THE CENTERED EVALUATION GUIDE

A collaborative product of the CENTERED Project *

*Community-based
Evaluation
Networks
Targeting
Elimination of
Racial and
Ethnic
Disparities

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SEPTEMBER 2003

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“OF ALL THE FORMS OF INEQUALITY, INJUSTICE IN HEALTH CARE IS THE MOST SHOCKING AND INHUMAN.”

-- Martin Luther King, Jr.

ADDRESSING "RACISM" & "RACIAL EQUITY" IN PROGRAM EVALUATIONS

"Racism remains the prime cause of the unequal and racially discriminatory provision of funds for health services and health care. Racism in consequence is the underlying structure causing the dreadful burden of excess morbidity and mortality, much of it preventable…"

Vernellia R. Randall
Professor of Law, The University of Dayton, School of Law*

*http://academic.udayton.edu/race/01race/RaceRelations00.htm

"...Racism is so entrenched in the American health care system that addressing it requires a holistic, systemic, organized approach that delves deep into the inner reaches of the system, deep into the halls of Congress and challenges the medical establishment"

Willard V. Edwards, MD, MBA
National Health Advocacy Director
The National Association for the Advancement of Colored People

"Racism is so deeply embedded in the dominant American culture that we fail to see that it continues to affect all of us: every person, male or female; every immigrant, every refugee; every race, every age group; and every religious, social, legal, artistic, business, educational, governmental institution in the country."

Sharon Parker, President
American Institute of Managing Diversity*

*http://clinton3.nara.gov/Initiatives/OneAmerica/Practices/pp_19980804.3881.html

"The history of public health might well be written as a record of successive redefinings of the unacceptable."

Sir Geoffrey Vickers
From "What sets the goals of public health?"
Lancet 1:599-604, 1958.

PREFACE

WHAT ARE "RACIAL AND ETHNIC DISPARITIES IN HEALTH"?

"Health disparities are the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."

Source: The National Institutes of Health (NIH) Health Disparities Work Group

What is the *CENTERED* Project?

The *CENTERED Evaluation Guidebook* is the product of a Centers for Disease Control (CDC) funded special interest project (SIP #25-1999; Cooperative Agreement Number U48/CCU409664-09) now known as the *CENTERED* Project. *CENTERED* is an acronym that stands for:

Community-based **E**valuation **N**etworks **T**argeting
Elimination of **R**acial and **E**thnic **D**isparities

The purpose of the project is to develop evaluation support for community-based public health (CBPH) programs that target elimination of racial and ethnic disparities in health. Health disparities are inequities in health of one group when compared to another group.

A Story of A Native Hawaiian Community Getting Involved: Empowerment Through Participatory Research Works

Invisibility: Native Hawaiians, as with many small ethnic groups, remain invisible on the national agenda. Numbering just over 200,000 in the 1990 US Census, Native Hawaiians have historically been either part of the "Other" group or the "Asian American/Pacific Islander" group as defined by the U.S. Office of Management and Budget's (OMB) Directive 15. In 1997, this directive was redefined separating the categories into: 1) Asian Americans, and 2) Native Hawaiians and Other Pacific Islanders. This desired change has yet to be fully integrated into the federal health and funding arenas, resulting in still inadequate data sufficient to fairly describe the health needs of this indigenous population.

In their own homeland, Native Hawaiians have a mortality rate 41% higher than non-Hawaiians; a heart disease mortality rate 38% higher than the state population; a cancer mortality rate 45% higher than the state population; and, a diabetes mortality rate that is twice that of the other four major ethnic groups combined (Blaisdell, 1996; Johnson, 1998; Look, 1995). This same pattern of disparities is also found in the behavioral risk factors and social indicators that are correlated with poor health status.

The need for current and accessible data specific to Native Hawaiians is critical when trying to compete for resources.

While the state of Hawaii collects ethnic-specific data through the CDC-sponsored Behavioral Risk Factor Surveillance System (BRFSS), Native Hawaiian data continues to be aggregated within the Asian American/Pacific Islander group. This practice renders the data "misleading" for use in advocating for health needs specific to Native Hawaiians, which is masked when aggregated with data describing the larger Asian American population. For example, while Hawaii boasts the longest life expectancy in the nation, this is largely due to the longer lifespan of the Asian American women who live in the state. This optimistic life expectancy masks the significantly elevated mortality rates found among Native Hawaiian for heart disease, cancer, and diabetes (see above).

While the health disparities among Native Hawaiian populations made them very attractive to researchers, a major division developed between the researchers and the Native Hawaiian community. Because the Hawaiian community wanted to pursue a participatory research model, but the university researchers did not, the first team of university researchers had to be replaced. This project has since become an example of what can be expected when the community is empowered and it's interests are valued and incorporated into the project.

The Wai`anae Cancer Research Project (WCRP) is one of seven avoidable-mortality research initiatives funded in 1990 by the National Cancer Institute. The original purpose of the project was to test the effectiveness of a community intervention to impact breast and cervical cancer screening practices among Native Hawaiian women. A participatory research strategy was used and defined by the community of Native Hawaiians as, "... research conducted with the full and equal involvement, at all levels and in all stages, of scientists and representatives from the intervention population." The Hawaiian community wanted to share equally in research planning, implementation, evaluation, and results dissemination. They also wanted to share in whatever benefits might result from the project. A major outcome of was a true partnership that utilized the scientific and technical knowledge in the area of research as possessed by the academic researchers, and the equally valuable personal and cultural knowledge possessed by the Native Hawaiian community, thus enabling documentation of the results of a true participatory research effort (Matsunaga et.al., 1996).

The distinguishing features of the WCRP Project included:

1. A community-driven, culturally appropriate intervention based on Hawaiian values and practices;
2. A core group of community members, researchers and health professionals working within a broader community network; and,
3. Tangible community benefits such as:
    - Grant management by the local community health center;
    - Jobs and training for community people involved in the project;

- Improved and new health services based on research findings; and,
- Dissemination of research findings to the community first (Banner et. al. 1995).

The WCRP Project's methodology produced demonstrated successes in:

- Increasing participants' awareness and knowledge about cervical and breast cancer risk factors;
- Increasing the cancer screening rates; and,
- Increasing the confidence of participants in their own ability to obtain health care.

The WCRP Project ended in 1995. In addition to demonstrating the effectiveness of participatory research in developing and conducting a culturally competent program, the project also established a number of long-term products including:

- Culturally appropriate cancer prevention and control education materials;
- Protocols for future research efforts, *"Principles and Guidelines for Participatory Research"* and *"Protocols for the Publication and Dissemination of Data"*;
- Guidelines for assisting other communities interested in establishing similar screening programs;
- Development of an evening cancer screening clinic; and,
- Establishment of a women's health network that currently applies the research intervention to the broader community

Told by JoAnn Umilani Tsark
Member, *CENTERED* Blue Ribbon Panel

The History Of Health Disparities In The United States

Health disparities between whites and African Americans in the United States have persisted for over 400-years (Clayton & Byrd, 2000). The impacts of racism on causing and perpetuating these disparities continue to frustrate communities-of-color. Institutionalized racism (those systematic barriers that block fair access of persons-of-color to goods, services and opportunities) built up over generations has created systematic obstacles to attempts to eliminate inequities in employment, education, power, wealth accumulation, and health. Those who seek to eliminate health disparities must address a range of inequities if gains that may be made in health are to be sustained.

Notwithstanding the long history of neglect of health issues in communities-of-color by mainstream health providers and researchers, these communities have survived. They have relied upon alternative ways of caring for community members and addressing health needs. Because of their inability to use the "white only" clinics, African American

communities in the Southeastern United States responded by establishing the first community clinics; and, even graveyards were segregated to prevent mixing of the races.

In American Indian cultures, medicine people have used stories passed from generation to generation to successfully treat those with illnesses. Just as Asians and others continue to rely on traditional systems using herbs and roots, acupressure, acupuncture, and entirely different models of the human body's functioning to understand health and disease. In many of these cultures, spirituality and the wholeness of the health of the body is emphasized—instead of the health of individual body parts. Ancient cultures often emphasized the interconnectedness of health of the individual and health of the community.

Communities need to fully participate in health disparity elimination program planning and evaluation processes as a natural extension of their continuous efforts to improve the health and well being of their members. One project manager, when commenting on the "alienating" factor of many evaluations observed that, "What's on the chart is not in the heart." Eliminating racial/ethnic disparities must allow each community to speak, act and work from what they know in their hearts is best for their situation, for their community.

In the 1960s, the Black Panther Party (BPP) pioneered free social service programs that now are in the mainstream of American life. The BPP's Sickle Cell Anemia Research Foundation, operated with Oakland's Children's Hospital, was among the nation's first sickle cell testing programs, and inspired the federal government's initial funding of sickle cell research (Source: http://freethepantherlegacy.com/yestandtoday.php).

In 1985, Secretary of the Department of Health and Human Services (DHHS), Margaret Heckler issued a major report describing the disparities in health found among racial and ethnic minorities (Malone & Johnson, 1985). With the release of the Malone-Heckler Report, the scale and chronic nature of health disparities became broadly appreciated.

One follow-up report (Byrd & Clayton, 1991) documented the persistence of health disparities over time and attributed their existence to the almost 400-year-old medical-social culture in the United States that the authors felt, "is heavily laden and burdened by race and class problems compounding continued social and economic deprivation. These factors interactively impact and contribute to the adverse health status and outcomes of African American and poor populations."

In 1995, the American College of Epidemiology adopted a health disparities position statement that included the following summary: "The health of all racial and ethnic groups, especially of their disadvantaged members, is of critical importance for public health. Epidemiologists, individually and collectively, are urged to promote health for all through their research, teaching, practice, consultation, influence on policy, and other activities." (Source: American College of Epidemiology, Minority Affairs Committee; 1995—available at www.ace.org).

In 2000, Byrd and Clayton published a scholarly review of the history of health and health disparities among African Americans and other non-whites that documents the

acceptance of double standards relative to what constitutes "normal" in the United States. This acceptance of dual standards has impeded progress towards equity in health.

Healthy People 2010 set as a national objective the elimination of racial and ethnic health disparities by the year 2010. America's legacy of historical scientific racist processes have left an acceptance by many that African Americans (and others) are not on the same level as whites and therefore substandard health care, health delivery, and subsequent poor health outcomes are acceptable for such populations. The existence of dual standards continues to impede efforts to progress towards equity in health.

WHY ARE AFRICAN AMERICANS IN SUCH POOR HEALTH?

"Why are African Americans in such poor health? **…** Every African American lives with the corrosive residue of a 2000-year legacy of presumed inferiority. It is a legacy so ingrained in our culture that we often fail to see it. But its far-reaching effects are clear enough:

- A race- and class-based dual-tier health care system;
- A resilient health deficit for black Americans that dates from slavery;
- The willing acceptance of starkly different indicators of "normal" health status for blacks and whites; and (perhaps most controversial of all);
- The medical profession's relegation of physicians and nurses of color to an inferior caste.

All these factors have a negative impact on African-Americans' health."

Kirk A. Johnson, PhD
Bowdoin College, Brunswick, ME
(In a review of: W. Michael Byrd & Linda A. Clayton. An American Health Dilemma: A Medical History of African Americans and the Problem of Race – Beginnings to 1900 (2000).

While the momentum behind *Healthy People 2010* and health disparities elimination was building prior to September 11, 2001, the events of that date shifted the nation's attention—and resources—to bio-terrorism. National public health priorities changed. However, the need for the national initiative to eliminate health disparities has not gone away, and the target populations clearly remain African Americans, American Indians, Alaskan Natives, Hispanics and Latinos, Asian Americans, and Pacific Islanders.

For that reason, the role of evaluation and documentation of programmatic successes and limitations has never been more important. Credible documentation is needed more than ever to demonstrate the effectiveness of community-based public health programs as they work to eliminate health disparities and other social inequities. It is hoped that the

CENTERED Evaluation Guide will be useful in helping build their ability to obtain essential program funding and other resources through telling their stories, evaluating their work, and demonstrating their successes.

Because there are already many excellent evaluation guides available, the *CENTERED Evaluation Guide* does not attempt to address all aspects of the evaluation process, but rather provides guidance to those existing resources (see Chapter 8). The intent of the *Guide* is to address aspects of the evaluation process felt to be most important for those community-based organizations that are working to eliminate racial and ethnic disparities in health. This includes taking steps to assure that evaluation planning and implementation processes are participatory in nature and effectively empowering in the process those most impacted by health disparities. This also includes consideration of racism as a probable contributor to local health disparities; and, the use of "racial equity indicators" as a method for monitoring efforts to eliminate racial inequities, including health disparities. The intent is for the *Guide* is to complement the excellent evaluation resources already available to community-based organizations.

THE CENTERED EVALUATION GUIDE

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CHAPTER 1: INTRODUCTION

Evaluation is becoming more and more of a "must-do" for organizations that have a mission that involves improving health and quality of life, and certainly for those working towards elimination of racial and ethnic disparities in health. Regardless of a community-based organization's (CBO's) primary focus, it is likely that periodic evaluations are expected by the funder – and possibly different evaluations by different funders. Evaluations provide the documentation needed by sponsors to determine both the scope and scale of future investments. As competition for resources increases, it is reasonable to expect an increased demand for high quality evaluations.

Even though evaluation is becoming more essential for CBOs, this is often a challenging task. CBOs, particularly ethnic agencies serving communities of color, have historically done two things very well: they have engaged and served their respective communities better than others; and, they have managed to survive while continuing to provide services. These are significant accomplishments, given that the target populations have considerably less access to health care insurance and often hesitate to use services unless a crisis exists. Given these two survival priorities, it should not be surprising if comparable priority has not been given to program evaluations.

There are a number of other important reasons that CBOs have given for shying away from the evaluation process. These include:

- Evaluations require time, money and energy, all precious to any CBO.
- An evaluator unfamiliar with the program may try to measure an outcome that was not intended by the program to have been accomplished yet.
- The evaluator may fail to measure outcomes that program staff and/or community partners consider to be very important, while focusing on issues, which for them have a much lower (or even no) priority.
- Program staff often find that the evaluation report is neither readable nor of practical use for improving program management or for enhancing the community's ability to meet identified needs.
- Worst of all, a poorly written evaluation report may even damage the program's reputation with the community it is working hard to serve, thereby jeopardizing community support, as-well-as current and/or future funding.

Because the emphasis of CBOs has been to serve and to survive, it is essential to build evaluation procedures and protocols compatible with the orientation of the CBO and its constituents. Many CBOs have significant management information systems. Very likely those systems are being used to conduct evaluations internally. Not to take into consideration the strengths of these organizations, or to try to mold evaluation efforts from an inflexible perspective, tends to establish an unequal partnership. The result usually will be one partner who is more invested in the process at the expense of another.

Successful evaluations in communities-of-color involve community partners, of whom consumers are primary. A key to successful community engagement is the willing

participation of the target population. Thus it is highly important not only to effectively communicate with service recipients, but to understand why certain strategies are more successful than others when working with this population. One may have masterful knowledge of dietary considerations that will significantly reduce diabetes; but, for your program to be successful, that knowledge has to be coupled with an understanding of the community's eating habits.

CBOs, whether mainstream- or race/ethnicity-based, exist within unique environments; and, each CBO exists to accomplish a particular mission. Both of these are factors must be incorporated and used as strengths in evaluating program success. The factors of the environment in which a CBO exists may be beyond its direct control, but they must be recognized and incorporated by the CBO into its strategies for success. CBOs must adapt to the community context to enhance their probability of achieving success in their missions. When supporting community-based public health (CBPH) interventions to eliminate health disparities, funders must also be prepared to adapt their expectations to incorporate the interests and perspectives of the communities and community partners.

Timely program evaluations can provide CBOs the information they need for assuring positive outcomes and community impacts. For improving health and quality of life through the elimination of racial and ethnic health disparities, the *CENTERED Evaluation Guide* can help your organization to realize that frequent, deliberate, and appropriate evaluations yield more effective programs, healthier communities, and progressively smaller and smaller health disparity gaps. Research supports the value of evaluation for enhancing the probability of achieving goals. This is why funders expect to see evaluation included as a program management component.

This guide can help you to address and overcome challenges you may confront when conducting program evaluations. Our goal is to help build your CBO's capacity to plan and implement evaluations so it can optimize program outcomes and impacts.

In particular, this guide is designed to provide:

- The motivation to learn more about the evaluation process;
- The methods to engage community partners in that process;
- The specific steps to ensure that the evaluation capacity you develop meets both your needs and those of your community partners and funders;
- The understanding to work effectively with independent evaluators; and,
- The ability to optimize the practical usefulness of evaluation findings.

What the *CENTERED Evaluation Guide* will not do is tell you precisely what your own evaluation should look like. In fact, no one from outside your community (regardless of their credentials or authority) knows enough about your program, your organization, your clients, your community and its culture and history to decide for you what the evaluation should measure or how. In these areas, you and your community partners are the experts.

CHAPTER 2: COMMUNITY-BASED EVALUATIONS

Successful community-based evaluations result from respectful partnerships between all of the stakeholders. "Community-based" means that the evaluation process is driven by the community at all stages of the process. This is reflected in the *CENTERED* Project's core principles.

THE *CENTERED* PROJECT'S PRINCIPLES FOR EVALUATION OF COMMUNITY-BASED PUBLIC HEALTH PROGRAMS

1. Community-Based Public Health (CBPH) program evaluations need to be tailored to reflect and respect the complexities and unique circumstances of the target community.

2. Good relationships must be established between community partners and CBPH program evaluators before any evaluation planning or work actually begins.

3. CBPH partners should be culturally competent relevant to the target community.

4. The target community should help to define indicators of success in culturally relevant terms.

5. The target community should help to determine the measurement and scaling of evaluation indicators so the evaluation findings are practical, useful, and easily understood by all CBPH partners.

6. Community-Based Organizations (CBOs) should assess, respect and build into each evaluation the community perceptions regarding sources of racism and the impacts racism may have on health disparities within their community.

7. CBOs should assess whether the evaluation process has helped to increase its own (and the community's) capacity to plan and conduct evaluations in the future.

8. CBOs should involve community partners in all stages of the evaluation process, including planning, implementation, data analysis, and reporting of findings.

CENTERED's CBPH Program Evaluation Principles emphasize the interests and values of both the CBO (whose CBPH program is to be evaluated) and the community served. It provides community partners with mechanisms for expressing their evaluation interests and priority questions early enough in the planning process to assure their incorporation. This "participatory evaluation" process emphasizes the importance of empowering the

community in the process. Outside evaluators (those contracted by the sponsor independent of community interests) should not drive the process, but rather facilitate the processes that identify the community's interests and incorporate them into the evaluation.

Building Your Evaluation Team

How much your CBPH program benefits from evaluations will depend upon how active you and your partners are in the evaluation planning and implementation processes. It is, therefore, important that the person assigned to lead the program evaluation team be fully committed to the task and to advocate for the community's interests. Selecting the right team leader and organizing an evaluation team that includes the diverse interests of the community and other stakeholders is critical to the success of the evaluation effort.

