  - of pre-clinical competencies to the clinical education period,
  - of graduate outcomes/competencies to professional life after graduation.
- Level 4: Evaluating the institutional, societal, and environmental changes brought about by the curriculum and its graduates, the activities and products realized in this direction, and the institutional, societal, and environmental impacts generated by them.

When these four levels are considered together, for example, the data that can be collected in the evaluation of the program within the concepts of social and ecological accountability will be as follows: (1) at the first level, the opinions of partners; (2) at the second level, the extent to which learners acquire the relevant competencies through different assessment practices; (3) at the third level, the extent to which they carry these gains into their professional lives through on-the-job observation, document analysis, etc.; and (4) at the fourth level, the social and/or ecological impacts of the program in this respect, through document analysis, reports, research, etc.

### 4. Evaluation Domains and Preferred Evaluation Methods and Tools

Considering the three theoretical/conceptual frameworks on which the model is based, four domains of evaluation have been identified in CPEM: “agents”, “context-process”, “emergent outputs” and “impact” (Figure 2). Considering the core concepts of complex systems theory, "agents" is preferred over "inputs". Since complexity theory is process-oriented and context-dependent rather than output-oriented, process and context as evaluation domains are essential for program evaluation. At the same time, since process and context are intertwined and the process is experienced within its context, they are combined as "context-process" instead of being handled separately. Since outputs are considered to emerge in a context-dependent process, "emergent outputs" are preferred instead of "outputs". Finally, since the third approach adopted in CPEM is social and ecological accountability, the fourth domain of evaluation was identified as "impact".

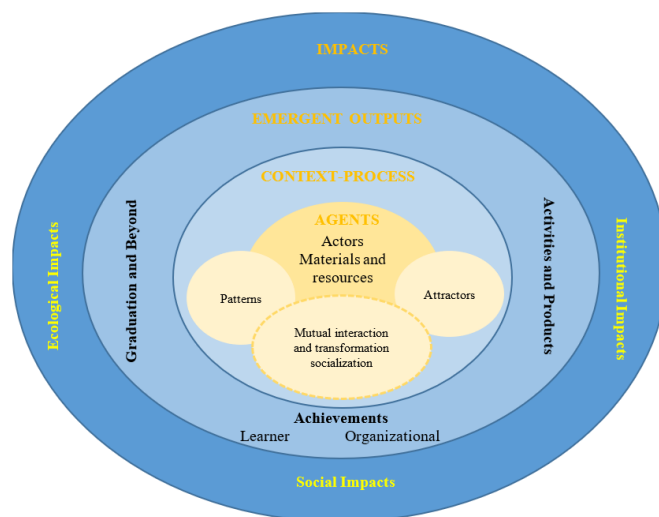


Figure 2. Contextual Program Evaluation Model (CPEM).

## 4.1 Agents (actors, materials, resources)

In complex social systems, "agents" are components that are involved in intra- and inter-system processes, determine these processes to a certain extent, and themselves change and transform with the contextual processes experienced in mutual interaction and transformation. Two sub-domains can be listed under this domain:

(1) Actors: This subdomain includes learners, trainers, health professionals, support unit staff, patients, different social segments receiving health care (underrepresented and vulnerable groups, ethnicity), administrators, departments, teams, education boards, etc. Using document analysis, reports, surveys, questionnaires, scales, research data, etc., data on the profiles (numbers, characteristics, needs, expectations) of these actors are collected and then analyzed.

(2) Materials and resources: This sub-domain includes education and health care settings and their equipment (education and hospital infrastructures, infrastructure of simulation centers or institutions where community-oriented medicine practices are carried out), educational materials, education, and health technologies, systems/automations used in institutions. This domain can also include economic data on education and health processes (income-expenditure, payment systems, performance systems) and legislation on education and health processes.

Institutional records, reports, national and regional reports, needs analyses and strategic plans, annual goals and action plans, on-ground observations and interviews with stakeholders, expert opinions, etc. can be used to collect data.

