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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“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?

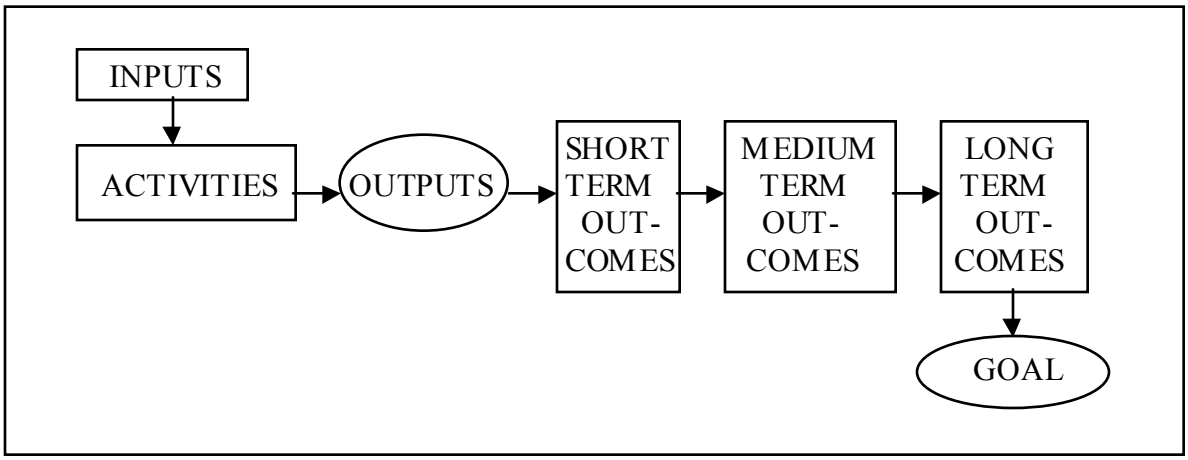
What Are You Going To Measure?

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.