Some evaluations can be carried out most effectively by internal evaluators (e.g. your CBO or program staff). Of course they have to have the technical skills and experience sufficient to do this with high credibility. This is the ultimate goal for CBOs as it allows implementation of their own periodic evaluations according to their own timeframes and needs. It enables the CBO to produce timely inputs to program management regarding: program resource utilization; problem identification and resolution; program progress; impact effectiveness; and, cost efficiency.

However, for most CBOs the evaluations are usually carried out by a diverse, hybrid evaluation team that includes internal program staff and an outside evaluator who is expected to provide the technical skills and/or evaluation experience that the program staff may lack. Community partners should be strongly encouraged to become a part of the evaluation team member "mixture" to strengthen the evaluation process.

Finally, some CBOs have to rely on an outside evaluator to perform their evaluations who may or may not know the community well. This is why this is the least desirable evaluation strategy. If you have no option but to use an outside evaluator, try to negotiate for one who has well documented CBPH program evaluation experience within the same or similar communities.

When building your evaluation team, keep the following in mind:

- Your evaluation goals;
- Your funding situation;
- Stakeholder evaluation requirements;
- Your internal experience and limitations relative to having the ability to plan and carry out the evaluation on your own;
- Staff availability to contribute their knowledge and experience to the process;
- The time available to complete the evaluation; and (when needed),
- The availability of an outside evaluator who is acceptable to all stakeholders.

Your staff and stakeholders have many assets to bring to the table, as do carefully chosen outside evaluators. The challenge is to craft relationships between the various team

members that respect your program's and your community's values and goals, and that use everyone's skills and experiences to optimize the processes outcomes.

Recruiting And Keeping Community Partners

The successful elimination of racial and ethnic health disparities requires valuing and respect of the community's interests. This can best be accomplished by assuring involvement of the diversity of community perspectives in all stages of decision-making.

Communities-of-color have long been the subject of scientific research for advancing "science", but all too often those communities have benefited little for their having cooperated with such efforts. At the same time, the researchers enhance their reputations through the knowledge and understanding that they developed about those communities. The movement to community-based participatory research grew out of the expectation of community members that they be included as equal partners in such research.

Involving community partners in all stages of your program planning and evaluation will help assure that your program is truly "community based" – that is, truly driven by community interests at all stages. Community members most impacted by health disparities, or who are in a position to support your efforts to eliminate them, are needed to contribute their viewpoints for use in guiding your efforts.

As you recruit community partners, consider the value each will add. Having a diverse set of view points is important if you expect to win and keep community support and to be effective in addressing the full range of community needs. This valuing of community perspectives must be effectively conveyed to potential partners, so they can appreciate that their views will be heard and respected.

Because people have other demands upon their time, you need to respect their time and value their involvement. The following can help build respect and trust:

- Hold meetings at times and places convenient for your partners;
- Offer either a stipend or reimburse reasonable expenses;
- Communicate in a manner that partners can easily understand;
- Craft the program to assure that partner interests are addressed;
- Empower partners in decision making; and,
- Conduct business in a fair and open manner, and share program reports.

Communities-of-color have not usually been empowered in program planning and evaluation processes, so it is important that a purposeful effort be made to demonstrate your credibility in this regard. As you build your relationships, your community partners will be able to facilitate the involvement of other potential partners with additional perspectives. If they do this, you need to recognize them publicly for these important contributions. Remember, your partners have placed their reputations with the community on-the-line on your behalf, so you need to let them know how much you appreciate their support. Community support is essential for long-term program sustainability.

Who Are Your Other Stakeholders?

Stakeholders are those [persons or agencies] who care about your program, have a vested interest in the program's progress and outcomes, or may be significantly affected by the program. Stakeholders include those who are in a position to do something with the program evaluation's results, so they need to be involved to be sure that their interests are met. Remember, it is in your interest to engage community partners and to assure that they are empowered to participate actively in the evaluation process.

Participatory Evaluations

Participatory evaluations are new to many, and will need to win new allies from among those who have worked only within the more traditional evaluation framework. Many are uncomfortable with the added complexity of a participatory process. They may even see participatory evaluation as an unwise involvement of non-technical persons into a technically based process for achieving "scientific rigor".

While the desire to achieve scientific rigor sounds reasonable, remember that racial and ethnic disparities in health in the United States have remained chronic, large, and generally unchanging since slavery (Byrd & Clayton, 2000). Over this long period, efforts to address the disparities have been notably unsuccessful. Byrd and Clayton point out, that "… the willing acceptance of [these] starkly different indicators of 'normal' health status for blacks and whites..." has enabled the problem to continue unabated.

Participatory evaluations seek to actively empower community partners from disparities-impacted communities. This is essential if the historical distrust that exists between communities-of-color and white communities, white-dominated healthcare agencies, and research institutions is to be overcome. The following story illustrates that there are other, much deeper, issues that involve Western concepts of research and evaluation that often contrast with the world views and culture of many communities-of-color.

"Cultural Concerns Regarding Contaminants In Alaskan Local Foods"*

The scientific community works to compartmentalize the world in an attempt to study its various pieces and how they work. They report on **a** level of **a** contaminant in **a** tissue of **an** animal. They understand from their experiments that the level of one factor may change, and at some point … there is impact on the normal functioning of the biological system. They work to understand the most frequent occurrences and to define rules that will apply to **most** cases.

In contrast, the Native community historically has observed the local ecosystem and its patterns in order to understand specific events. They have passed on through their oral histories and practices the information needed for daily survival. They understand from their observations that large cycles and patterns exist with people as part of an undivided whole and that if any part is contaminated, then the entire system is out of balance. Their knowledge is that of experience and addressing survival of **all** cases.

The communication of low levels of contamination, without an understanding of what local foods mean to Alaskan Natives and their belief of the interconnectedness of all things, is quite a different message than it would be for those who view the world in units and never see that part of the animal on their grocery shelf.

Communication across cultural precepts is frustrating to those scientists who state, for example, that people should just avoid eating kidneys if the cadmium levels have been shown to be elevated. However, from the Native perspective, if the kidneys contain "too much" cadmium, it does not matter where it came from; if the scientists are concerned and reported it, then the entire animal has "too much" cadmium.

* (Source: Hild CM, 1996)

This example illustrates the clash in cultural concepts that occurred when Western scientists attempted to resolve a potential health issue caused by environmental pollutants coming from other parts of the world and contaminated the food of Alaskan Natives. The solutions that the "Western" scientists came up with did not fit the Alaskan culture. Alaskan Natives would not choose to harvest younger animals because they need the hides and tusks of larger adult animals; eating younger animals requires more hunting effort and increased risk; and, hunting younger animals would more easily deplete the stock. Clearly, there was a clash between two very different world views.

Efforts to eliminate health disparities in traditional communities must engage the community to learn the cultural contexts in which health disparities have developed. It is essential that community interests be identified, heard, and valued; and, the community be empowered to participate in crafting culturally appropriate and community acceptable solutions to the problems. The evaluator must recognize the cultural differences; that there are different rules, expectations, goals and objectives; and, then enable a participatory evaluation planning process that respects and values the community's interests and produces an evaluation tailored to incorporate the community's needs. This is essential for building trust between the community, the program, and the other stakeholders.

Engaging And Empowering Community Partners Through Consensus Mapping

One method for engaging and empowering community partners to assure that their perspectives are heard regarding health disparities and what they feel needs to be done to eliminate them, is the "consensus mapping" process. This process involves the development of a set of 5 illustrative program maps that fairly describes the community context in which health disparities have developed and will be addressed by the program.

Consensus Mapping Process — Five Map Sequence → Set:

1. *The Big Picture Map:* This map addresses what the community feels are the causes of health disparities and those factors that contribute to them. This is the product of "qualitative" discussions and revisions, and in its finished form, fairly reflects the views of the committee as a whole.

2. *The Community Assets Map:* This map identifies all relevant community and other assets (resources) available for addressing the elimination of health disparities within the community.

3. *The Solutions Map:* This map reflects the shared thoughts regarding how the community assets might be used to address the elimination of health disparities and those factors that contribute to them. The map strives to show how the aligning and building of assets forms the core framework for the program.

4. *The Program Activities Map:* This map describes how program staff put into practice the vision illustrated in the "Solutions" map. Illustrated/described on the map are the key activities of the program.

5. *The Making A Difference Map:* This map illustrates the short-, medium-, and long-term indicators (objectives leading to program goals) that they will need to monitor to determine if the program is succeeding. The map includes the sources of credible information that are to be used to measure program success relative to each indicator.

Consensus mapping is a valuable tool for engaging and empowering community stakeholders to consider the causes of racial and ethnic disparities in health within their own community, and to help craft possible solutions. Remember, if it is to be effective, the consensus mapping process must not only identify community perspectives, but assure that those perspectives are respected and valued as the stakeholders work towards consensus regarding in the program planning and evaluation processes. When done well, this process will help to establish the program's trustworthiness with the community. The ultimate test of the success of this effort will be having achieved long-term sustainable community support for the program's health disparity elimination efforts.

CHAPTER 3: DESIGNING EVALUATIONS TO ADDRESS COMMUNITY INTERESTS

On a practical level, planning an evaluation involves answering several basic questions:

1. What are you going to measure?
2. How are you going to measure it?
3. What do your measurements mean?

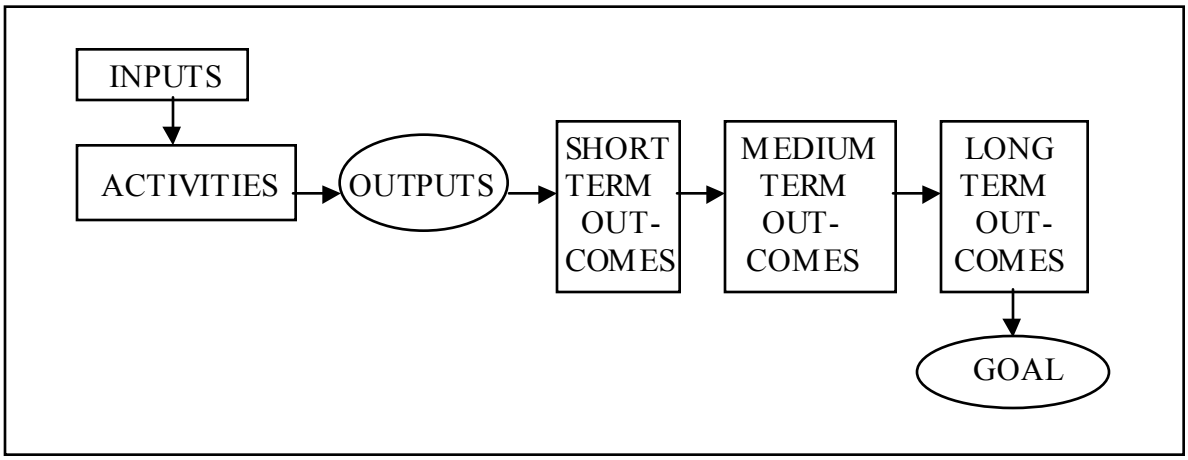
What Are You Going To Measure?

Typically, evaluations try to capture what happens as a result of the program. During the earlier stages of program development, evaluations measure whether program activities are occurring as expected, and if they are leading to the desired outcomes. Later, the evaluation may also assess how participants and communities change in response to services provided by the program. In other words, the evaluation also measures personal and community-level program outcomes.

The key to a successful evaluation is to ask and answer those questions that will provide the most valuable information. The program's consensus mapping process will help to generate key questions stakeholders need answered about whether the program is accomplishing its objectives and goals. The consensus mapping process provides you with the information you will need to develop your program's logic model.

A program logic model provides a blueprint of the pathways through which your program is designed to "work". It shows how you will use your resources to create and implement your program, and how your program will achieve its short- and medium-term objectives as it progresses towards its long-term goals. Developing a program logic model can strengthen your case for funding an evaluation plan, because it helps others to visualize the rationale behind the program and its evolution.

Figure 1. The Basic Components Of A Program Logic Model.



Components Of the logic model are:

-*Inputs* are the resources that go into the program.
-*Activities* are the actual events that take place as part of the program.
-*Outputs* are the direct products of program activities.
-*Outcomes* are the intended effects of the program.

- *Short-term outcomes* are the immediate effects of a program and often focus on changes in knowledge, attitudes, and skills of the target audience.
- *Medium-term outcomes* include changes in behavior or policies.
- *Long-term outcomes* take years to achieve.

The logic model can be thought of as a series of "if/then" questions. For example:

- If we obtain grant funding (input) to address teen pregnancy and abortion prevention, then we can implement such a program (activity).
- If we implement such a program (activity), then we can provide training to teens in making healthy lifestyle choices that influence their risks for becoming pregnant (output).
- If teens are exposed to information about healthy lifestyles (output), then some may choose healthier lifestyles (short-term outcome).
- If teens choose healthier lifestyles (short-term outcome), then they may reduce their risks for having an unplanned pregnancy (medium-term outcome).
- If teens reduce their risks for having unplanned pregnancies (medium-term outcome), then the rates of unplanned pregnancies may decline among these teens (medium-term outcome).
- If rates of unplanned pregnancies among these teens decline, then rates of low birth weight infants may also decline (long-term outcome).
- If rates of low birth weight infants decline, then infant mortality rates among teen mothers may decline (goal or health impact).

Using the consensus maps, work from left to right as the logic model develops. There are a number of excellent resources that may be of help as you develop your logic model. (See Chapter 8.)

Logic models can be broad or specific. They can be linked to one another to express how programs connect at the national, state, and local levels; or, you might want to prepare a set of logic models that represents different aspects of the program. The level of detail you put into your logic model should be determined by the purpose for which you intend to use the model – it is up to you. By using a logic model to describe your program, you can identify critical evaluation points that help your stakeholders to appreciate that the nature, scope, and focus of each evaluation may vary as program implementation progresses.

Although drafting consensus maps and logic models can be challenging, both are extremely worthwhile. The consensus mapping process helps empower and build trust with your community partners–both are critical for sustaining community support of your

efforts. And logic models help you to think through your program's activities so the rationale is clear as to why you feel your program as planned will achieve its objectives and ultimately produce the desired long-term outcomes. The consensus mapping process and the conversion of the maps into a logic model allow your stakeholders to join in creating a visual description of your program that will be useful in ensuring that all understand the program, its missions and goals, the context in which it operates, the resources it needs to be successful, and the activities and services it will provide, and the logic behind the program's efforts to enhance the health of the community.

Logic models also help your partners to formulate questions that they would like to have answered by the evaluation process at each phase of the program.

How Are You Going To Measure Program Success?

How "big" the evaluation will need to be will depend on what you and your stakeholders want to learn, the resources you have to support the evaluation (including time), and how efficiently you use those resources.

Evaluations are simply management tools that inform decision-making. You and your stakeholders must determine which critical decisions are to be influenced by the evaluation results. Once this is known, you can then plan to be sure that the evaluation process produces the information required to inform those decisions.

One critical question is: Should the program continue? The answer will probably depend upon answers to several questions that collectively determine whether or not the program is successful enough to warrant a continued investment of staff, time, and dollars.

Another important question is: Can program effectiveness be enhanced? The evaluation should ask questions that test program effectiveness and seek data/information/inputs that can help guide effectiveness refinements.

Evaluation can also inform a funder's decision regarding whether or not to fund program expansion or replication.

Once the ideal full scope of questions has been established, it is easier to scale back to stay within the your budget. By identifying the critical questions that you want to answer you begin to determine the design needed for your evaluation.

Table 1 describes several types of both formative and summative evaluations, and gives examples of the types of questions that each type can answer. You should pick the design that best fits your program's needs. For a mature program you may want to use elements of both formative and summative evaluations to create a continuous, quality assurance monitoring system that can identify problems early so corrective action(s) can be taken.

Table 1. Types Of Evaluation.

Formative Evaluations are conducted early in a program to guide program refinements. They strive to answer the question: "Which process or method works better?"

Process Evaluations answer questions such as:

- Is the program operating as intended?
- Who is the program supposed to be serving and how?
- Who is the program actually serving and how?
- Why is the program succeeding, failing, or in need of revision?
- What unforeseen barriers/opportunities (if any) have impacted program services?

Program Implementation Evaluations answer questions such as:

- Is the program complying with program objectives, protocols, and procedures?
- Does the investment in the program match the tasks to be accomplished?
- What constraints and opportunities are impacting program performance?

Summative Evaluations are conducted at the end of a program to inform decisions about a program's worthiness for continuation or expansion.

Outcome Evaluations answer questions such as:

- Did the program have its intended effects on those individuals served by it:
  - Short-term outcomes? (e.g. Was the risk of disease occurrence among program participants significantly reduced?)
  - Long-term outcomes? (e.g. Was the short-term reduction in risk of disease occurrence among program participants sustained over time?)
- If yes, what helped this happen? What unintended effects did the program have?

Impact Evaluations answer questions such as:

- Did the program have its intended effects on the target community? If yes, why?
  - Short-term impacts? (i.e. Was disease occurrence significantly reduced?)
  - Long-term impacts? (i.e. Were short-term reductions sustainable?)
- What unintended effects/consequences did the program have?

Cost-Effectiveness Evaluations answer the question:

- What did it cost to deliver the desired outcome(s) and/or impact(s)?
- How does this cost compare to delivering similar results using other strategies?

In general, **process evaluation** questions provide information about how the program is working, who it is reaching, and under what community contexts. **Implementation evaluation** seeks to answer questions about your program activities and whether they are taking place as expected. These types of evaluation are often called **formative evaluations** because they provide useful information for building successful programs, and they usually allow you to sort, categorize and correlate evaluation data.

Summative Evaluations answer questions about program outcomes and impacts and attempt to prove its credibility. They seek to answer questions about the sum effect of your program activities. These usually take more time and money and may require the assistance of an independent evaluator to assure that they address causality and permit comparing and tracking of change over time.

After deciding what the evaluation is going to measure, you will need to decide how that measurement will take place. This involves the selection of the specific progress and/or outcome indicators that the evaluation will be assessing, and the practical consideration of how each indicator will be measured.

As an example, let's suppose your program was designed to reduce the level of smoking among teens in your community by replacing billboards that glamorize smoking with an anti-smoking campaign that features a diseased lung. This intervention seeks to counter the glamorous message designed to lure young people into becoming consumers. Given this as the underlying logic for the smoking-promotion program, then it might make sense to focus the evaluation of the anti-smoking campaign by answering such questions as:

- Have the number of cigarette billboards declined in the target community since the anti-smoking campaign began? Have the number of anti-smoking billboards increased?
- Are the anti-smoking billboards located where teens can easily see them?
- What do teens think of both the smoking and anti-smoking billboards?
- Have the teens perceptions of the image of smoking and non-smoking behaviors changed? And if so, in what way (positive or negative; etc)?
- Have cigarette sales to teens in the community changed since the anti-smoking campaign began? If so, did they go up? Remain the about the same? Or decline?