## 4.2 Context-Process

The perspective of "contextual/reflective process directedness" in complex social systems has placed the "context-input" domain at the center of program evaluation. The main question in program evaluation is how and in what context educational processes are being experienced. The second set of questions relates to the emergent outputs and impacts of this contextual experience.

In complexity theory, curriculum and program evaluation systems as complex systems are conceptualized as context-dependent processes that are carried out through framework planning based on a small number of simple principles. The focus of evaluation in the "process" domain is on the nature of "interaction" and "sociocultural interrelationships" in education and healthcare processes; the existing attractors and patterns (approaches, behaviors, attitudes, etc. specific to individuals, teams, and institutions) that guide this process; and the new patterns and attractors that emerge as a result of these interrelationships. The nature of the interaction (direction, depth, interaction patterns, outcomes, etc.) and how and in what direction the attractors' work is decisive for emergent outputs.

At this point, the questions to be answered in program evaluation are: In general, how does the process work, and in what direction? Are the processes coordinated as planned, how and to what extent do the defined guidelines work? What are the challenges and disruptions encountered in the process and how are they overcome? What are the consequences of the process working in this way? What is the nature of the relationships between actors in the process; what are the patterns for building relationships? What are the patterns of interaction within and between teams and committees? How and in what ways does the interaction between the materials used in education and health care processes (e.g., education and health technologies, automation systems, etc.) and the actors (learners, trainers, health workers, patients) affect education and health care experiences? What are the attractors in the system that support or constrain interaction and socialization, and how and in what ways do they function?

As mentioned earlier, complexity systems are context-dependent. The process is experienced and gains meaning within its specific context. Context and reflective process are intertwined. Among the sub-domains related to the "context" are the following: (1) the environment created by the physical settings, materials, and technologies used in education and health care processes, (2) the culture and climate of the institution, (3) the emotional, sociocultural, humane environment in the institution, units, teams, and team/board dynamics; (4) the emotional, social, humane environment that emerges in different educational and clinical processes; (5) the climate created by institutional (university, faculty, hospital) and national education and health systems, policies, structures, processes, and regulations; the climate created by managerial and leadership processes; (6) society (sociocultural characteristics and the environment/climate they create in education and health care processes).

Therefore, the questions sought to be answered in program evaluation are related to these sub-domains. What is the nature of the interaction between the processes experienced and the contexts in which they take place? How and in what way do contextual features influence the process? More concretely, how and in what ways do the organizational culture and the prevailing discourse in the organization (paradigm, language, power relations, etc.) influence the learners' professional identity formation? How and in what ways do the dominant culture and climate in education and healthcare processes affect attitudes and behaviors towards professionalism? What unprofessional behaviors emerge at this point?

Evaluation methods and tools that can be used to collect quantitative and qualitative data on the "context-process"

domain include: Post-program evaluation forms and interviews (in-depth one-on-one, focus group, participatory interview) with learners and trainers; analysis of learning and assessment activities and processes, analysis of community-oriented activities; analysis of observation and assessment tools for professionalism (P-MEX, Mini PAT, 360<sup>0</sup> assessment) and reflective portfolios; analysis of on-the-job observation and evaluation, interviewing parties, analysis of reflection sessions, analysis of critical incidents; systems analysis, analysis of documents, reports on education and health systems and practices, analysis of board reports on functioning; analysis of narratives, metaphors, emotions, discourses, etc. in education and health care processes through qualitative research with narrative design, discourse analysis; ethnographic research on educational and clinical experiences; research designed with a socio-material approach. For example, research designed with a socio-material approach can reveal how and in what ways the technologies used in healthcare processes affect patient-physician interview environments, what learners learn from this context in terms of professionalism, and how technology-oriented health practices affect hospital culture and climate. By conducting ethnographic research, contextual patterns (e.g., attitudes and behavioral patterns towards professionalism) that are dominant in the organization can be revealed.