Each question to be answered requires one or more indicators to develop the answer. The indicator might be as simple as documenting the number of enrolled participants for comparison with the number estimated when the program objectives were established. On the other hand, client feedback may identify a variety of areas that you need to explore, such as the times and locations of clinics; the nature of the enrollment process; the cultural competence of program staff; the perceived quality of the services provided; or, the availability of childcare for clients using the clinic's services.

No evaluation can examine every aspect of your program. Therefore, the evaluation should focus on your most important issues and questions. As each question is considered and indicators identified, the modes of collecting information and the means for measuring each indicator must be determined. Client visits can be counted; the time that it takes to deliver a service can be measured; the number of clients lost to follow up during a specified period of time can be counted and converted into a percentage of total enrollees; and, each can be monitored for changes in the indicator over time (weeks, months).

Whichever methods you decide to use for data collection and for indicator measurements, once set up, those methods should be documented in an evaluation protocol that standardizes the methods to assure that they are used consistently throughout the life of the program. Staff training and supervision are needed to emphasize the importance of adhering to the evaluation protocol. Ideally, a continuous quality assurance monitoring system will be implemented to assure protocol compliance. Remember, the credibility of the program's claims to success will be determined by the accuracy of the indicator measurements and the fairness of indicator trends as program implementation progresses.

The evaluation protocol should be developed with the full range of stakeholders, recognizing that the perspectives of various stakeholders may legitimately differ, so they need to have input into the development of the evaluation protocol. Consider that program staff are happiest when clients are on time and ready to be seen when their name is called. To the staff a bit of a backlog of patients is good because it assures that that they do not have to wait for a patient to show up. On the other hand, the clients are happiest when they have an appointment and are seen on time, so they do not have to waste their time waiting for the staff to become available. Clearly, it takes inclusion of the full diversity of perspectives to get a fair and accurate portrayal of the program's operations. In this example, a participatory process that includes both clients and staff in the determination of measurements of operational efficiencies would increase the likelihood of a fair assessment from both perspectives.

Participatory evaluation planning, coupled with the valuing of the diversity in perspectives, can strengthen the program evaluation and enhance the quality of the results and recommendations that your management team needs to make proper judgments about the success of program operations.

In addition to deciding what to measure, it is critical that you also decide with your stakeholders how those measurements will be made. Here are some questions that illustrate some of your options:

- If your program is successful, who will change and how will they change?
- Are you looking for changes in behavior, knowledge, attitudes, awareness, beliefs about oneself, relationships among people, or something else?
- Which objectives/goals are measurable in the time frame available?
- Which changes do you expect to see in the short-term?
- Which changes are not expected until the program has been around a while?

Another consideration is the resources available for evaluation measurements. Those methods that yield highly accurate results are usually the most costly. One method for assessing success while adhering to your budget is to assess short- and medium-term changes in established indicators that are known to be correlated with health status. For example, in the case of a hypertension program, an early marker of success might be the degree to which clients change their diets, increase their exercise, or take medication on a regular basis. Or you could look even earlier in the change process at whether or not the client learns techniques for controlling their hypertension and demonstrates preparedness to make changes in their lifestyle.

In order to claim "success", a smoking-cessation program doesn't need to document that it has reduced lung-cancer deaths among its participants, only that it has reduced long-term smoking rates. There is already documentation that quitting smoking reduces death from lung cancer.

Once you decide what the focus of your measurements will be, take full advantage of what is already known in the scientific literature, both about how to measure and about the relationships between behaviors and the target disease/condition. Using a logic model can help you to identify what will serve as your short-term, medium-term, and long-term indicators.

Another cost-effective evaluation option is to document that clients are receiving services similar to those of a proven effective program. A process evaluation can show that your clients are engaged in the same way as clients in the program that you modeled your program after, and having similar results. You should use the same (or similar) short-term outcomes as did the model program. With this evidence, your program can make the case that its long-term outcomes will be similar to those previously demonstrated.

While this sounds straightforward, there may be some very real challenges with such validation studies. Outcomes often vary when similar programs are applied in different settings. Even if you are dealing with a population that is similar, you may have difficulty implementing the program in the same way. Often model programs are rich in resources and expertise. When they are replicated, the new programs do not have the same capacity and capability. Therefore, quality of the program activities is likely diminished.

What Do Your Measurements Mean?

Your logic model provides a great deal of guidance about which outcomes and issues the evaluation should focus on. In testing whether or not these things occur, you are essentially answering a series of evaluation questions, such as the following:

<u>To Determine Program Context:</u>
-What is the community/environmental context within which the program operates?
-How well does the program "fit" this context? How has this context helped and/or hindered the program?
-What is the organizational context within which the program operates? How has this context helped and/or hindered the program?
-Does the program duplicate the work of other programs and/or compete for participants?
-Does the program fill a gap in the community? If so, which gap?
-What other programs have tried to address this issue in this community? What was their experience?

<u>To Document Program Implementation:</u>
-How has the program been implemented?
-Are program activities occurring as expected? If not, why not?
-What resource (human, material) investment is made in the program activities?

-How do resource issues impact program implementation?
-How committed is the community to the program?

To Assess Program Results:
-Whom (or what) does the program serve best? Least? Under what circumstances?
-What does the program mean to the clients and to the community?
-How is this related to what the program has set out to accomplish?
-What are the indicators of progress towards these accomplishments?
-Has the program produced the intended results? What other effects has the program had?
-How well has the program addressed the initial needs it focused on?

To Develop Recommendations For Program Enhancement:
-How could program activities, resources, and goals be better aligned?
-What is reasonable to expect in terms of accomplishments given the community/environmental context, and resources available?
-What should the program keep doing to accomplish established objectives and goals?
-What should be changed, and how if those objectives and goals remain unchanged?
-How can the program be most effective without sacrificing community values?

Regardless of which questions you start with, stay open to others that may arise during the evaluation process and add to the value of the evaluation's insights. These may be added if reliable indicators can be developed to answer them. Remember to anticipate how your evaluation results will be used, and focus on your stakeholders' needs. Eliminate those questions that are just "easy" or "interesting", and keep those that focus on finding information essential for program success and accountability.

Demographic Information: If It's Not Collected, It Can't Be Analyzed

It is important to capture all the information you might need for your evaluation analysis right from the beginning of your program in order for it to be there when you need it. Think this through as you are planning your evaluation. While specific answers to questions or actual measurements are important, so are demographic characteristics (birth date, age, gender, marital status, race/ethnicity, tribe, primary language, education level, household income, employment status, etc.) that you will need when it comes time to do your analyses.

Be aware also that if you plan to eventually analyze your data by specific subgroups of clients, you must collect the information from the start in a way that will allow you to separate it into those subgroups when you are ready. Outlining all the types of information you will need to collect into an analytic plan, including the tables, etc. you plan to produce for reporting purposes, will help you to more easily identify areas you might have overlooked so they are not left out.

CHAPTER 4: ADDRESSING RACISM THROUGH EVALUATIONS

"SANKOFA"

The West African concept of "sankofa" is derived from King Adinkera of the Akan people. "Sankofa" loosely translates into English to mean "it is not taboo to go back and fetch what you forgot". "Sankofa" teaches that we must go back to our roots in order to move forward. Also, the philosophy teaches that whatever has been lost, forgotten, forgone, or stripped away can be reclaimed, revived, preserved and perpetuated.

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'Study the past if you would devine the future."
--Confucius

The legacy of racism and the devaluation of persons-of-color over the course of existence of the United States have resulted today in chronic disparities between persons-of-color and their white counterparts in relation to wealth accumulation, educational achievements, and health status. If the national initiative to eliminate racial and ethnic health disparities is to succeed, then factors that contribute to the development and/or sustaining of such inequalities must also be clearly identified and eliminated. Otherwise, the gains that are made during this extraordinary national effort will not be sustainable.

The socially constructed nature of race and racism contributes to racial and ethnic disparities in health (Jones, 2001). Racism creates a negative environment that impacts the developmental, life-long, and intergenerational health of people-of-color. It violates fundamental human rights and diminishes the quality of life for individuals, families, and entire communities. Racism is sustained and accepted simply as "the way it is" -- especially by those who are not its victims.

According to Jones, the three forms of racism are:

- *Institutionalized racism:* Systematic barriers that block fair access of persons-of-color to goods, services and opportunities that society has to offer.

- *Personally-mediated Racism:* The acceptance of advantages for whites (a.k.a. "white privilege") and disadvantages for persons-of-color by those who consider non-whites to be less capable, less motivated, and less deserving.
- *Internalized Racism:* The acceptance by persons-of-color of the negative messages about themselves and other persons-of-color regarding their own abilities and intrinsic worth within the community.

RACISM DEFINED*

An ideological structure and historic stratification process by which the population of European descent, through its individual and institutional distress patterns, intentionally has been able to sustain, to its own best advantage, the dynamic mechanics of upward or downward mobility to the general disadvantage of the population designated as non-white, using skin color, gender, class, ethnicity or nonwestern nationality as the main indexical criteria used for enforcing differential resource allocation decisions that contribute to decisive changes in relative racial standing in ways most favoring the populations designated as "white".

Source: Dr. Helan Enoch Page, Center for the Study of White American Culture: *A Multiracial Organization* (http://www.euroamerican.org/library/Racismdf.asp).

Empowering Communities To Address Racism Through Eliminating Racial Inequities

Racism in its various forms has resulted in historical differences in acquired wealth, education, and power in the United States, with whites having advantages over persons-of-color in each area. These relative advantages are termed racial inequities. While racism is difficult to measure directly, racial inequities can be identified, measured, and tracked for changes over time.

Participatory program evaluation processes empower communities-of-color to be better prepared to address racism through focusing on the elimination of racial inequities within their communities. "Racial equity indicators" (see Chapter 5) should be included in CBPH program evaluations so communities can identify "racial inequities", measure them, and monitor them as tangible evidence of the successes of efforts targeting their elimination. This is particularly important because it allows communities to keep racial inequities on their local agendas until they have been eliminated.

To identify racial inequities, evaluations need to include questions that can help the program capture perceptions of racism and racial inequities within the community. Evaluations of the potential impacts of racism might include such questions as:

- What role does racism play in the health and well being of your community?

- What role does racism play in the provision and use of disease prevention and/or healthcare services in your community?
- When you seek health care, are you treated fairly and with respect?
- Do people in your community hesitate to use disease prevention and/or healthcare services because of race-related issues?

If your community partners identify racism or racial inequities as a factor that contributes to health disparities in your community, then those perceptions need to be respected and explored during the evaluation process. Those perceptions should also be addressed in the final evaluation report, along with a discussion of relevant evaluation findings and trends over time in the racial equity indicators that have been selected to target and monitor by the program. Those who read the evaluation report should be able to appreciate not only the community's perceptions and expressed concerns regarding racism, but they should also be presented with the program's plan for addressing this issue and for measuring the success of such efforts. They should be presented sufficient information so they can consider how they might also contribute to the elimination of racism and racial inequities that are impacting their community.

In communities where racism may be playing a role in racial and ethnic disparities in health, programs attempting to eliminate the disparities need methods for measuring and monitoring racism and its adverse impacts. If done with credibility, this will help the community:

- To understand the context within which the program operates;
- To identify and characterize those structures, policies, and practices through which racism exerts its adverse impacts; and,
- To establish racism indicators and baselines for use in assessing program success.

The challenge is how to credibly measure racism. But, if community partners raise racism as a factor they feel is contributing to health disparities within your community, then it needs to be addressed in the evaluation process. Trends in racism indicators need to be monitored over time and analyzed for correlations between these trend patterns and the timing of interventions designed to reduce or eliminate racism and its impacts.

Steps To Creating Measures Of Racism

You can develop your own indicators of racism. The challenge is to come up with indicators and modes of measurement that are credible and reproducible. A good place to start is mapping out the social-political landscape of the community, locating where racism exists, and then considering how it might be "measured", both qualitatively (stories, etc.) and quantitatively (number counts). The following steps can help in this process.

Step #1. Convene a diverse group of community residents and leaders to consider the following questions:

- What role does racism play in the use of health promotion, disease prevention, and healthcare services within the community?
- Are you treated fairly and with respect whenever you attempt to use any health promotion, disease prevention, and/or healthcare services?

- Do people hesitate to use such services because of race-related issues? If so, what are those issues?

Step #2. Search for evidence of "racial" disparities within the community:

- Review local "public access" databases to determine whether health or other important outcomes within the community vary by "race". Don't limit yourself to reviewing only health-related databases. For example, education indicators might include one or more of the following: school admission rates; absenteeism rates; drop-out rates; and/or, graduation rates. Work force statistics might include one or more of the following: the percentage of public employees in various categories (by gender; by race/ethnicity) when compared to the proportions within the community -- remember to consider not only the proportionate composition of the workforce, but also the proportions within each level of employment (i.e. entry-level, mid-level, senior-level, and managerial-level). You may want to compare insurance rates by geographical area; or, crime, law enforcement, and/or prison statistics by race. You might even consider the proportions of public sector contracts that have been awarded to "minority" businesses; or, public transportation routes, their schedules, their fares, and profiles of those who use public transportation. These are but a few examples of indicators that may be useful as "racial equity indicators" for your community. The actual list of options will result from your data search.

Step #3. Calculate Relative Rate Ratios for each Racial Equity Indicator (see Table 1*):*

- Because racism is hard to measure credibly, it is simpler to measure the potential impacts of racism. When there is public access data available regarding an occurrence that the community feels may be influenced by racism, rates of occurrence by race/ethnicity need to be calculated for use as "racial equity indicators". Once you have race/ethnicity-specific rates of occurrence, then a simple mathematical ratio can be developed by dividing the rate of occurrence for the target population/group of interest (i.e. African Americans) by the rate of occurrence for whites. This results in a single number that is called the "relative rate ratio".
- If the relative ratio is 1.0 or less, then no racial inequity was found relative to the occurrence of this outcome-of-interest in the target population/group.
- If the relative ratio is significantly greater than 1.0, then a racial inequity has been documented, and the scale of the inequity is determined by the size of the relative rate ratio. For example, a relative ratio of 3.0 indicates that the outcome-of-interest occurs among the target population/group (i.e. non-whites) at a rate three times that of its occurrence among the white population/group.

Step #4. Based upon relative rate ratios that are indicative of potential influence of racism, explore to determine possible mechanisms for sustaining racism's influence by:

- Asking and attempting to examine the question: "How might racism be operating here?"
- Examining written policies; and

- Characterizing (through surveys and focus group discussions with key informants) any unwritten norms and practices that might enable racism's impacts.

Also, take into consideration structures, policies, practices, and norms:

Structures:

- What are the boundaries of local voting districts; and, how were they established?
- Are health promotion activities, disease prevention activities, and health care clinics located where community needs are the greatest?
- Do public bus lines run routes through communities where, and at times when, transportation needs are greatest? And, are bus signs in languages appropriate for the community's needs?
- Where are the Medicaid HMOs located? Are they user friendly and culturally competent?

Policies:

- What are the membership criteria for key public decision-making bodies?
- What are the criteria for local hospital admitting privileges?
- What are the local zoning policies and do they adversely impact selected communities?
- Is there a racial/ethnic difference in emphasis on prevention versus treatment?
- Are public service providers culturally competent? Are they multilingual?

Practices:

- Are public employer hiring practices fair? Does equity exist in job promotions?
- Are disease prevention activities targeting highest need communities?
- Are disease screening/early diagnosis programs targeting highest need communities?
- Does the composition of the HIV Prevention Community Planning Group reflect the profile of most HIV/AIDS impacted populations?
- Are health promotion activities, disease prevention intervention, and health care services "community friendly" (times, locations, staffing) and culturally sensitive to the community?

Norms:

- Do operational practices evidence respect for community residents?
- Do services for similar conditions vary depending upon the race of the client?
- Are communications client friendly? Friendly, clear and easily understood, culturally competent?

Step #5. Monitor relative rate ratios of racial equity indicators for changes over time:

- Recalculate relative rate ratios periodically over time to determine if intervention efforts are having desired impacts on racial inequities, including health disparities.
- Broaden consideration of adverse impacts of racism to include various areas of impact, not only health.

Racial Equity Indicators

While some may argue that the size of a relative rate ratio may have little to do with documenting that "racism" exists within a given community, credibility is derived from the consistency in being able to document racial inequities over time using a broad set of indicators. Open and candid discussions of racial inequities and racism and its adverse impacts can increase community support for corrective actions. Identification and monitoring of a broad set of racial equity indicators while health disparity elimination interventions are implemented enables outcome monitoring for evidence of program success.

Table 1. Examples of racial equity indicators and how they are calculated.

RACIAL EQUITY INDICATORS	DATA SOURCES	CALCULATION
Income by Level of Education Attainment by Race/Ethnicity • < High School • GED or HS Equivalent • High School Diploma • 2-Year College Diploma • Bachelor Degree • Masters Degree • Doctorate Degree	US Census http://www.census.gov State & County Quick Facts http://quickfacts.census.gov/qfd/states/45000.html	White Male Income / Non-White Male Income Range: <1.0 to >2.0 The larger the number is over 1.0, the greater the inequity or disparity.
Employment within State/ Local Government Agencies: • % of Pop. non-White • % of Pop. White • % of State employees non-White • % of State employees White	State Office of Personnel, Human Resources Commission, or Equal Employment Opportunities Office	% of state/local population that is non-white / % of state/local gov't employees that are non-white Range: <1.0 to >2.0 The larger the number is over 1.0, the greater the inequity or disparity.
Infant Mortality Rates (IMR) within State: • African American • Hispanic • Am Indian/Alaska Native • Asian/Pacific Islander • White	State Health Department, Vital Statistics Unit or Epidemiology Bureau	RR = Non-White IMR / White IMR Rel Risk Range: <1.0 to >2.0 The larger the number is over 1.0, the greater the inequity or disparity.
HIV Incidence Rates within State: • African American • Hispanic • Am Indian/Alaska Native • Asian/Pacific Islander • White	State Health Department, Vital Statistics Unit or Epidemiology Bureau	RR = Non-White HIV Incidence / White HIV Incidence *Relative Risk Range: <1.0 to >2.0 The larger the number is over 1.0, the greater the inequity or disparity.

CHAPTER 5: COLLECTING THE DATA

Data is information that can be used to create statistics, graphs, and tables to summarize your evaluation findings. But data is more than simply numbers. Data can come from written questionnaires, interviews, record counts, measurements, group discussions, and even pictures and story telling. And data collectors will vary in their ability to successfully get persons with information to participate. So, careful selection of the evaluation team's data collection staff is important.

Data collection can be accomplished through a variety of planned actions designed to gain the insights needed to answer the evaluation questions. Working from the program consensus maps and logic model, you will develop your set of prioritized evaluation questions to then guide the planning of the data collection process and methods. The process will be completed when you have determined mechanisms for collecting the essential data/information needed.

Once collected, data/information will need to be processed, computerized, edited to eliminate errors and assure data completeness and accuracy (to the degree possible), and then analyzed. Once analyzed, the results still have to be interpreted and incorporated into an evaluation report that can then be disseminated to the stakeholders.

The Steps For Data Collection

The steps for data collection include:

- Clarifying what data/information are needed;
- Reviewing data collection resources;
- Locating data sources;
- Choosing the most appropriate data collection methods and instruments;
- Deciding how much data is enough;
- Deciding who will collect the data;
- Deciding what sources the data will be collected from;
- Obtaining "informed consent" from clients willing to allow their data to be used in the evaluation process;
- Deciding when and where the data is to be collected;
- Protecting data confidentiality during data collection and processing;
- Determining how, where, and by whom data will be processed and analyzed; and,
- Staying attentive and sensitive to what the evaluation process is revealing.

A participatory evaluation process will assure the use of culturally appropriate ways to collect data from your community. If an outside evaluator is involved, be sure that the data collection methods proposed by the evaluator are reviewed by and agreed to by your community partners. Remember, the quality of your evaluation findings rests on the quality of the data you collect. An inclusive participatory process assures highest quality without sacrificing cultural appropriateness and practical usefulness of the findings.

Common Data Collection Challenges

The following questions illustrate common challenges involved in data collection:

- *How Complex Should Our Data Collection Process Be?* Data collection can be simple or complex, depending on what you are interested in finding out and the available resources. Unless you are required to meet scientific research standards, keep your evaluation methods as simple as possible.
- *Where Do We Get Data?* Often, the most effective data collection techniques are the ones you already use. Identify those sources of information that are available and can be used to evaluate program operations, client outcomes, or community impacts. As you begin collecting information, remain flexible enough to modify your process to assure that the findings are optimally useful for enhancing program operations and outcomes. If you discover critical issues as your evaluation proceeds, you will want to note these and enhance your data collection efforts to provide sufficient insight into each issue for sharing with the program management team. At the same time, you do not want to become sidetracked.
- *How Much Data is Enough?* Collect only that information/data that is needed to answer the evaluation questions agreed to by the stakeholders. Do not gather data that you won't use. And, prioritize the questions to be answered and focus your efforts on these.

Clarifying What Types Of Information You Need

Think about what kinds of data will best answer your questions -- "quantitative" or "qualitative" data. The strongest evaluations collect both.

Quantitative methods produce things that can be counted or measured and are most useful when we want to know: How many? How much? Rank order? Degree of change? Projected program impacts? The varieties of quantitative data types are important because they limit or enable the analyses that can be performed. The three primary types of quantitative data are:

- *Nominal Data* – counts by categories that cannot be ranked.
  For example: "Yes" versus "No"; "Male" versus "Female"; or, "Hispanic" versus "Non-Hispanic".
- *Ordinal Data* – counts by categories that can be ordered or ranked.
  For example: "None", "Moderately", "Most"; "Don't Smoke", "Occasionally Smoke", "Smoke Daily"; or, school grade.
  (Ordinal data is useful for assessing relative changes over time.)
- *Interval Data* – measured or scored data that falls along a scale that produces measurements that allow the observer to calculate the measurement intervals.
  (For example: temperature; weight; age; blood pressure; or, test scores.)

Of the three types of quantitative data, interval data is the most powerful because it allows comparisons of measurements over time so the degree of change can be credibly assessed. Interval data enables the most powerful statements to be made regarding program outcomes and impacts. The downside of interval data is the cost that can take to collect it. If resources are an issue, you might reserve interval data measurement for answering only the highest priority evaluation questions.

Qualitative data, on the other hand, often includes quotes from interviews or from the descriptive stories people share that bring the culture, spirit and vibrancy of your program alive. The purpose of qualitative data is to:

- Capture contextual information.
- Provide depth and detail for understanding and interpreting observations.
- Discover the meaning and impact of your program from the perspectives of others.

"A Story From The Hispanic Culture"

My mother worked in a hospital in a town where I grew up, a little town called Miami, Arizona, a copper mining town that was about one-half Mexican and one-half White. There were some Indians on a reservation twenty-four miles from there, but mostly Hispanic and White, and most of us poor. She worked in the kitchen and the nurses there, most of them were non-Spanish speaking, but we used to get a lot of Spanish-speaking people in the hospital. So, they went to my mother and asked her if she would help them with some basic phrases they could read into the cases. So, she had written them down and even done them phonetically so that they could get people to cooperate with the blood pressure, temperature, things like that.

Well, the nurse came down and she said, "I need some help upstairs," and my mother went to do the translations. My mother said to the nurse, "This lady understands what I'm saying. What were you telling her?" And the nurse said, "Well, I read the stuff just like you told me." So my mother turns to the patient who doesn't speak English and said, "This lady was talking to you in Spanish." And the lady said, "Oh, she was? Well, I was listening in English."

Now, there is an important message in that. It's like, she was trying to use mainstream frame of reference because that's where she was. And mainstream frame of reference, for a change, was trying to reach her, so there was definitely a misfire there."

Told by C.H. Balderama
CENTERED Blue Ribbon Panel Member

Data Sources

Now that you know what you would like to learn and your resource situation, you need to determine who has the data you need. There are two kinds of data sources: "primary data" that you collect yourself, and "secondary data" that someone else has collected but allows you to use.

Secondary Data:
What data will be most helpful to you depends on the data/information necessary to answer your evaluation questions, and which data sources are most credible. While secondary data is usually less expensive and quicker to obtain, it must meet your needs. Consider the following questions to help you judge how "good" the data source is:

- Whose data is it? How was it collected? Who funded it and for what purposes?
- How accurate is the data? How up-to-date? Do you have a mechanism for validating the data?
- How well does the data reflect the community? Is it representative?

The answers to these questions will enable you to identify possible sources of bias that you need to be aware of and reflected in your evaluation report if you choose to use them.

Chapter 8 includes a listing of secondary data sources that may be helpful to you. You can also request data from your state and/or local health department. You will want enough data to establish baselines for the program indicators you've chosen so you will have a point of reference to compare with over time as your program progresses.

Remember, not all data sources are going to provide data useful for your purposes. You will need to determine:

- Does the secondary data source represent the target area for our program?
- Does the secondary data source allow data to be analyzed in accordance with your program's priority populations (i.e. racial, gender, and age categories)?

If the data source does not allow you to approximate the boundaries of your program's target area, it will probably be much larger than the area that your program has defined as its target. This means that whatever impacts your program expects to make in enhancing the health of the community will be hidden because the secondary statistics include data from areas in which your program has not been providing services. If you still decide to use this data source for assessing program impacts, it will almost always take longer to evidence those impacts because the data includes persons not involved with the program. If you can, select target areas with boundaries that coincide with secondary data sources, such as using census tract or county boundary lines.

A common problem with secondary data is that the source does not summarize its data into the same categories as you need for your program. For assessing your program's impacts on local health disparities, you will want data that is categorized specifically into those racial/ethnic subpopulations that your program targets. Data broken down only into general "White", "Black", or "Other" categories is not helpful. For example, if you are working with American Indian, Hispanic, or Asian/Pacific Islander communities that have been lumped together into the "Other" category, how could you possibly develop baseline prevalence rates or trends in incidence rates over time?
Because of the *Healthy People 2010* national initiative, efforts have been initiated to make data available for those subpopulations that are the focus of the national initiative.

However, this will take time as data has not traditionally been collected and reported to this level of detail in many juridictions. Just placing your request to the secondary data sources for data broken down to the specific racial/ethnic group level that you need to best serve these high interest populations will strengthen appreciation for the need and the likelihood to collect this data. So, strongly express your need for your specific data needs and encourage others to do the same.

Primary Data

The alternative to using secondary data is to develop your own data — primary data. In this case, you control what is collected, from whom, and what is done with it. This can be highly valuable data, because it is specific to your target population. However, primary data also has its own challenges and limitations. Consider the following:

- What information already exists about how your program and how it is working?
- What stories have you heard from clients, staff, and others about the program?
- How does the program track how many clients receive program services?
- How does the program assess client satisfaction with the services offered?
- How are you assessing changes in client knowledge, attitudes, or behaviors as a result of program participation?
- What information did you use to support the need for funding for the program?
- What changes in client health outcomes or in indicators of community health have you targeted as program objectives/goals and how are you monitoring progress?

Also, think about who may have information that would be useful to your evaluation process:

- Program clients (past, present, and drop-outs);
- People who chose not to participate in your program at all;
- Program staff;
- Community members who know the program;
- Family members or friends of program clients;
- Others working who have witnessed client changes attributable to the program;
- Staff working in other agencies or institutions you are trying to make changes in;
- Community members able to observe changes at the community level; and/or,
- Key authorities (e.g. Board of Health, School Board).

It is extremely important to include community members most impacted by racial and ethnic disparities. Their voices are critical, yet they are often not included. As you collect information from the community you are developing your own primary data sources. You will have the opportunity to gain insights that your evaluation would miss if you only focused on those directly involved with the program. Remember, the community can help identify the reasons your program may be underutilized by certain target groups; and, help your staff to be more sensitive and responsive to those groups.

Many community programs operate under challenging conditions where racial inequities and other negative social forces work against efforts at social progress. If this is the case in your program's target community, you need to collect data from those within the community willing to share their perspectives. If and when the community raises these

issues, they should become high priorities for the program to add to the evaluation. Beyond assessing the perspectives of the community, if action on the issues lies beyond the scope of your program, then you should still refer the issues to appropriate parties/agencies with cc's to the community so they are informed of those referrals. You may still want to incorporate these concerns into the periodic evaluations to demonstrate your support of community interests.

Choosing Data Collection Methods And Tools

The consensus mapping process (Chapter 2) guides you in developing the questions to be answered by your evaluation. Some can be directly answered by a count or a measurement, while others may require interviews or surveys. Still others may best be answered by culturally appropriate group discussions, such as took place during the consensus mapping process.

Data can be collected in a variety of ways, including:

- *Direct assessment:* Counts or measurements.
- *Survey:* Standardized or open-ended questions (for contextual insights).
- *Interview:* Structured (guided by predetermined questions); or, unstructured (open-ended responses).
- *Focus group:* Structured and led by a neutral facilitator to address a predetermined set of issues.

The ability to collect the needed data depends not only upon selecting the appropriate format, but in the case of interviews, surveys, and focus group discussions, it also depends on the ability to raise the issues of interest in a manner that encourages honest and full responses. This process involves working with informants on the wording to be used, and how questions should be framed to be most acceptable.

Respondents can also guide the selection and training of data collection staff, to optimize their reception by the community. Whenever possible, persons used for data collection should come from the community. All data collection instruments should be pilot tested with members of the target community prior to being finalized. Sometimes the wording and the order in which questions are asked can make a difference, and the pilot testing will help to identify any need for refinements.

Resources that can provide more in-depth discussions and examples of data collection instruments are listed Chapter 8. Invite an experienced evaluator from the health department, university, or another CBO to help as you develop your data collection instruments. Table 1 reviews common data collection methods. You may decide to use less mainstream methods, but the funder and/or independent evaluator should be involved early to assure the acceptability and reliability of the method—does it measure what it is supposed to measure? Consider the following options to overcome concerns about reliability:

1. Conduct parallel data collection systems and compare the results.
2. Reinforce use of culturally appropriate methods with validity documentation.

3. Invite concerned community partners to observe data collection efforts so they can see how people are responding to the method(s) used.

Once you have settled on which methods to use, you need to develop your data collection instruments. This includes development of both the interview guide (for training data collection staff), and data collection instruments. You can develop these or borrow ones that others have found to be useful.

Table 1 . Commonly Used Data Collection Methods.

METHOD	ADVANTAGES	DISADVANTAGES
Written Survey	Comfortable for people coming from a reading and writing culture. Can collect data from many people at the same time. Relatively inexpensive. Can be anonymous if sensitivity is an issue.	Unless supervised, people may not return the survey. Literacy issues can interfere with response rates. Follow-up for fuller explanations of responses may not be possible. Incomplete information is common. Little chance of building relationships with respondents.
Interview (individual or focus group)	More comfortable for people from an oral culture. Interviewer can clarify issues for participants. Reduces literacy issues. Can develop evaluator-participant relationship.	Time-consuming, labor-intensive, relatively expensive. Evaluator training is critically important. Data may be hard or very time-consuming to analyze (qualitative).
Records Review (data collected for other purposes)	Unobtrusive. May enable validation of data collected through other methods.	Time-consuming, expensive, & labor intensive. Relies on accuracy of the record and on knowledge of data collector. Incomplete information is common.
Direct Observation	Opportunities for new issues to arise. Provides context. Observer sees first-hand what the community or program is like and the intensity of feelings expressed by both clients and program staff as they interact.	Time-consuming, expensive, & labor intensive. Observer training is critical as the presence of the observer may cause clients or staff to change their normal behavior. Can be open-ended if the process lacks clarity regarding what the observer is to look for and how observations are to be interpreted. Data may be hard to analyze.
Clinical Test	Stakeholders value highly. Objective assessment is possible; enables detection of changes in the selected	May violate client confidentiality and require permission to view results. Evaluator training or external expertise may be necessary

	indicators being measured. Results can be validated.	to interpret results. Time, labor, & technically intensive; expensive.
Knowledge, Attitudes, & Behaviors Surveys (a.k.a. KAB Surveys)	Can be standardized. Stakeholders may value highly. Provides baselines to assess change over time.	If not culturally appropriate, may provide misleading results. Literacy may impact results. Self-reports are difficult to validate.
Storytelling	Common in some cultures. Allows participants to guide the conversation.	Open-ended. Difficult to analyze. Produces data on a variety of topics, some unrelated to the topic at hand.
Writings (journals, logs, other writings, etc.)	Good for reflection-oriented culture or communities. Captures what someone "says". Informer convenient. New or embarrassing ideas able to emerge "safely".	People must write comfortably. Hard to analyze as very open-ended. Difficult to obtain as it depends on writers "sharing" writings. Knowledge of "shared" writings may influence what is written—self conscious censoring.
Drawings, Photographs	For visual cultures & communities. Avoids literacy issues. Provides a non-word, non-number method for sharing ideas and feelings.	Difficult to analyze, may need explanations in writing or verbally. May be difficult for some to understand or find credible. Very open-ended.

What Questions to Ask And How To Ask Them

Your stakeholders represent the community's interests and help to inform it about the evaluation and why it is in its interest to support the evaluation, and encourage community cooperation. The questions to be asked must be sensitive and appropriate to the unique culture and history of the community. The wording of the questions must show respect and appreciation for those willing to share the information sought.

"AN ALASKAN NATIVE STORY: THINGS PEOPLE DON'T TALK ABOUT"

While working in Anchorage on an evaluation project for a cancer screening program for Alaskan Native women, we wanted to better understand the following: What are the cultural beliefs that these women have around cancer? We were told, "You can go in and ask even the nurses and some of the community health aides, and people who deal with them about cultural beliefs. But, they're not going to want to tell you because they have the beliefs themselves and when you talk about them, you give them power. When you say these things out loud, you're going to give the cancer more power," and there are things that people don't talk about. So as an outside evaluator coming into a community, you can't even say, "Oh, we have to be culturally sensitive and collect information on some of the stuff." You're not even going to get it, you're not going to get people talking about it.

Ask questions on subjects that are appropriate for the community, but beware of introduction of biases by the way questions are worded. For example, do not ask questions in a way that places guilt or reflects negatively on the informant. Let's say that, based on participants' age, weight, and overall health situation that doctors with your program are recommending selected participants walk regularly to increase their exercise. Now consider how the participant might feel if their community has no sidewalks – let alone walking trails – to enable getting out daily to walk on? The following are examples of evaluation questions that raise the exercise issue in different ways:

- What did your doctor tell you about why you should get more exercise?
- To what degree do you agree with your doctor about the need to get more exercise?
- What was helpful in terms of your doctor's encouragement?
- What would have been more helpful?
- What would support you in getting more exercise?
- How might you need to change?
- How might other things need to change?

The close-ended first question can produce "guilt" in the participant without yielding information that could help in finding ways to make routine exercise more likely. The open-ended questions that follow allow issues to be raised that could enhance the success of the client and your program, if you could convert the insights into recommendations to be shared with other community partners.

If you use methods that ask open-ended questions, it is helpful to do this in ways where a neutral facilitator can guide the conversations or interviews to keep the discussions focused on program-related issues, but without killing opportunities for important unanticipated issues to surface.

Sampling: How Much Data Is Enough?

In general, it is not possible or necessary to collect data from every member of the community or even from all clients in order to evaluate the program. When done properly, sampling can provide sufficiently accurate insights to satisfy your needs while keeping the effort and cost of data collection to a minimum. The minimum sample size you will need to use will be determined by your study design, the nature of the questions you are seeking to answer, and the precision of the results required by your stakeholders. An epidemiologist or statistician can help you calculate the minimum sample sizes needed so you can be sure that your sample sizes are adequate for your intended purposes, while controlling costs.

The following are important rules to consider when sampling:

1. The population to be sampled must be well defined and the members of that population reliably identifiable.

2. The sampling mechanism must be such that for every member of the population the probability of that person's inclusion in the sample is known and is not zero.
3. The sampling design (which is based upon these probabilities) must be implemented as planned (or bias will be introduced).
4. Conclusions based on the sample results can only be attributed to the sampled population.

Sampling Options

- *Random Sampling:* Produces results representative of the population from which the sample was taken. The probability of being included in the sample is the same for all individuals in the population. The goals and objectives of the study dictate those to be included in the sample.

- *Stratified Random Sampling:* A sampling fraction is determined for each strata based upon the relative proportion of that strata within the total population to be sampled. If this population is made up of two subpopulations (African Americans, 30%; and, whites, 70%), those selected would be included in the sample in proportion with their representation in the population (i.e. if 1000 persons were to be included in the sample, the goal would be to include 300 African Americans and 700 whites). This is called a "proportionate allocation" sample.

  If the sample contains equal numbers of each subpopulation (i.e. 500 African Americans and 500 whites), regardless of their proportion within the total population, then this is called an "equal allocation" sample.

  If the random sample is a true representation of the population as a whole, it is called a "self-weighted" sample.

- *Cluster Sampling:* Groups rather than individuals are selected for inclusion in "cluster" sampling. Random selection still occurs, but groups are selected at random and all individuals in the selected groups are sampled. When the data is analyzed, the cluster is the unit of analysis rather than the individual.

- *Systematic Sampling:* The first individual is selected at random, then all other selections are made based on a predetermined pattern. For example, every 10th person might be selected until the desired number needed for the sample is reached.

- *Purposeful Sampling:* In some cases a random sample will not meet the needs of the evaluation – for example, if you are interested only in members of the Catawba Nation (a federally recognized American Indian tribe), then you might first screen on the basis of race/ethnicity, then from these, sample only from those who report being Catawba. In these cases you purposefully select *those key individuals because* they have the information you need. When using this sampling method you need to understand that while you have gained specific insights about the key group sampled (Catawba), you cannot make generalizations from this group back to the larger population group (American Indians) as you could with random sampling. Usually,

purposeful sampling is done to gain additional more detailed insights into high interest subpopulations.

- *Convenience Sampling:* Sampling by selecting anyone willing to be surveyed or to show up for a group interview/focus group produces the least credible data and is frowned upon by most funders and public health professionals. One use of convenience sampling is to field test survey instruments prior to finalizing the documents for actual use.