### 4.3 Emergent outputs

In a complex system, contextual process experiences with agents' interaction will result in emergent outputs. The mutual interaction and transformations in this process can be accompanied by the emergence of new patterns (contextual, behavioral) and attractors, and the transformation of the agents themselves (individual and institutional learning and development). At this point, the third domain of evaluation in CPEM is "emergent outcomes". Three sub-domains can be defined under this domain.

(1) Activities and products: In this context, curricular and extra-curricular activities, and their products (student research, presentations, articles, social responsibility projects, workshops, club activities, scientific, cultural, artistic, and sportive activities and their products/ designs, panels, congresses, exhibitions, festivals) are evaluated. In addition, another evaluation that can be made in this area is the well-being of learners and the activities carried out in the counseling and mentorship process offered to learners.

(2) Achievements: These achievements can be divided into the achievements of the learners and those of the educational institution (units, teams, boards). The methods and tools that can be used to evaluate learner achievements and the quantitative and qualitative data that can be collected are as follows: learners' views on their learning outcomes/ competencies (L-1, evaluation forms/surveys, interviews); analysis of learners' exam results, analysis of formative/developmental assessments (L-2, on-the-job observation and evaluation forms, rubrics, reflective/narrative writings); analysis of learner log-books, portfolios (L-2); analysis of pass-fail, repetition, dropout rates; analysis of assessments made during the clinical education to see how much learners are able to transfer their achievements from pre-clinical education to clinical education (L-3).

Data that can be collected on the learning and development of the organization include new approaches, attitudes, values, and behaviors emerging in the contextual process at the level of the institution, unit and/or teams; new contextual outputs (culture, climate, environment); attractors that are decisive in institutional transformation, contextual factors that support and hinder transformation; and new attractors emerging in the process. Methods and tools that can be used include evaluation forms/surveys and tools, interviews (in-depth, focus group), on-the-job observation and evaluation, analysis of reflection sessions on institutional experiences, critical incidents analysis, analysis of documents, and progress reports on education and health care processes.

(3) Outcomes related to graduation and beyond: Quantitative and qualitative data related to this sub-domain can be collected in three periods.

- *During graduation:* Analysis of statistics related to graduation (how many students graduated, how many years did they graduate, who graduated with honors? etc.); graduate opinions on the educational process they completed, their achievements in the process, and their professional competencies at the time of complete graduation (L-1, evaluation forms, interviews);
- *Within the first two years:* student views on the medical education they completed through their first post-graduation experience (L-1, evaluation forms/ surveys, interviews); analysis of exam results such as residency entrance exam, USMLE and placement results (L-2); analysis of career choices and continuing development processes after graduation.
- *10-15 year evaluations:* analysis of post-graduation career choices (clinical, research, community health, management in the field of health, out-of-field choices, etc.) and continuing development processes; evaluations from the collaborators in the institutions where they work (L-3, Mini-PAT, 360<sup>0</sup> evaluation); changes, transformations,

projects they have carried out in the institution where they work (L-4).

#### 4.4 Impact

Within the social and ecological accountability framework, the fourth evaluation domain of CPEM is "impact". In this domain, evaluations are made on institutional/team, societal and/or ecological impact sub-domains, considering the objectives of the evaluation (Barber et al., 2020; Boelen & Woollard, 2009; Leinster, 2011).

- *Institutional impact*: Institutional impact can be addressed in two ways. The first is the impact of the educational program on the educational and healthcare processes of the faculty and hospital where medical education is carried out. The second is the impact that learners who graduate from the medical education program contribute to the institutions where they work: impacts on the quality of health care processes offered in the institution (in terms of relevance, quality, access, equity, and cost-effectiveness), impacts on the functioning of the institution/the team they work with (group dynamics, institutional environment, climate, culture), impacts on managerial/leadership processes in the institution.
- *Social impact*: In terms of relevance, quality, access, equity, and cost-effectiveness, this refers to the activities and impacts of the graduate, alone or as a member of a team, towards community health (community health needs and priorities): improvement in community health outcomes/ community health-related indicators (morbidity, mortality), reduction in risk factors, health promotion, management of specific health care processes (chronic diseases, maternal-child health, elderly health), management of health-related psychosocial and cultural processes, health education for the community, health advocacy, equity in access to health, avoidance of bias, management of community-oriented projects/social responsibility projects, membership in NGOs and their roles and activities.
- *Ecological impact*: The arrangements, activities and emergent impacts of the graduate, alone or as a member of a team, to address the ecological risks associated with individual and community health and the ecological impacts of the health care processes they manage: management of environmental/ecological risks affecting individual and community health, contribution to regulations on environmental health and occupational health, ecological (footprint, handprint) health in health care processes, advocacy for ecosystem health.