No matter how you select the sample of persons from whom you will collect your data, you will need to be able to explain to others the sampling method(s) used. This allows others to appreciate the strengths and/or limitations the sampling method(s) may have imposed. Sampling methods do impact the quality of the evaluation results and must be taken into consideration as the data results are interpreted. As previously suggested, you may want to involve an epidemiologist or statistician to help in: considering your sampling options; calculate the minimum sample sizes needed for your intended purposes; and, fairly describe the methods used and limitations imposed by those methods.

Who Will Collect the Data?

One way to enhance the quality of the data you collect is to use locally recruited data collectors who understand the local "culture" and can encourage active and honest participation. Persons selected in the data collection sample need to feel that the insights they provide are valued, and that anything they share will not result negatively on them. Trust comes more quickly when the data collector is from the community.

You and your stakeholders should decide who would make the best data collectors, because you know both your community and your program. If there is a need to control community biases from impacting data collection, then it may be best to use data collectors who come from outside the community. You and your partners need to weigh the advantages and disadvantages of your options.

If you have a diverse data collection team, you should make the most of the strengths and experience of each team member in deciding roles and responsibilities. Training and supervision of the collection team is essential for achieving high quality data collection.
Think about offering payments or the use of alternative incentives for rewarding the community data collectors you employ. While skill-building or "giving-back-to-the-community" incentives might be enough, cash payments may be a more suitable way to acknowledge people for their sustained commitment to supporting the evaluation process. Whenever possible, community partners should be paid for their important contributions to the evaluation effort, and acknowledged publicly for their supporting efforts to eliminating the health disparities that exist within their community.

When Is Data To Be Collected?

You will need to collect data before your program begins in order to establish baselines for the indicators that you will be monitoring throughout your program. You will then re-assess these indicators periodically throughout the program, and then again at the end of the program. This will allow you to determine short-, medium-, and long-term client outcomes and the community-level impacts. You will also want to collect data throughout your program to monitor the operational processes and be able to make and assess program refinements.

Informed Consent: Protecting People Who Provide Data

You also need to consider what types of information those providing data will need in order to make an informed choice as to whether or not to participate in the evaluation process. While it is rare, information you collect may be subject to subpoena. Therefore you need to consider such options as collecting data anonymously and/or avoiding questions that can put those who provide data to you at risk. Confidentiality protection must be included in training for program staff and for all members of the data collection team. Confidentiality protection assessments should also be incorporated into the evaluation. The National Institutes of Health provide a number of excellent on-line tutorials about confidentiality and human rights that you may want to use in training your staff. Table 2 summarizes some of the data confidentiality issues that you will want to address as you plan your program evaluation.

Table 2. Data Confidentiality And Data/Client Protection Issues.

QUALITATIVE DATA	***QUANTITATIVE DATA***
Includes notes taken by hand, tape recordings, typed transcripts, and reports.	Includes data collection instruments, databases, compilations of findings, and final reports.
-Who is allowed access? -How can you control access? -How will you share stories while protecting the identity of the source? -Consider substituting names and other identifying information with codes. -Who owns the data? -How can it be used after the report is completed? This should be made clear to outside evaluators, staff, stake-holders, and to those contributing their stories, interviews, or who are under observation.	-Who will have access to the raw data? -Who will need client identifiers to enable validation? -Where and how will data be kept and secured? How will data be shared without revealing the identity of the source? -Consider using codes or unique identifiers instead of names. -Who owns the data? -How can it be used after the report has been completed? This should be made clear to outside evaluators, staff, stakeholders, and to those contributing their data.

Always secure any records that may contain client or patient identifiers. Ideally records should be secured inside a locked file cabinet inside a lockable room. Only those staff

with a valid need-to-know should have access to those records. A responsible person should be charged with maintaining the records security and for supervising any release of records. Conditions of release should be addressed in the program's Institutional Review Board (IRB)-approved data release policies.

Here are some examples of things you will need to bear in mind about each person providing data (informant):

- Who they are? Do I need their name and other personal identifiers, or can I substitute a unique code and still satisfy the program's needs?
- What is their role in the program and/or the evaluation? Client? Staff?
- Why is this data/information being requested?
- Why is it important for this person to participate?
- Who else will have access to the data?
- How will the data they provide be used?
- What are the consequences if they chose not to allow use of their data?
- What would happen if they decide after agreeing to allow their data to be used, to change their mind? What impacts will this have on them? On the program?
- What types of data will be collected? On what topics?
- What kinds of things would have to be reported to authorities (e.g., child abuse) if they came out during data collection?
- What are the risks for those clients/staff members who agree to participate?
- What are their benefits?
- What incentives are you providing?
- How much time will this take?
- What will happen to the data/information once the evaluation is completed?

Make sure participants understand that *they may ask questions at any time* of a responsible person familiar with the program. You should *document* in writing or on videotape that *an official informed consent has been obtained* from each person involved in providing data/information collected during the evaluation process.

Incentives And Stipends

To encourage clients or community members to participate in the evaluation process you may want to offer some sort of incentive. Cash stipends, a gift coupon, clothing, or other incentive may be offered in appreciation of their participation. The nature and scale of the incentive is best decided with both the community stakeholders and funder(s). If there are expenses that will be incurred to support the evaluation process, these need to be anticipated before they are incurred, or reimbursement procedures established and described ahead of time. Non-monetary incentives may include public recognition. In some cases, giving persons or organizations something they need may be the preferred incentive – e.g., providing training or other technical support that your resources allow. In other cases, just knowing they are participating for a worthy cause or being listened to may be sufficient.

Managing Your Data

A data flow plan should be developed that illustrates: Where data is collected; how it will flow to computer entry; and, where data will be analyzed. The data flow plan should show where and how data coding (if used) will take place, by whom, and where the code key will be located and secured. The plan should include a detailed description of who is responsible for data security, including how access to the code keys (if used) will be controlled and the criteria for breaking a code (subject to Internal Review Board (IRB) approval).

Data storage, editing, transformation, reproduction, dissemination, and disposal also need to be considered relative to data security and ownership issues. Data quality assurance systems need to be developed, including data management protocols and how monitoring for protocol adherence will take place. The data flow plan and protocols need to address when and how logical data edit routines will be used, and how missing data/information will be handled. Planned data analyses should be described, including designation of the person(s) responsible for conducting those analyses and interpreting the results.

Finally, the ultimate fate of the data collection documents and data must be addressed. Will paper records be retained or destroyed? If retained, will the records need to be de-identified (removal of names and other identifying information), or will coded data sets be retained and need to be secured against future abuse?

By setting up and describing the data flow systems and ways of operating in advance, you help assure that your data is consistently recorded and organized in ways that insure both data quality, and data confidentiality. Thorough training of data collectors and data handlers; judicious use of back-up systems (e.g. two tape recorders for interview sessions in case one breaks down); backing-up of all data bases with secure off-site storage (in the case of a fire, break-in, etc.); and, continuous quality assurance monitoring for staff adherence to program policies and protocols are all essential elements of the data plan.

Data Management Supervision

Supervision of all aspects of data collection and processing is a major management responsibility since the data will eventually be used to document the activities, outcomes, and impacts of the program, as well as enable cost benefit assessments to be made. The date analyses produce the results that ultimately determine the fate of the program and of the services upon which the clients and community may have become dependent. This is a major responsibility that also requires periodic evaluation to assure its effectiveness.

You are encouraged to hold regular meetings with those involved in data flow so they can share their experiences and frustrations and help in the early identification and resolution of potential data-flow problems. Be prepared to refine your data collection instruments as you learn what works and what doesn't. Always seek to do what appears to be most effective for accomplishing the stated objectives and goals. When refinements involve elements needed for meeting a stakeholder's needs, be sure the stakeholder is involved. Keep in mind that it is important that your data be organized to enable others to analyze the same data using the same techniques in order to see if they produce the same findings.

Although interpretations may vary, data analysis should strive to achieve and maintain scientific rigor, including an objective description of any limitations due to data collection methods that might influence interpretations of analytical results.

CHAPTER 6: ANALYZING & INTERPRETING THE DATA

A correct, complete analysis of data and interpretation of the results requires the active involvement of people who understand the program and the community. The following Native Hawaiian story illustrates how misinterpretation can occur when community perspectives are not understood.

A NATIVE HAWAIIAN PERSPECTIVE ABOUT LABELS

"As a Native Hawaiian, the labels that have been put on us are 'lazy, not interested in our health, slow, all of the above,' [and these labels] have been put on many other minorities. When they did a survey on Molokai ... they asked the community to identify what they felt the community's strengths were: one of the things on the list was "slow-paced." They saw that as a definite strength..."

JoAnn Umilani Tsark, MPH
Research Director
Papa Ola Lokahi
Honolulu, HI

It is critical that this stage of the evaluation process uses the data to address the questions posed by the stakeholders. The analytic methods used need to be clearly described along with any limitations that might cause a misinterpretation of the results.

Statistical analyses are usually done on a computer by someone trained and experienced in data analysis. You may have such persons on your staff, but if not, technical support may be available from your health department, university, or an independent consultant. If you decide to have the analysis done by others, you will still need to specify the level of involvement that you expect to have; and, to what degree you want your staff to be involved and (ideally) trained as data analyses proceed.

Analyze The Data

Data analysis is the process by which you convert the "raw data" (the measurements, survey responses, interview and focus group recordings, pictures), into summary results that attempt to answer the evaluation questions. The process used for the analysis needs to be structured to assure as much as possible that the conclusions reflect an objective assessment of the data. The goals of data analysis and interpretation are:

- To determine if program indicators are changing as anticipated;
- To determine if program objectives are being met;
- To determine if the rate of progress is sufficient to meet long-term goals within the allotted time;
- To inform stakeholders of the degree of success of the program;

- To provide recommendations for improving program operations; and,
- To determine if your program is using its resources effectively and efficiently.

Chapter 8 lists many books, articles, and websites that can walk you through the specifics of how to analyze your data. Remember, you will not only want to analyze your program's data, but also to interpret it in clear and understandable language.

Establishing Your Data "Standards Of Success"

When you developed the indicators to be used in the evaluation process, you considered the stakeholders' interests, the indicators of success that you would use, and how you planned to measure each indicator. Those considerations formed the base from which you will now be able to determine if your program is a success. In the analysis phase of the evaluation process, you will compare each indicator measurement that you have collected with a "standard of success". To keep the analysis as objective as possible, these standards should be agreed upon prior to the analysis – they represent the objectives set to be accomplished during the period since either the last evaluation, or, if this is your first evaluation, since the program began.

For example, if the indicator under consideration is the "number of clients enrolled in the program in 3 month"; and your objective was "to enroll 100 new clients per month", then total program success would be "to have achieved at least 300 new client enrollments during the past 3 months". The standards of success are established for each indicator along with the nature of measurement used for that indicator. Table 1 used the above example to demonstrate this.

Table 1. Variations In "Standards Of Success" According To Level Of Data Measurement.

LEVEL OF MEASUREMENT	MEASUREMENT	STANDARDS FOR SUCCESS
Nominal	Objective met: "Yes" (300+) or "No" (<300).	"Yes" = success.
Ordinal	<135 136-165 166-195 196-225 226-255 256-285 286-315 316-345 346-375 376+.	45% or less 45.3-55% 55.3-65% 65.3-75% 75.3-85% 85.3-95% 95.3-105% 105.3-115% 115.3-125% Over 125%. Estimated % of goal met.
Interval	Number of new clients enrolled.	$\frac{\text{Actual \#}}{300} \times 100 =$ Percent of objective met.

Some standards may require more support from an independent evaluator but may be worth the investment because they can produce stronger evidence of your program's successes. Your story is told most effectively as a tailored analysis that includes interpretation of the qualitative insights gained from your clients and other stakeholders to complement and "explain" the quantitative findings. Table 2 gives examples of several commonly used community-determined success standards.

Table 2. Examples Of Community-determined "Standards Of Success".

Documented Progress -- "Before" and "After"	Compares your program's performance to where you started from, or (if this is not the first evaluation) to where you were at the time of the last evaluation to see how much progress has been made. Before ("baseline") and after information must measure the same indicators. The comparison addresses both how fully the program is now implemented/improved and how the indicator measurements have improved.
Program Objectives	Compare your program's accomplishments to what it set out to accomplish – staged program implementation objectives. This comparison relies on your having developed solid and phased objectives (realistic, allowing for the stage of the program as it evolves, somewhat ambitious, and comprehensive). It may be helpful to review similar programs to see where you are at in comparison. Remember, you are "telling your own story", don't drift away from your aims with too much comparison to other's programs.
Toughness/Difficulty of the Job	Often programs work under difficult circumstances that may not be appreciated by others. For example, if you work with "hard-to-reach" clients, your accomplishments should be evaluated in this context. This "toughness" or "difficulty" factor needs to be allowed for when establishing your "success standards" (prior to analysis).
Our Community's Way	If your community has its own traditional method for judging program success, try to accommodate that method within your evaluation analysis. For example, it may entail taking the stories you have collected about your program to a spiritual guide who serves as the liaison with the ancestors to learn their views regarding the program. It is important to value and respect such cultural ways while recognizing that they may need to be supported by more standard evaluation methods for those of your stakeholders who are not familiar with the cultural traditions.

Once you've settled on your success standards for each indicator, you will need to consider how to analyze your data (see Table 3). There are many resources on the specifics analytic options, but here are some common issues to consider.

- Quantitative data is usually the result of counts or measurements. If you had your participants fill out a survey, you can report the percentage who chose each answer by tallying how many chose each possible response to a multiple choice question,. This produces a "proportionate frequency distribution" describing the percentage of respondents who chose each answer. This can be graphed and easily shared with others. During subsequent evaluations the "proportionate frequency distribution" can be compared with earlier distributions and the changes that have occurred (if any) attributed to the "success" of the program.

- If you craft questions that provide a range of non-overlapping responses to issues you feel can reflect the changes your program is trying to make in client knowledge, behavior, or attitudes, then you can create a gauge for measuring those changes over time.

- If the survey contains multiple answers and clients are asked to choose all of the correct answers, this will allow you to describe what percentage chose either correct or incorrect responses. If this same survey is given before and after a health education class (pre- and post-test), you could use the changes in the percentage with correct answers as the gauge for measuring improvement in knowledge attributable to the class. And, if this same survey is given to the same clients six months later, you could determine the percentage who retained that knowledge over that time period.

- If your survey asks whether or not clients have engaged in a variety of health-related behaviors in the past week, then you would be able to describe the percentage of clients who reported having engaged in each behavior during that period. The behaviors might be smoking, exercise, binge drinking, use of a condom, visit to a doctor's office, or any other behavior relevant to your program's interests. Again, the proportionate frequency distribution would allow you to summarize the responses of those surveyed so they could be described and compared with earlier or future survey results to determine changes over time.

Table 3. Examples Of Types Of Quantitative Data Analyses.

ANALYSIS TYPE	DESCRIPTION	EXAMPLE
Proportionate Frequency Distributions: Describes how often people choose each answer. Uses only one variable.	Shows the percentage of persons choosing each answer option for each question. The percentage is calculated by dividing the number of persons choosing that answer option by the total number who answered the question, then multiplying the result by 100.	Of 50 clients who answered the survey question, "was the class: a) very helpful, b) somewhat helpful, c) a little helpful, or d) not helpful?": 20 persons (40%) answered "a"; 15 persons (30%) answered "b"; 5 persons (10%) answered "c"; and, 10 persons (20%) chose "d".

ANALYSIS TYPE	DESCRIPTION	EXAMPLE
Measures of Central Tendency: (Used when answers are whole numbers, such as age, number of children, number of visits). Uses only one variable.	**Mean:** Add all the answers together, then divide this sum by the number of answers -- Also termed the "average". In the example at the right: [0x21] + [1x14] + [2x9] + [3x5] + [4x1] = 51 divided by number of respondents (50) = 1.04. **Median:** The middle-most answer in a ranked listing of answer options -- half the responses below, half above. **Mode:** The answer given most. **Range:** The lowest & highest answer.	Of 50 teen program participants, the number of children they reported giving birth to: Number of Children — Number of Teens Giving This Answer 0 — 21 1 — 14 2 — 9 3 — 5 4 — 1 **Mean** = 1.04 children per teen. **Median** = 1 child. **Mode** = 0 child. **Range:** 0 – 4 children.
Cross-Tabulation: Helps to show which types of respondents answered in what ways. Uses two variables (bi-variate) in the analysis.	Enables descriptions of respondents to one question on the basis of responses to another. To do this, take 2 kinds of information (the "helpful" scores and, for example, whether people say they are doing your class for "weight loss" or for "healthy heart." Add up how many people fit into each category for each answer. For example, how many of the 50 clients said "very helpful" and "weight loss"; how many said "very helpful and "healthy heart"; etc.?	Helpfulness of Class by Respondent's Health Issue: Weight Loss — Healthy Heart *very helpful* 18 (36%) — 2 (4%) *somewhat helpful* 10 (20%) — 5 (10%) *a little helpful* 2 (4%) — 3 (6%) *not helpful* 0 (0%) — 10 (20%) 30 (60%) — 20 (40%) 60% of the respondents reported taking the class for weight loss purposes. Of those, 93% (28/30) stated the program was 'very helpful' or 'somewhat helpful'. Of the 40% of respondents who took the class for 'healthy heart' 65% (13/20) rated the program as 'a little helpful' or 'not helpful'.

ANALYSIS TYPE	DESCRIPTION	EXAMPLE
Tests of Statistical Significance: Helps to identify whether changes and relationships are attributable to chance alone, or whether the probability of being due to chance alone is significantly small, indicating the probability that a real relationship exists between these variables.	These tests are usually run by computer to determine the probability that there is a relationship between variables. The tests available depend upon the nature of the data. For most community applications, non-parametric statistical tests can be used. The appropriate test depends on the study design and level of measurement used. Statistical software (EpiInfo available for free from CDC at: http://www.cdc.gov/epiinfo/) are available from CDC and from commercial sources.	See Chapter 8, Resources.

The measures of central tendency described in Table 3 help you to describe the quantitative data you've collected for each data element. The methods for calculating these measures are not complex and most statistical software allow them to be easily generated, as demonstrated in both Tables 3 and 4.

As an example, if your program goal was to assist clients to lose weight over time, and you have been weighing clients monthly to determine their weight change, then you have several insights available for describing the success of this effort. You can demonstrate weight changes of individual clients over time to determine if the client lost weight, and also how much was lost over what period of time. You can also look for patterns of weight loss in relationship to their participation in the variety of program offerings, such as nutrition and diet counseling; structured exercise classes; a daily walking program; or, active participation in peer support networks.

You can also analyze your data for evidence of program-level outcomes by combining the observations of all of your clients in order to calculate standard measures of central tendency across all clients. This will provide your stakeholders with a much more helpful picture of the overall program benefits.

Table 4 illustrates how the measures of central tendency are determined for two sets of interval data (males versus females).

Table 4. Examples Of Measures Of Central Tendency (mean, median, mode & range).