Quantitative and qualitative data on these domains can be collected through analysis of institutional, regional, and national reports, analysis of institutional health care delivery statistics, analysis of health indicators, analysis of project reports, observations and assessments at the workplace, interviews with collaborators, focused research on these domains.

### 5. An Example of a Program Evaluation Framework Prepared According to CPEM

In the complex system approach, more global planning (framework) is developed during program evaluation practices instead of detailed planning as in the complex system approach. An example of a program evaluation framework is presented below, considering a six-year medical education program with pre-clinical and clinical education phases. This framework consists of the aim and objectives of the evaluation and a blueprint that matches the domains of program evaluation with the evaluation methods and tools.

#### 5.1 Aim of the Program Evaluation System

- evaluate the six-year medical education process (including pre-clinical and clinical phases) and the post-graduation process, in its own context and with its emergent outcomes.
- within the accountability framework, evaluate the educational program in terms of the processes, activities, outcomes, and impacts experienced in terms of institutional, social and/or dimensions concerning the ecosystem.
- revise the education program at regular intervals using the results of the evaluation.
- contribute to the creation of a culture of continuous evaluation, renewal, and development in education.

#### 5.2 Objectives of the program evaluation system

- 1) Evaluating pre-clinical and clinical education phases and instructional programs regarding program structure, contextual educational processes, and outcomes.
  - a. evaluating the pre-clinical program in terms of preparing students for the clinical education period.
  - b. evaluating clinical education programs in terms of the level of preparing students for professional life.
- 2) Evaluating extra-curricular activities (student club activities, cultural/art activities, social responsibility projects, student research) together with their processes and contexts, activities, and products.
- 3) Evaluating the six-year process in terms of educational, clinical, and managerial processes, the contexts in which

these processes occur (system, institutional culture and climate, emotional climate and socialization, environment, and climate for professionalism), and their emergent outcomes.

- c. evaluating the effects of the contextual processes experienced (planned and implicit learning) on learners' attitudes and behaviors towards professionalism and the formation of their professional identities
  - d. evaluating the counseling and mentoring processes offered to learners.
  - e. evaluating systems for monitoring the emotional, social, and spiritual well-being of learners in the process
- 4) Monitoring the professional development processes of graduates and evaluating them in terms of the educational program.
- 5) With a social and ecological accountability approach, evaluating the related activities and products realized during the six-year education process; and determining the institutional, social and/or ecological impacts of the program.

### 5.3 Selection of program evaluation areas and evaluation methods and tools

In line with the program evaluation objectives, an evaluation blueprint was developed using multiple evaluation methods and tools over four evaluation domains. The blueprint presented in Table 1 indicates which evaluation methods and tools can be used for which domains, from whom/which sources the data can be collected, and in which periods. In addition, the quality of the data collected through the four levels of evaluation was determined.