Male Clients	Beginning Weight (lbs.)
1	165
2	171
3	183
4	185
5	190
6	204
7	215
8	229
9	252

	1794

RANGE

Mean: 1794 / 9 = 199 lbs.
Range: 165-252 lbs.
Median: 190 lbs.(#5, middle-most)

Female Clients	Beginning Weight (lbs.
1	133
2	140
3	151
4	160
5	160
6	160
7	177
8	185
9	194
10	203

	1663

MODE

RANGE

Mean: 1663 / 10 = 166 lbs.
Range: 133-203 lbs.
Median: 320 / 2 = 160 lbs.
Mode: 160 lbs.

By adding up the baseline weights of all clients (their weight at the time they entered the program), and then dividing this sum by the total number of clients, you will have the **mean** beginning weights (199 lbs. for males, versus 166lbs for females). The **range** of baseline client weights is 165-252 lbs. for males, versus 133-203 lbs. for females. The **median** (middle-most) weight for males is 190 lbs. versus 160 lbs. for females (calculated by adding the weights of the two middle-most clients [clients 5 and 6] and then dividing their combined weight by two). For females the **mode** (most common weight) is 160lbs. In this case, the mean and mode for females happened to be the same, while for males there was no mode determined as none of the males had the same weight.

Individual vs. Program-Level Data Analyses: Considerations Of Sampling And Bias

Why would you want to shift from individual to program-level analyses? Clearly, it takes more work. However, if you plan to do it you will have included a routine method for taking each individual observation (weighing a client, for example) and recording it onto a central log at the weight station along with the client's program identification number. This will allow you to periodically enter the log entries into a computerized database with data representing all clients.

If you do not have program-level database, you can only describe selected clients. In so doing, you run the risk of receiving criticisms from those stakeholders who expect an objective assessment of the program's overall "success". A selection of only those clients

who have responded well will introduce "bias" (unfairness) into your results because the analyses did not consider the full range of possible client outcomes.

As was discussed in Chapter 5, there are sampling methods that can be used to develop representative estimates of the clients' outcomes without having to consider every client. As long as the sample is selected randomly, bias can be avoided, or at least minimized. At the same time, the sample must be large enough to allow the results of the analyses to be considered "representative" of the whole population of clients. There are tables and software that can assist you in determining the minimum sample sizes needed depending on the level of precision that you want to achieve in your estimates of the populations' true characteristic of interest.

The decision to shift from individual to program-level data enhances the value of your results. When done properly, they provide a fair and easily understood description of the experience of all of the clients in your program. If the random sampling procedure has been followed, you will have the ability to state the methods used and to describe the changes that have occurred in the average client weight over time with a degree of accuracy that will be accepted as scientifically credible. Credible analytical results allow stakeholders to compare your program results with those of similar programs; and, they allow you to make comparisons over time to demonstrate whether or not the program results have been sustainable.

Aggregating Data

You will want to consider whether you should analyze all of your data together (aggregated) or whether it should first be separated into natural groupings (disaggregated) prior to each analysis you carry out.

In the case of body weight, it is clear that other client characteristics might influence the interpretation of the results. For example, what constitutes "normal" when determining if a person is overweight or not, will vary by the client's gender (male or female), age, and height. The taller a person is the more they can weigh before being considered overweight. Similarly, the older a person is the more they would be expected to weigh for a given height up to a point. Then in older ages, they may be expected to decrease in both height and weight for a variety of reasons. Finally, males of the same age and height of a female would be expected to weigh more due to their generally heavier "body build".

Such biological differences could complicate your ability to fairly describe your client population if it included men and women of varying ages. For this reason, it would be reasonable to consider separating, or disaggregating, your client data on the basis of these factors (gender, age, and height) prior to analyzing the data. There are pros and cons to disaggregation. The more groups you have, the more analyses you will have to perform. However, you should end up with more precise results that enable more accurate comparisons with the same groups — as trend monitoring over time (i.e. before and after

the program); or, comparisons with results on similar groups involved in other programs.

While disaggregating the data can increase the accuracy of the results, at the same time, the more groups you have, the larger your initial sample size will have to be to assure that you have enough clients in each group. If this is a problem, but the number of groups cannot be decreased to achieve larger numbers per group, alternative sampling designs (such as cluster sampling, and stratified sampling) should be considered.

To complete the example of client weight changes, one solution would be to group clients by gender and broad age group (adult [≥18 years] and adolescent [<18 years]), and to then characterize each group by height. This would allow descriptions of the following major groups: adult males, adult females, adolescent males, and adolescent females. Each group would be further characterized on the basis of height by providing the measures of central tendency for height [range, median height, and mean height).

Multivariate Analyses

More sophisticated analyses can be conducted if you have the ability to easily manipulate your data, such as by using a computer and statistical software. These make it easier to consider more than one variable at the same time. We've touched on this in the above example involving weight by using one or more variables (e.g. gender and age) to enable the disaggregation of the database into natural groups prior to analyses. You should do this anytime you expect that groups (e.g. women and men) may react differently to the issue under consideration, or if you think that the factors that influence client outcomes might vary on the basis of the client's group (e.g. gender, age category).

For example, women with small kids may have more difficulty participating in your program due to lack of childcare. On the other hand, men may not be attending the program at the expected levels for a very different set of reasons. If you have the ability to separate your clients into groups based upon their gender, then you can do the analysis separately for males and females and then compare the findings to see if your expectations were correct.

Other variables that you might consider when running such multivariate analyses include the client's race or ethnicity, tribe, whether the client is employed, is able to read and write, primary language, owns a car, has medical insurance, or has access to public transportation. Clearly, if you are targeting young adult women and don't provide child care service while the mother is participating in the program, then you would expect lower levels of participation. You would also expect those young adult women who are able to attend the program to be "different" from those with the kids who could not attend. A multivariate analysis would allow you to consider if this "logical" explanation is supportable by the data.

For example, if you were to do an analysis of only young adult women in your program and then described the proportionate distribution based on marital status and number of kids they have; and, if you developed the measures of central tendency for household

income, you could then compare the findings with the county-level census data for similarly aged women of similar race/ethnicity in that geographical area to see if your impressions are verifiable. If such a comparison reveals that the census profile for young adult women in the county indicates higher rates of marriage, more kids, and lower household income levels than your young adult female clients, then this suggests that those not attending are probably more likely to be married, have more kids, and have a lower income level than your clients. This would help you make the case to your stakeholders that perhaps you need to add a free on-site childcare service so you can attract and serve more of this high interest target population.

It is important to capture all the information for your evaluation analysis right from the beginning of your program – you cannot analyze data that you did not collect. The list of all the data elements that you will need for the analysis should be developed during your evaluation planning phase. While specific answers to questions or actual measurements are important, the demographic elements (like birth date, age, gender, marital status, race/ethnicity, tribe, primary language, education level, household income, employment status, etc.) are equally important.

As in every other phase of the evaluation, be sure to keep your stakeholders informed of the plans and progress of the data analyses and findings. There is almost always more analysis that you could do, but it is important to know when you have done enough. When you have answered the priority questions and looked at the most likely relationships in your data, you should seek feedback from your stakeholders on these preliminary findings and draft recommendations. Accept their critiques and discuss their concerns in order to assure that you are being fair with your data and that the stakeholders' interests have been considered and addressed, then move on.

Analyzing Qualitative Data

Analyzing qualitative data is a whole different process. It involves reading through the data and noting the things people talked about. From there, you develop categories that allow you to organize similar quotes together. For example, if the issue is identification of program weaknesses from the clients' perspectives, you would go through your data and "code" the text according to the categories you came up with. Finally, you would rearrange your data, by hand or by computer, to organize it by code so you can see what patterns emerge. Text may be listed under more than one code, and additional codes can be added as you go.

Sometimes, this process of pulling things apart can blur important information about the context in which your program operates or a client lives. A way to protect against this is to tell the whole story (called a "case study") of a few key clients so your audiences and the analysis team can remember how these results fit into the larger rhythm of the client's life and community.

If you want to be even more thorough in your coding and analysis, you can use a computer software program or can hire someone to help you with this. Either way,

because qualitative analysis involves personal interpretation more than quantitative analysis does, it's important that you:

- Are clear and up front about any inherent biases among the analysis team members so you can take steps to minimize their impacts.
- Maintain a chain of evidence so someone reading your evaluation report can understand how you reached your conclusions.
- Have others code and analyze the same data to find where and why differences in coding and analysis emerge -- any differences may warrant discussion in the results.
- Compare your quantitative findings with your qualitative results to see if similar trends are emerging – any differences may warrant discussion in the results report.
- Get feedback on your findings early: Choose some of your key stakeholders (including program clients) to "check" your findings. Does your interpretation of the data seem correct to them? Is it easy to understand? If not, you may need to go reconsider how you arrived at your conclusions.

In some cultures, the process of taking apart a story or comment provided by another is not appropriate. This may mean that the sections of text fields you code for categorizing will need to be large. Even in cultures where this is not such a direct issue, it is still important to think through how to will maintain the "voices" of those who have provided the data. This can be challenging when you also need to maintain anonymity of the sources. Table 5 describes the more common types of qualitative data analysis.

Table 5. Types Of Qualitative Data Analysis.

ANALYSIS TYPE	DESCRIPTION	EXAMPLE
Supporting Quotes	Based on what you find in your quantitative data, hunt through your qualitative data for supporting quotes.	Of those clients taking the class for weight loss purposes, 93% stated that the program was 'very helpful' or 'somewhat helpful.' A participant commented, 'You know, I never really thought about how much of my cooking is something like frying up greens with ham hocks. Everything goes good with frying! I've lost a few pounds just from cutting back on the cooking fat. That's what I liked about this class – learning how to cut the fat but still eat what I grew up with.'"
Analysis-by-Hand	Based on your evaluation questions and other ideas that come up as you read your qualitative data, develop codes for categories in which to group your quotes to help see patterns. Mark up your transcripts using the codes then cut up your text and	*{From a code for "increased control:"}* • "Many participants experienced an increased sense of control over their own and their family's health care from being in the program:" • "I had just about given up on going to the doctor's. Just no respect. But I learned how to hold my own there, how to get my questions answered, and it's been better." • "Yeah, I used to get all sweaty just thinking

	organize by code. (This can also be done by cutting and pasting on the computer.)	about having to talk to those guys at the hospital – especially when I was translating for one of my relatives."
Software-Assisted Analysis	Usually uses a qualitative analysis software package (such as NUD*IST) to have the computer search for items you might have missed in the hand analysis (above). For example, you can ask the computer to search and organize your text by key words or phrases related to your coded categories. The computer-based approach makes it easier to search not only for commonalities but also for differences found in your data.	*{From a search for "change":}* Many participants reported having a better understanding of how to make changes in their neighborhoods. "When we finally got everyone to come to a community meeting, we found out we all were worried about some of the same stuff. We set our minds to making some changes and, a year later, our drinking water is almost as clear as it is on the other side of town, and we won't stop there." "It's all about knowing what you want to be different and then figuring out how to change it. We had a lot of people dealing [drugs] around here. But we knew it wasn't enough just to hassle them. We had to help them connect with some good folk, some good schooling, some good jobs."

Avoid thinking through "solutions" for what you see in the data at this stage. That will come later.

As you analyze your data, you may find yourself saying: "If only we'd realized we needed to ask another question here or do some more data collection there." Make a note of these ideas as they will help you in planning for future evaluations.

When working with qualitative data, if you continue seeing the same themes and a general consistency in your analysis, then you know you are finished with the analyses and are ready to share your analysis results with your stakeholders to obtain their feedback regarding what you and they feel should be the key results themes.

Interpreting Your Data

Interpretation is the stage of the analysis where you convert your findings into understandable language for sharing with others. This is where you use the standards set up earlier to assure that the evaluation findings reflect your program and stakeholder interests. Whenever possible, you want your team to reach consensus, where all are in agreement, about the analysis findings. Though time consuming, this will help to produce the strongest interpretations possible.

You need to be able to describe to others the analytic methods used when sharing the results. For example, the story from Hawaii shows that one person's interpretation can be incorrect if that person doesn't understand the cultural context. It is critical that the evaluation report include sufficient explanations of contextual issues so those who read the reports are not misled. Having a Native Hawaiian to assist in interpreting the clients' responses would have helped the non-Hawaiian to understand this unique community.

Before attempting to interpret your results, take time to describe the context of your community, organization and program. Describe what your program does, who does it, how it is done, who the clients are, the resources available, and the conditions in which the program operates. Then you can begin to describe what the evaluation has revealed about the programs performance and whatever problems and/or constraints have been identified and how they may have hurt program implementation. It is essential that your community partners be actively involved so your program's story is told fairly and accurately.

You are now ready to begin interpreting your evaluation results. Again, it's important to keep in mind which "standards of success" you have selected for judging your results. Based on those standards, begin formulating conclusions from what the data tell you. Below are some questions that may help guide you in this process.

- How did your clients change in terms of knowledge, attitudes, and behaviors?
- How did organizations/systems change in terms of internal culture, staffing, protocols, policies, laws, etc.?
- Are these changes in line with your standards?
- Did some clients and/or systems change more than others? If so, why?
- If changes took place, were they because of your program? What else may have caused these changes?
- What contributed to your meeting your standards? How can you use this learning?
- What took away from your meeting your standards? How can you use these insights?
- How has your organization and/or community been enhanced, due to the program?
- What other important issues has your data revealed?

Consider grouping the relevant data analyses (quantitative and qualitative) under the appropriate question to help in organizing your thoughts. Remember, some findings will be considered "positive" and others "negative" under each question. Some may have had no change at all and remain neutral.

As you begin to draft answers to your evaluation questions, seek feedback on your interpretations from your stakeholders. It's important to help them distinguish between their feelings about the findings/interpretation ("I don't like hearing this!") and their questioning of its accuracy. The mainstream culture is very measurement-oriented and expects objective data assessments and interpretations, but you may have stakeholders who expect things to be measured "their way". Remember that <u>objectivity must be</u>

maintained if the credibility of your efforts is to be assured. By involving stakeholders at all stages of the evaluation process, they will appreciate the benefits to be gained from identifying operational challenges so they can be addressed and resolved.

In addition to addressing your evaluation questions, the following are other questions to ask as you proceed with interpreting your analyses:

- Do the results of your analyses make sense?
- Are there any surprises?
- What are some possible reasons for these surprises?
- Have you highlighted all of your successes? How about failures?
- Did your data collection possibly skew your data? If so, how?
- Did your data analysis possibly skew our data? If so, how?
- Which results do you feel most sure about? Least sure about?
- What additional data would you need to fully understand your program and its results?
- What did you not manage to capture in your data that you think is also happening? How could you better address this in the future?
- How might these findings help to improve your program? What would you want your program to do differently in the future?
- How might these findings help to improve future evaluations? What would you want to do differently in future evaluations?

It is important to realize when your interpretation has gone far enough. Your goal is to maximize the benefits of the evaluation, including demonstration of program successes, documentation of challenges, and development of recommendations for program improvements. Once this has been accomplished to your stakeholders' satisfaction, then the final step will be to finalize and distribute the evaluation report.

Keys To A Strong Interpretation Of Evaluation Findings

For a strong interpretation and understanding of your findings:

1. Don't assume that a few success stories will make a strong case for a successful program. Stakeholders will want to see that there are broad effects from your program and a sense that the cost of the program is in proportion to the number of clients served and the scope of their positive changes.

2. Don't assume that all positive changes you have found are the result of your program alone. There are so many things going on within communities that may also influence the health and well being, knowledge, attitudes and behaviors of your program's clients. These other influences can be both positive and negative. Since most analyses can't prove that your program single-handedly accounted for the positive results, it is important to talk about this in the evaluation report.

3. Don't assume that all your data collection methods, data collectors, and data sources are giving you equally strong or accurate information. There are many reasons for misinformation, so documented efforts to assure data quality (continuous quality

assurance monitoring; validation of data collected; validation of data entry into computer files) need to be addressed in the report along with a frank discussion of known data limitations.

4. Don't assume that your program's results in one community will be repeatable if the program is applied to another community. Remember, the strength of your program is the empowerment of the community in the planning and operation of your program. Each community needs a similar opportunity to join in planning the nature and implementation strategies to assure their own interests and values are also respected and built into the program, perhaps with adaptations. Each community is unique.

Recommendations

To get the most out of your evaluation efforts, you should include at the end of your evaluation report very specific recommendations that are solidly based in the evaluation results and designed for to help enhance program operations and outcomes. The recommendations should meet the following basic characteristics:

- Be timely;
- Be practical, including sensitive to program resource limitations and the community's culture/context and values;
- Be specific, to the point, and stated in a minimum of words;
- Use language that is easily understood by all; and,
- Provide the specific reason, based upon evaluation findings, for each recommendation.

Be aware that these are simply recommendations. It will be up to the program management team and stakeholders to receive the evaluation report and then determine what, if any, follow-up actions will be taken. For those operational constraints that directly limited the ability to answer specific evaluation questions, you will want to recommend corrective actions – this may involve retraining program staff to assure that they are adhering to program protocols so at the time of the next evaluation, you will have the documentation needed that may have been found to be incomplete or missing. Other corrective actions may require a commitment of new resources, such as hiring additional staff, purchase of additional equipment, or relocating clinics or offering them at more client-friendly times. Recommendations of this type require program management consideration and support before implementation.

However, regardless of the follow-up actions that may or may not be taken, use the last evaluation report as the basis for the next evaluation planning process. This way, you will have an opportunity to document the results of those actions acted upon. For those recommendations that were not acted upon, you will have another opportunity to consider the issue and inform program management of the current status – "resolved", "condition unchanged", or "condition has worsened and should be reconsidered".

Acknowledgments

Be sure that you include in the finished evaluation report an acknowledgement of those who have provided key support in the evaluation process. Keep in mind that this has been a participatory process that you want to be sustained and encouraged, so be sure to include your community partners and other stakeholders. This may be as simple as a few lines of text acknowledging the support provided; but, it would be helpful to actually include a listing of the members of the evaluation committee, including each member's affiliation. This not only provides a richly deserved pat-on-the-back for those who have worked so hard during the process; but, it also documents those directly involved in the evaluations in case there is an interest in revisiting some of the findings and recommendations.

CHAPTER 7: HAVE WE DONE IT RIGHT? HOW GOOD IS OUR EVALUATION?

> *"A standard is a principle mutually agreed to by people engaged in a professional practice, that, if met, will enhance the quality and fairness of that professional practice."*
>
> Joint Committee on Educational Evaluation

Now that you have gone through the *CENTERED Evaluation Guide* and, have been successful in planning an evaluation for your program, you might wonder what the criteria are for determining the quality of that evaluation. Standards have been developed by the American National Standards Institute (ANSI) and endorsed by the American Evaluation Association and other professional organizations.

As a quick review, the basic steps of the program evaluation process should already be part of a CBOs routine work. For success, both the evaluator and the CBO need to:

- Meet regularly with the community partners and other program stakeholders;
- Define with the community partners and other stakeholders the program's goals;
- Assess whether the program's activities are helping to achieve those goals;
- Ask questions that help in good decision-making relative to use of resources;
- Collect, analyze, and interpret program data;
- Assess program success based on expectations and program performance; and,
- Share managerial decisions, and the rationale that led to them, with the CBO's governing board, community partners, and with other key stakeholders.