**Table 1. Program Evaluation Domains and Evaluation Methods/Tools Blueprint Sample**

Data collection methods/tools and stakeholders	Domains of evaluation							
	Agents: actors, materials/resources	Context-Process	Emergent outputs			Accountability and Impact		
			Achievements	Activities & Products	Graduation & Beyond	Institutional	Social	Ecological
<b>Document analysis</b>	1. Analyses on education and health service infrastructure (every 3 years) 2. Analyses on individuals/patients and different social groups receiving health services (every 5-10 years)	3. Analyses on the implementation and coordination of the instructional programs in pre-clinical and clinical education phases (changes, disruptions, processes related to assessment, difficulties encountered (annually) 4. Analysis of processes related to health care delivery in clinics (annually) 5. Analysis of processes related to community-oriented medicine practices and their coordination 6. Analysis of group reflection sessions (learners, trainers, other health professionals) in which experienced educational and clinical practices are reflected on in their contexts	7. Analysis of learners' exam results (L-2) 8. Analysis of learners' developmental (formative) assessment documents (patient file, on-the-job observation and assessment tools, logbook, reflective portfolio, etc.) (L-2) 9. Analysis of learners' status of academic success (class success, grade point averages, pass, fail, freeze, dropout rates, etc.) (L-2)	10. Analysis of student research activities and products (research, presentations, articles, awards) (every 2 years, L-3) 11. Student club activities and products; social, artistic, sports activities and outputs 12. Analysis of the counseling, guidance, mentoring systems offered to learners and related outputs	13. Number of graduates, graduation degrees, duration of graduation (annually) 14. Gaining specialization and settling in, job placement, fields of work (in the first 2 years and in years 5-10)		13. Analysis of social responsibility projects, community-oriented projects in which learners participate and its products (every 2 years, L-3)	
<b>Learner evaluations</b>	1. Profile analysis of the of learners (annually)	2. evaluations made with the evaluation form/survey at the end of the program for each instructional program in the clinical and pre-clinical education program (L-1) 3. General evaluation conducted with the evaluation form during the transition from pre-clinical phase to clinical education phase (L-1) 4. Interview with learners (focus group, in-depth one-on-one) (every 2 years, L-1) 5. Interview with learners about critical incidents (L-1)						
<b>Evaluations for trainers and other staff</b>	1. Analyses for trainers, health workers and support staff (every 3 years)	2. General evaluation with trainers at the end of the academic year using the evaluation form (annually, L-1) 3. Interviews with trainers and/or other staff (focus group, in-depth one-on-one interview) (every 3 years, L-1)		4. Analysis of trainer development programs for trainers, workshops and their outputs (L-1 & L-2)				

<b>Graduate evaluations</b>		1. General evaluation of with the evaluation form/survey (at graduation, once, L-1)			3. Analysis of the results of residency entrance exams, USMLE, etc. taken by graduates (L-2) 4. Evaluations conducted with graduates through general evaluation forms and/or interviews regarding their career processes (two evaluations, the first in the second year and the other in the tenth year, L-1)	5. Interview with the team members with whom the graduate worked at the institution (first in the second year, second in the tenth year, L-1)	6. Activities carried out by the graduate for the promotion and protection of community health and their impacts (first in the second year, second in the tenth year, L-3 & L-4)
			2. Graduates' opinions on graduation competencies/outputs with the evaluation form (at graduation, once, D-1)				
<b>External stakeholders and evaluation</b>					1. Focused (climate change & health, health & systems, advanced technologies, artificial intelligence, etc.) search meetings, workshops, brainstorming with external stakeholders and expert panels (administrators, health professionals, NGOs, alumni, etc.) (every 8-10 years)		
<b>Needs/problem analysis, research, projects</b>	1. Studies on society, patients and their relatives, and different social groups receiving health care services.	2. Focus studies on the processes of education and health care delivery and the context in which they take place (relationships, socializations, team dynamics, beliefs, attractors, emotional environment/climate, attitudes and behavioral patterns, education/health systems, technologies and the context in which they occur, etc.).			3. Needs/problem analyses for focused programs (electives, ecology and health, medical humanities, learner well-being, etc.) to meet the changing health needs and priorities of society and the priorities of learners.		

L-1,-2, -3, -4: Levels of evaluation

## 6. Conclusion

Recently, there has been a paradigm shift in all educational processes, including program evaluation. In this article, a proposal for a program evaluation model, whose conceptual/theoretical framework can be defined as 'complexity', 'contextuality', and 'reflexivity', has been drafted. This draft will gradually evolve into a model with feedback from theoreticians and practitioners.

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