If these steps are being taken by your CBO, then "informal" evaluation is already a routine part of your managerial process. Evaluation standards against which to compare what you are already doing (or plan to do) in evaluating your program will help you to decide if the evaluation is well-designed for optimizing the likelihood that your program will be successful. Compliance with the standards will assist in assuring that the evaluation process is sound, fair, and practical.

The following are thirty standards recommended by the Joint Committee on Educational Evaluation that have been adapted for application to community-based public health programs. Compare your evaluation plan with these standards and then refine your evaluation plan as needed to assure that:

- It meets your needs;
- Is "doable";
- Is both legal and ethical; and,
- Is capable of producing the accurate and credible results your stakeholders need.

EVALUATION STANDARDS CHECKLIST

(Based upon recommendations from the Joint Committee on Educational Evaluation)

UTILITY STANDARDS: To ensure that the evaluation meets stakeholder needs.

- ❑ Stakeholder Identification: So their needs can be assessed and addressed.
- ❑ Evaluator Credibility: To assure the trustworthiness and competence needed to achieve maximum credibility and acceptance of the evaluation findings.
- ❑ Information Scope and Selection: Selected to develop the set of information needed to answer the questions about the program as posed by the stakeholders.
- ❑ Values Identification: A careful description of the perspectives, procedures, and rationale used to interpret the evaluation findings.
- ❑ Report Clarity: The evaluation report should clearly describe the program evaluated, including its context, and the purposes, procedures, and findings.
- ❑ Report Timeliness and Dissemination: Significant findings and evaluation reports should be disseminated to intended users in a timely fashion.
- ❑ Evaluation Impact: Evaluations should be planned, conducted, and reported in ways that encourage stakeholders to use or otherwise act upon the findings.

FEASIBILITY STANDARDS: To ensure that the evaluation is realistic, prudent, diplomatic, and frugal.

- ❑ Practical Procedures: Program disruptions are minimized while information needed to do a credible evaluation is obtained.
- ❑ Political Viability: The evaluation values the different perspectives of diverse interest groups, enables their participation and seeks their cooperation, and strives to avert efforts to curtail evaluation operations or to bias or misapply the findings.
- ❑ Cost Effectiveness: The evaluation must be efficiently conducted and produce the information requested by stakeholders about the programs performance/success.

PROPRIETY STANDARDS: To ensure that the evaluation is conducted legally, ethically, and with due regard for the welfare of those involved in or affected by the results.

- ❑ Service Orientation: The evaluation addresses and effectively serves the needs of the full range of targeted participants and stakeholders.
- ❑ Formal Agreements: Agreement in writing of the obligations of all formal parties involved in the evaluation (what is to be done, how, by whom, and by when).
- ❑ Rights of Human Subjects: The evaluation is designed and conducted to respect and protect the rights and welfare of human subjects.

- ❑ Human Interactions: Evaluators (and program staff) are expected to respect human dignity and worth in all interactions with others associated with the evaluation, so participants are not threatened or harmed by the evaluation process.
- ❑ Complete and Fair Assessment: The evaluation should be complete and fair in its examination and recording of program strengths and weaknesses, so program strengths can be built upon and problem areas addressed.
- ❑ Disclosure of Findings: The full set of evaluation findings and pertinent limitations are made accessible to those affected by the evaluation, and to others with expressed legal rights to receive the results.
- ❑ Conflict of Interest: Conflict of interest is dealt with openly and honestly.
- ❑ Fiscal Responsibility: The evaluator's allocation and expenditure of resources reflect sound accountability procedures and is prudent and ethically responsible.

ACCURACY STANDARDS: To ensure that the evaluation will reveal and convey technically adequate information about those features that determine program merit.

- ❑ Program Documentation: The program is described and documented clearly and accurately.
- ❑ Context Analysis: The context in which the program exists is examined in enough detail, so that its likely influences on the program can be identified.
- ❑ Described Purposes and Procedures: The evaluation purposes and procedures are monitored and described in enough detail, so they can be identified and assessed.
- ❑ Defensible Information Sources: The sources of information used in the evaluation are described so the adequacy of the information can be assessed.
- ❑ Valid Information: The information gathering procedures should be chosen or developed and then implemented so they will assure that the interpretation arrived at is valid for the intended use.
- ❑ Reliable Information: The information gathering procedures should be chosen or developed and then implemented so that they will assure that the information obtained is sufficiently reliable for the intended use.
- ❑ Systematic Information: The information collected, processed, and reported is systematically reviewed and any errors found corrected.
- ❑ Analysis of Quantitative Information: Quantitative information is appropriately and systematically analyzed so that evaluation questions are effectively answered.
- ❑ Analysis of Qualitative Information: Qualitative information is appropriately and systematically analyzed so that evaluation questions are effectively answered.
- ❑ Justified Conclusions: The conclusions reached are explicitly justified, so stakeholders can assess them.
- ❑ Impartial Reporting: Reporting procedures guard against distortion caused by biases of any party to the evaluation, so that the report fairly reflects evaluation findings.
- ❑ Meta-evaluation: The evaluation itself should be evaluated against these and other pertinent standards, so that its conduct is appropriately guided and, on completion, stakeholders can closely examine its strengths and weaknesses.

CHAPTER 8: EVALUATION SUPPORT RESOURCES

The first line of resources that you should consider are people from the community you serve. Actively recruit community members for the evaluation team. You may be surprised to find that among the local accountants, teachers, administrators, healthcare workers and business men and women within the community, there are people with skills relevant to evaluation who may be excited to have an opportunity to help your program. If you get out the word that you need help and value community involvement, they may well become active program volunteers.

Next, be sure to ask lots of questions and to acknowledge your appreciation for the community's insightful input into the consensus mapping process. As you proceed, and as the community sees their input valued and incorporated into the developing maps, others will begin to join the effort so their perspectives will also be heard and included. The process of trust building has started.

You should clearly understand what is going on, even if not in detail yet. You or your evaluation team leader should facilitate the process, assuring that all perspectives have an opportunity to be heard; and, assuring that once heard and discussed, the consensus views are accurately reflected in the maps as they emerge.

Technical evaluation resources that have been developed in recent years may be useful for helping you to frame your efforts and raise essential questions for discussion. Some sources are designed for those who are new to evaluation, while others include information and discussions for more advanced participants. This wealth of information about conducting program evaluations is easily and quickly accessible. We will not attempt to replicate or replace these, but will guide you to them for complementary readings.

As you review the variety of support resources, find what meets your needs and fits your style. Then use them. No one can ask the questions that you and your team can about your program. You have the "big picture" understanding and perspective that will enrich the evaluation. Remember the purpose of your program evaluation is not to put your team on trial. Rather, it is a tool for you to use to better your program and to document your successes for sharing with the stakeholders.

When searching for information about specific evaluation or research topics, your local public and university libraries are good places to start. The reference librarian can answer questions and help you get started in your search. Books, periodicals, scholarly journals, and the World Wide Web are possible sources of for information on evaluation.

This chapter should help you to find your way to the myriad of evaluation resources that are available. Situations in the community are always unique, so no one resource will directly answer all your questions. Be persistent!

ONLINE EVALUATION GUIDES

The World Wide Web is a collection of documents or "web pages" that vary in their amount of information, accuracy, and relevance. Searching the web can be a quick and easy way to find connections among issues, get background information, and discover others who share your interests. Most libraries have computers connected to the web for use by the public. Check with your library to find how to get connected and for valuable instruction on searching for information on the web.

There are a number of web sites with online user-friendly guides and resources to help you plan and implement a realistic evaluation. Topics covered typically include: choosing an appropriate design, identifying stakeholders, designing survey questionnaires, collecting and analyzing data, and utilizing findings. A variety of online resource guides to evaluation are identified below as "web pages". For a more complete and continually updated list of resources, visit the *CENTERED* Project's web site at **www.scdhec.net/centered** and click on resources. Explore and learn.

The ***Community Toolbox*** is an excellent resource web site developed by the **University of Kansas Work Group on Health Promotion and Community Development**. Like other sites, it contains a guide to performing evaluations. What sets it apart is its wealth of other resources and guides. These include information on community assessment, promoting community participation, strategic planning, building organizational leadership capacity, conducting advocacy campaigns, and improving marketing skills. The web site address is: **ctb.ku.edu**

The **Outcomes Measurement Resource Network** is a **United Way of America** initiative to assist local organizations in improving the quality and positive impact of their programs. It is intended to help organizations transition from a focus on program activities to a focus on program outcomes. Located online, it offers a list of publications, videos, training kits, and an online resource library. One of its most relevant publications is *Measuring Program Outcomes: A Practical Approach*; this is a step-by-step handbook that teaches non-profit organizations how to identify, measure, and report program outcomes and use that information properly to improve programs. An especially useful feature is the frequent use of real case studies and hypothetical organizations to demonstrate how to apply the methods taught. The web site address is: **www.unitedway.org**

The **Centers for Disease Control and Prevention (CDC)** offers a listing of online Logic Model Resources as part of its **Evaluation Working Group** resources. These materials will be very helpful during the program description phase of your evaluation process: **www.cdc.gov/eval/resources.htm#logic%20model**

The site also lists Step-By-Step Manuals for use in evaluation. The web site to access the manuals is: **www.cdc.gov/eval/resources.htm#manuals**

Other sites of interest from the CDC Evaluation Working Group include "Ethics, Principles, and Standards", "Organizations, Societies, Foundations, Associations", and "Planning and Performance Improvement Tools": **www.cdc.gov/eval/resources.htm**

The W.K. Kellogg Foundation. *Evaluation Handbook* – This guidebook provides a clear description on how to develop different types of logic models (activities, outcomes, concepts, etc). Published January 1998; Battle Creek, MI.: **www.wkkf.org**

The University of Wisconsin's Program Development and Evaluation Unit provides training and technical assistance that enables Cooperative Extension campus and community-based faculty and staff to plan, implement and evaluate high quality educational programs. The program development process is captured in a model that includes situational analysis, priority setting, program action - the logic model - and evaluation: **www.uwex.edu/ces/pdande/evaluation/evaldocs.html**

The **National Science Foundation's** *User-Friendly Handbook for Mixed Method Evaluations* is intended for individuals or organizations working on research or educational projects and contains useful information on developing an evaluation that will answer whether or not project goals were met: **www.ehr.nsf.gov/EHR/REC/pubs/NSF97-153/start.htm**

The Food and Agriculture Organization of the United Nations, Sustainable Development Department/Research, Extension and Training Division, *Improving Agricultural Extension: A Reference Manual*, Chapter 11 – "Evaluating Extension Programmes", David Deshler, Cornell University, Ithaca, New York, 1997. Chapter 11 explains starting the evaluation, avoiding self-sabotage, focusing the evaluation and setting limits, selecting methods for evaluation as well as data collection, and interpreting the findings. Also of particular relevance are the sections on the politics of evaluation and how to identify stakeholders: **www.fao.org/docrep/W5830E/w5830e0d.htm**

The Evaluation Assistance Center-Western Region-New Mexico Highlands University, *Evaluation Handbook*, Judith Wilde, Suzanne Sockey, Albuquerque, NM, December, 1995. The purpose of this document is to offer more advanced information for the "how to's" of a good evaluation. It is divided into five sections each with its own appendix, however, the appendices are not available online: **www.ncbe.gwu.edu/miscpubs/eacwest/evalhbk.htm**

ONLINE CDC EVALUATIONS FOR SPECIFICALLY TARGETED PROGRAMS

The **Centers for Disease Control and Prevention** offers a variety of evaluation materials for disease-specific programs. Besides offering information and techniques for evaluating specific types of programs, these sites cover a number of general evaluation issues such as engaging communities in participatory evaluation, etc. CDC's Evaluation Working Group homepage is **www.cdc.gov/eval.**

Other CDC Web sites include:
Framework for Program Evaluation in Public Health. CDC developed this framework for program evaluation to ensure that amidst the complex transition in public health, we will remain accountable and committed to achieving measurable health improvements: **www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm**

Introduction to Program Evaluation for Comprehensive Tobacco Control Programs, Chapters included are: "Engage Stakeholders", "Describe the Program", "Focus the Evaluation Design", "Gather Credible Evidence", "Justify Conclusions", "Ensure Use of Evaluation Findings", "Share Lessons Learned with Executive Summary", "References" and a "Glossary": **www.cdc.gov/tobacco/evaluation_manual/contents.htm**

Evaluation Manuals--Coordinated School Health Programs. This manual can be used to help develop and institutionalize coordinated school health programs (CHSP) at the state and local levels. It contains information on the need for CSHP infrastructure; why the CSHP infrastructure development process should be evaluated; process elements for CSHP infrastructure development; progress indicators for each process element; and worksheets for documenting the CSHP infrastructure evaluation process. **http://www.cdc.gov/nccdphp/dash/publications/infrastructure/index.htm**

Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs--CDC-NCHSTP-DHAP-IRS-PERB. This manual describes various strategies that can be used by health departments to collect, analyze, report, and use Guidance data. These strategies reflect the collective experience and wisdom of health department staff gleaned during the first year of Guidance implementation. CDC acknowledges that there is no one way to implement the Guidance and developed this manual to help consider a variety of approaches to conducting Guidance activities. This manual is intended to stimulate health departments to enhance their systems for implementing the Guidance. **www.cdc.gov/hiv/aboutdhap/perb/guidance.htm**

Physical Activity Evaluation Handbook. This CDC resource outlines six basic steps of program evaluation and illustrates each step with program examples. Appendices provide information about physical activity indicators, practical case studies, and additional evaluation resources. **www.cdc.gov/nccdphp/dnpa/physical/handbook/index.htm**.

ETHICAL CONSIDERATIONS FOR PROGRAMS AND EVALUATIONS

Although our health programs are designed to do "good", sometimes conflicts arise between the good of the individual and the good of the community. Online web sites that can help you work through or prevent such conflicts include the following two:
www.cdc.gov/eval/resources.htm#ethics
www.nih.gov/sigs/bioethics/
These sites have information to help frame your thinking about ethical dilemmas, guide you in the protection of people who participate in your programs (as subjects in the evaluation), and offers standards for release of evaluation reports.

HEALTH DISPARITIES, RACIAL MISCLASSIFICATION, RACISM, AND ETHICAL ISSUES IN HEALTH IN THE USA

Facing the Challenge of Racism and Race Relations is one resource that may help your community guide its efforts to facilitate dialogue and action around racism. For further information, visit the web site at: **www.studycircles.org**

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www.communityinitiatives.com/article2.html

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Takeuchi DT. "Race as a separate and independent factor in children's mental health status"—(Part of a panel on Health Service: Access, Quality, and Diversity; Surgeon General's Conference on Children's Mental Health) **www.surgeongeneral.gov/cmh/childreport.htm**

Thoroughman DA, Frederickson D, Cameron HD, Shelby LK, and Cheek JE. "Racial misclassification of American Indians in Oklahoma State surveillance data for sexually transmitted diseases." *American Journal of Epidemiology.* Jun 15; 155(12): 1137-41, 2002.

American Nuclear Guinea Pigs: Three Decades of Radiation Experiments on U.S. Citizens. Report prepared at the Subcommittee on Energy Conservation and Power of the Committee on Energy and Commerce – Document 0707035, a.k.a. "The Markey Report"; 1986. **http://tis-t.eh.doe.gov/ohre/ roadmap/overview/070350/6.html.**

Wallerstein N. "Power between evaluator and community: research relationships within New Mexico's healthier communities", *Social Science and Medicine* 1999; 49:39-53.

Western Regional Center for the Application of Prevention Technologies, "Building a Successful Prevention Program": **www.open.org/~westcapt/ev2.htm.**

DO-IT-YOURSELF EVALUATION GUIDES

If you are not required to do an evaluation for funding or other purposes, but would like to know how your program is doing, **Horizon Research** has published a guide to help you. It explains how to examine your methods of operation to determine whether they are providing the quality of activities and services you intended. It is entitled, *Taking Stock: A Practical Guide to Evaluating Your Own Programs*. It is applicable to a wide range of community-based organizations, from small to large, and it uses many real-world examples and case studies that engage the reader and make the subject matter more relevant to everyday activities. It is available online in PDF format or copies can be ordered: **www.horizon-research.com/publications/stock.pdf.**

The University of North Carolina's *Measure Evaluation* is committed to coordinated, cost-effective approaches in data collection, monitoring and evaluation of population health and nutrition services worldwide. It includes topics such as monitoring and evaluating HIV/AIDS programs, maternal health programs and quality of health care services: **www.cpc.unc.edu/measure**

The Institute for Healthcare Improvement (IHI) is a not-for-profit organization driving the improvement of health by advancing the quality and value of health care. It offers a free monthly newsletter on *Continuous Improvement*: **www.ihi.org.**

University of Arizona. Evaluation Tool Kit for Community Health Workers – available on CD-ROM.

ANALYSIS SOFTWARE

CDC offers free downloads of **EPIINFO** statistical software. EPIINFO assists in the development of surveys, computerization of survey responses, data analyses, graphics, and mapping. Associated tutorials on the use of EPIINFO are also downloadable from CDC at: **www.cdc.gov/epiinfo.**

Analysis of qualitative information: **NUD*IST** or **N**on numerical **U**nstructured **D**ata **I**ndexing **S**earching and **T**heorizing software, is a robust and reliable program, appropriate exclusively for qualitative research analysis. This software is a good choice for simple analyses, such as text transcripts from focus group summaries or open-ended survey data to more complex theory construction and analysis. It is designed to automate much of the tedious work associated with qualitative data analysis, by auto coding signified text data, importing table data and using command files to regulate analysis processes: **www.nursing-informatics.com/qsr1.html**

GENERAL HEALTH INFORMATION

If you need information about selected diseases or conditions, or want to see how your community or client population compares to the rest of the nation, or want to learn what assistance is available to CBOs, the following links should be helpful.

If you would like to know how your community is doing in terms of its health, start with the **Community Health Status Indicators Project**. It was formed through collaboration between the US Health Resources and Services Administration (HRSA), the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the Public Health Foundation. You can review online data for each of the over 3,000 counties in the US for a wide variety of health indicators. This is an invaluable resource for comparing your community with others around the country; and, for finding data to help support funding applications or encourage community assistance:
www.communityhealth.hrsa.gov/searchCounty.asp

The National Center for Health Statistics, MEDLINEplus is a web site created by the National Library of Medicine, the world's largest medical library, to provide users with information on all types of medical topics. If you click on "Health Topics", and then on "Population Groups", you will find sub-categories of information targeted towards specific population groups. For example, going to the "African American" population group will take you to a page with resources on nutrition, prevention, specific diseases and conditions, organizations, news, and statistics, all focused on African American health issues: **www.nlm.nih.gov/medlineplus**

If you are looking for detailed, authoritative information on a diverse array of demographic, social, and health indicators for special interest populations in the US, one of the best places to start is at the **US Census Bureau's** web site. At the "**Minority"** (see glossary) **Links** page you can select one of the four major population groups and then view specific information on that group. Types of information available for each group include racial and ethnic demographic data down to the county level, disability data, and access to health insurance, income and poverty levels: **www.census.gov/pubinfo/www/hotlinks.html**

The World Health Organization's (WHO) Statistical Information System **(WHOSIS)** is a guide to health and health-related epidemiological and statistical information available from the WHO and elsewhere. Most WHO technical programs make statistical information available through linkages from this web site. You also have the possibility to search by keywords within the WHOSIS or throughout the entire WHO web site: **www3.who.ch/whosis/menu.cfm**

GOVERNMENT RESOURCE LINKS

Selected government sites for information on programs, services, funding opportunities, and initiatives include:

A central location to find federal, state, and local government online information and web sites: **www.firstgov.com**

The **US Department of Health and Human Services** (US-DHHS): **www.hhs.gov**

The National Initiative to Eliminate Racial and Ethnic Health Disparities: **http://raceandhealth.hhs.gov**

The U.S. Census Bureau State Data Center Program: www.census.gov/sdc/www

The Federal Office of "Minority" (see glossary) **Health: www.omhrc.gov**

The Health Resources and Services Administration (HRSA**): www.hrsa.gov**

The home page of the **Healthy People 2010**, a national campaign to bring together all levels of government, non-profit organizations, community groups, professionals, and the private sector to achieve objectives such as reducing health disparities, increase years of healthy life, and increase access to health services**: www.health.gov/healthypeople**

The home page of **the Centers for Disease Control and Prevention: www.cdc.gov**

UNITED NATIONS ORGANIZATION'S WEB SITES

The World Health Organization (WHO): **www.who.int/en**
The United Nations Children's Fund (UNICEF): **www.unicef.org**
The United Nations Joint AIDS Control Program (UNAIDS): **www.unaids.org**
The United Nations Development Program (UNDP): **www.undp.org**
The United Nations Office on Drugs and Crime (UNODC): **www.unodc.org/odccp**
The World Bank Group: **www.worldbank.org**

PROFESSIONAL ORGANIZATION'S WEB SITES

American Evaluation Association (AEA): **www.eval.org**
American Public Health Association (APHA): **www.apha.org**
Coalition For Healthier Cities & Communities: **www.healthycommunities.org**
National "Minority" (see glossary) Aids Council: **www.nmac.org**

ONLINE REPORTS ON EVALUATION

Framework for Program Evaluation in Public Health. Evaluation Working Group, Centers for Disease Control and Prevention. MMWR 1999; 48, No.RR-11:1-40 Sept 17, 1999: **www.cdc.gov/eval/framework.htm**

Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin. A chart book prepared by Council of Economic Advisors for the President's Initiative on Race. Web site has PDF file with chart book, and spreadsheets with data for all the indicators discussed in the chart book: **w3.access.gpo.gov/eop/ca/index.html**

Racial and Ethnic Disparities: Key Findings from the National Survey of America's Families, Urban Institute: **newfederalism.urban.org/html/series_b/b5/b5.html**

An Evaluation Framework for Community Health Programs. Center for the Study of Community Based Public Health. June 2000. Center for the Advancement of Community-Based Public Health (funded under a CDC funding supplement through the University of South Carolina's Prevention Research Center and the *CENTERED* Project [aka SIP25PR 1999; CDC Cooperative Agreement No. U48/CCU409664-07]: **www.cdc.gov/eval/evalcbph.pdf**

World Health Report 2000 Health Systems: Improving Performance. World Health Organization, June 2000: **www.who.int/whr/2002/en/**

REFERENCES USED IN THE PREPARATION OF THE *CENTERED EVALUATION GUIDE*

To better understand the theory and practice of evaluation, a review of the relevant literature in the field was conducted by the *CENTERED* Project. The references given at the back of *The CENTERED Evaluation Guide* were found to be very useful for helping the Project's participants to develop a fuller appreciation of program evaluation, how it has developed, and its applications to community-based public health programs. These references can be accessed through your local public library, university library, or the Internet.

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GLOSSARY

AMERICAN COLLEGE OF EPIDEMIOLOGY: A voluntary society of epidemiologists established to set standards for professional epidemiologists, including a professional code of ethics. [The American College of Epidemiology's web site is: www.ace.org].

AMERICAN NATIONAL STANDARDS INSTITUTE: The **A**merican **N**ational **S**tandards **I**nstitute is a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system. The Institute's mission is to enhance both the global competitiveness of U.S. business and the U.S. quality of life by promoting and facilitating voluntary consensus standards and conformity assessment systems, and safeguarding their integrity.

ACTIVITIES: Events or actions that take place.

AEA: The **A**merican **E**valuation **A**ssociation is a voluntary society of professional evaluators.

BIAS: A deviation of results or inferences from the truth; any trend in the collection, analysis, interpretation, publication, or review of data that can lead to conclusions that are systematically different from the truth.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS): An ongoing, CDC-funded, state-administered, annually conducted survey that produces representative state level profiles of adult health-related behaviors (i.e. smoking, nutrition, exercise, self reported history of ever having been diagnosed as having diabetes, heart disease, etc). The BRFSS data is available from the CDC web site at www.cdc.gov/brfss.

BRP: The national **B**lue **R**ibbon **P**anel of evaluation and community-organization experts developed to serve as advisors to the *CENTERED* Project.

CBOs: **C**ommunity **B**ased **O**rganizations.

CBPH: **C**ommunity **B**ased **P**ublic **H**ealth – a strategy for improving the level of health of a community that is driven by the community at all phases (planning, implementation, and evaluation).

***CENTERED*:** A CDC-funded special interest project (1999 SIP25PR) committed to building the evaluation capacity of CBPH programs that are targeting elimination of racial and ethnic disparities in health. *CENTERED* is an acronym that stands for: **C**ommunity-based **E**valuation **N**etworks **T**argeting **E**limination of **R**acial and **E**thnic **D**isparities. The *CENTERED Project* web site is http://www.scdhec.net/hs/epi/centered.

CDC: The **C**enters for **D**isease **C**ontrol and Prevention – that part of the federal Department of Health and Human Services that supports disease prevention and control through public health applications.

COMMUNITIES OF COLOR: African–Americans, Asian-Americans, Hispanic/Latino Americans, Pacific islanders, Native Americans, and Alaskan-Natives.

CONTROL SUBJECTS: Persons similar in nature to your target population, but not enrolled in your program – controls are used to determine the rates of outcome occurrence among persons similar to your program clients, but who have not had the services provided by your program.

DATA TYPES:

Nominal: Unscaled descriptive categories, such as: male, female; urban, rural; African American, Hispanic, American Indian, Asian/Pacific Islander, White).

Ordinal: Relatively scaled categories, such as: <5, 5-9, 10-14, 15+; categories can be organized into rank order, but differences between categories are not measured.

Interval: Measured using a standardized scale so differences are also measurable, such as: height, weight, temperature, blood pressure, etc.

DHHS: The federal **D**epartment of **H**ealth and **H**uman **S**ervices. The federal lead agency in matters related to health. The agency includes the National Institutes of Health, the Food and Drug Administration, and the Centers for Disease Control and Prevention.

ENABLING ENVIRONMENT: Conditions under which the probability that your program will succeed is enhanced.

EVALUATION: The systematic collection, analysis and reporting of information about a program for the purpose of assisting in operational decision making.

EVALUATION TYPES:

Formative – evaluations conducted early in a program to assess processes and program implementation.

Summative – evaluations conducted at the end of a program to inform decisions about a program's worthiness for continuation or expansion.

EVALUATOR TYPES:

Outside (a.k.a. external or independent): Contracted from an outside agency or organization to conduct the evaluation.

Internal: A staff member charged with the responsibility for evaluations.

FACING THE CHALLENGE OF RACISM AND RACE RELATIONS: www.studycircles.org.

HEALTHY PEOPLE 2010 (HP2010): The DHHS initiative to improve access to health care and eliminate health disparities -- **http://www.health.gov/healthypeople**.

IMPACTS: Community level changes attributed to program effects may be positive or negative.

INCIDENCE: The rate of occurrence of new cases of the issue of interest during a stated period of time (generally one year) among a defined population. Incidence is calculated by dividing the total number of new cases within the community by the total number of persons at risk within that community. Incidence rates are generally expressed as numbers of cases per 100,000 population.

INDICATOR: Indicators are pieces of information (for example: your body temperature, and "how you feel") that reflect some larger system (in this case: your general health). Their function is to communicate something about the system without having to spend significant amounts of time and resources seeking comprehensive, detailed information about that system.

INFORMATION TYPES:

Qualitative: Information in the form of text or descriptions, such as interview responses, which are characterized by measurements on a nominal scale or ordinal scale (see Data Types).

Quantitative: Information in the form of numerical quantities such as measurements or counts, which are characterized by measurements on an ordinal or interval scale (see Data Types).

INFORMED CONSENT: A process by which persons in the process of being recruited to participate in studies/evaluations are advised of the study/evaluation and given opportunities to question the proposed nature and extent of that participation and the relevant consequences for themselves and for others; their options are described to them and they are asked to consider granting their consent to participate and to allow the requestor(s) to utilize information provided by them for the specific purposes stated.

INPUTS: The resources invested in the program (money, time, effort, commitment).

INSTITUTIONAL RACISM: The differential access to the goods, services and opportunities of society by race that has been codified in societal structures, processes and values (Jones C, 2000).

INTERNALIZED RACISM: The acceptance by members of the stigmatized "races" of negative messages about their own abilities and intrinsic worth (Jones C, 2000).

INTERVAL DATA: See **DATA TYPES**.

IOM: The **I**nstitute **O**f **M**edicine, that component of the National Academy of Sciences that deals with health issues.

LOGIC MODEL: An illustration of the steps that you will follow to achieve your target goal; it illustrates the anticipated chain of events that will link your community's planning and program implementation efforts (**inputs**) to its activities and services (**outputs**) that are intended to produce desired objectives (client **outcomes**) and goals (community level **impacts**).

MEAN: The mean is the mathematical "average" of a set of observations/measurements. The mean is calculated by adding up all observations/measurements and then dividing by the number of observations/measurements. (See Chapter 6).

MEASURES OF CENTRAL TENDANCY: Mean, median, and range of observations/measurements. (See Chapter 6).

MEDIAN: The "middle-most" in a set of observations/measurements; for an odd number of observations/measurements, when the data are arranged in rank order the median is literally the number in the middle (i.e. in a set of nine observations arranged in rank order, the median observation would be the fifth observation in that series); for an even number of observations/measurements, when the data are arranged in rank order the median value is determined by adding up the two middle-most observations and then dividing the sum by two (i.e. in a set of ten observations arranged in rank order, the median observation would be calculated by adding up the values of the fifth and sixth observations and then dividing that sum by two). (See Chapter 6).

"MINORITY": Often used to refer to non-White persons or communities. This term is not used in this document except when it appears in the name of an agency that has incorporated it into its name or web site. Its continued application to racial/ethnic communities of color has been found to be demeaning and to perpetuate a negative stereotype.

MMWR: **M**orbidity and **M**ortality **W**eekly **R**eport – a weekly publication of the US Public Health Services Centers for Disease Control and Prevention (Atlanta, GA).

NIEHS: **N**ational **I**nstitute of **E**nvironmental **H**ealth **S**ciences (that branch of the National Institutes of Health dealing with environment and its influence on health).

NOMINAL DATA: See **DATA TYPES.**

ORDINAL DATA: See **DATA TYPES.**

OUTCOMES:

- **LONG-TERM (Community Level):** Those benefits or changes in community level indicators (i.e. levels of knowledge, attitudes, behaviors, physical conditions, or health – including the prevalence/incidence of risk behaviors [such as rates of regular exercise, smoking, good nutrition patterns] and disease, use of healthcare services [such as hospitalization or use of emergency department services], and mortality) that occur over longer periods of time – for program activities to affect community level indicators often takes years.

- **MEDIUM-TERM (Client Level):** Those benefits or changes in individual client indicators (i.e. behavior, physical condition, or health) that occur over time as a result of participation in your program's activities.

- **SHORT-TERM (Client Level):** Those immediate benefits or changes in individual client indicators (i.e. knowledge, attitude, and skills) that occur as a result of participation in your program's activities.

OUTPUTS: The products, services, or activities produced.

PATHWAYS: An abbreviation for an early *CENTERED Project* publication, *Pathways to Community Based Evaluation* (February, 2000; available from the *CENTERED* web site at www.scdhec.net/hs/epi/centered).

PEOPLE OF COLOR: Refers to non-White people, including African-Americans/Blacks, Asians, Hispanic/Latinos, Pacific Islanders and Native Americans.

PERSONALLY MEDIATED RACISM: The differential assumptions about the abilities, motives, and intents of others by "race"; differential actions towards others by "race"; resulting in prejudice and discrimination (Jones C, 2000).

PRC: **P**revention **R**esearch **C**enter: One of the centers across the United States funded by CDC's National Center for Chronic Disease Prevention's Prevention Research Center's Program to be a leader in prevention research. Funding for the *CENTERED Project* came through the University of South Carolina Prevention Research Center located within the USC School of Public Health.

PREVALENCE: The rate of existing cases of the issue of interest at a given period of time ("point" prevalence) or during a stated period of time ("period" prevalence; generally one year) among a defined population. Prevalence is calculated by dividing the total number of existing cases (old and new) within the community by the total number of persons within that community. Prevalence rates are generally expressed as numbers of cases per 100,000 population.

PRIMARY DATA: Data that you collect yourself.

PROJECT ADVISORS: Persons who provided input into the *CENTERED Project* on an as needed basis as deemed necessary by either the Project Investigators, CDC, or the Blue Ribbon Panel.

PROJECT INVESTIGATORS: Persons included by name in the grant as part of the core investigative team. Over the course of the *CENTERED Project* there have been four Co-Principal Investigators (one from SC-DHEC and three from the University of South Carolina Norman J. Arnold School of Public Health's Prevention Research Center.

QA: Quality **A**ssurance – refers to an ongoing data/process monitoring effort to provide assurances of adherence to program protocols and operating procedures, acceptable data quality, and to provide early warnings to assist program management in early identification and resolution of potential problems.

QUALITATIVE DATA: Data collected from interviews, surveys, stories that helps to describe contextual issues (see Chapters 5 & 6).

QUANTITATIVE DATA: Data collected through measurements or counts (see Chapters 5 & 6).

RACISM – see "institutional racism", "personally-mediated racism", and "internalized racism".

RACIAL EQUITY INDICATORS: Relative rates developed by dividing the rates of event/disease occurrence among one racial/ethnic group by those rates for another racial/ethnic group. Racial equity indicators enable a single number description of the relative rate (also known as the "health disparity gap") to enable monitoring of the size of the disparity gap over time. The national *Healthy People 2010* goal is to eliminate racial/ethnic disparity gaps by the year 2010 – ideally, with the elimination of racial and ethnic disparities in health the racial equity indicators would indicate relative rates at or near 1.0 – indicative of having achieved racial equity for the subject event or disease.

REACH: The **R**acial and **E**thnic **A**pproaches to **C**ommunity **H**ealth Program, a CDC-funded set of CBPH projects that are targeting elimination of health disparities.

RFP: **R**equest **F**or **P**roposals – one mechanism for use in obtaining bids from potential independent evaluators interested in supporting your evaluation efforts.

SC-DHEC: The **S**outh **C**arolina **D**epartment of **H**ealth and **E**nvironmental **C**ontrol, the agency responsible for planning and implementing the *CENTERED Project.*

SECONDARY DATA: Data collected by others to which you have access.

SIP: **S**pecial **I**nterest **P**roject, a category of research grants funded by CDC's Center for Chronic Disease Prevention and Health Promotion through the CDC-funded Prevention

Research Centers located at major universities around the nation, including the University of South Carolina, School of Public Health.

STAKEHOLDER: A person, organization, or agency/institution either involved in or affected by your program.

STUDY SUBJECTS: Persons who are enrolled in your program and receiving program services.

SURROGATE OUTCOME INDICATORS: Alternative outcome indicators that are used in evaluations in place of indicators that may be either too rare, too expensive, or too difficult to measure in a timely manner (i.e. while HIV incidence may be the indicator chosen, one might decide instead to use the incidence of other common sexually transmitted agents, such as Chlamydia or Gonorrhea as surrogate outcome indicators for determining if a condom promotion campaign was effective at reducing "STD" incidence with the target community. If the desired changes can be demonstrated using the surrogate indicator).

TEMPORAL TRENDS: Patterns of occurrence or measurement as they occur over time for a specific health/behavioral indicator when measured at predetermined time intervals. For example, if a client is trying to lose weight through participation in your program, you will want to weigh the client when they enter the program and then reweigh the client at regular intervals, such as weekly or monthly, to see not only if weight is being lost, but to also document the client's weight at specific points in time so comparisons can be made between client weight and program activities or such other outcomes as the client's involvement in a series of nutritional self-help classes, or participation in a routine exercise program. Temporal trends provide the basis for analyzing whether it is reasonable to attribute changes in the target indicator(s) to the efforts of your program.

USC: **U**niversity of **S**outh **C**arolina, home of South Carolina's School of Public Health and the Prevention Research Center – together with CDC and SC-DHEC, USC is a *CENTERED* core agency partner.

YOUTH RISK BEHAVIOR SURVEY (YRBS): An ongoing, CDC-funded, state-administered, survey conducted every 2-years and produces representative state level profiles of adolescents (in grades 9-12) regarding health-related behaviors (i.e. smoking, nutrition, exercise, sexual behaviors, etc). The YRBS data is available from the CDC web site at www.cdc.gov/yrbs.

APPENDIX

IF THE SHOE FITS … About the Author: Donald Clayton Wheeldin

Donald Clayton Wheeldin was born in 1914, in Hartford Connecticut. Next to youngest of six, he spent his childhood and youth there and in New Rochelle, New York. His was a close-knit family which stressed the values of education for both sexes and active church participation. In addition a love of involvement in music was an important aspect of family life. A strapping young man, he was active in sports especially.

Coming to manhood in the thirties, he became involved in labor and human rights causes. These movements were particularly in the forefront in the Great Depression Years. He still, to this day, has a keen interest in the human condition and in particular, the need for affordable housing.

During World War II Don served in the U.S. Navy in the Pacific as a medical corpsman, and on discharge, moved to Los Angeles, in 1946 settling in Watts and later Pasadena. He became a writer and a columnist for the L.A. People's World and worked for the L.A. Legal Journal, and for several years was also active in the Carpenters' Union, both as a member and a leader. The thrust of his work continued to be in the human rights environment. After the Watts riots in 1965, a consortium of churches arranged for prominent leaders -- among them, Don Wheeldin – to hold public hearings on the problems of the black community. He subsequently designed and taught courses in black history both at the University of Southern California and at Fresno State University, and wrote a black history outline. He has also qritten reviews for the newsletter of Industrial Relations Center at the California Institute of Technology. He continues to be active in Pasadena community affairs, having served on may boards and commissions, and is regarded today as one of the spokespersons for the black community.

From, "If The Shoe Fits …"