Some Experiential Lessons in Supporting and Evaluating Community-Based Initiatives for Preventing Adolescent Pregnancy

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Adolescent pregnancy is a major public health concern in the United States, with more than 1 million pregnancies to adolescent females annually (Alan Guttmacher Institute, 1994). According to the 1995 administration of the Youth Risk Behavior Survey (Kann et al., 1996), approximately 66% of high school age youth report engaging in sexual intercourse, with less than 50% using condoms and 25% using birth control pills. Teenage childbearing has several negative outcomes for the mother and her children, including low educational attainment due to dropping out of school, poor health, low-birth weight...

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infants, and poor job prospects resulting in poverty (Dryfoos, 1990; Hays, 1987; Santelli & Beilenson, 1992). Furthermore, considerable financial costs to communities are associated with having children during the teenage years (Maynard, 1996).

Risk for adolescent pregnancy is associated with multiple factors, including limited or incorrect information about sexuality and contraceptive methods, little access to contraceptives, poor school performance, and limited life options (Dryfoos, 1990; Santelli & Beilenson, 1992). Prevention strategies include sexuality education curricula, peer support and education, school-based programs, and youth development activities (Dryfoos, 1990; Kirby, 1997; Santelli & Beilenson, 1992). Furthermore, comprehensive community-based initiatives involving multiple interventions delivered through a variety of community sectors (e.g., schools, health organizations, and the faith community) are seen as promising approaches (Brindis et al., 1997; Dryfoos, 1990; Kirby, 1997; Santelli & Beilenson, 1992). A growing science of community health promotion (Fawcett et al., in press) is complimented by expanding experiential knowledge of this work.

The authors’ experiences with the School/Community Sexual Risk Reduction Replication Initiative (Paine-Andrews et al., 1996, 1999) for the prevention of adolescent pregnancy provide the context for this article. The Initiative was a 4-year (1993–1997) replication effort to implement a multicomponent school and community-based project (Koo, Dunteman, George, Green, & Vincent, 1994; Vincent, Ciarie, & Schluchter, 1987) in three Kansas communities (Geary County [Lewis et al., in press], Franklin County, and selected areas of Wichita). A support and evaluation team was composed of researchers at the University of Kansas and the model originator at the University of South Carolina. Kansas Health Foundation, a philanthropic organization whose mission is to improve the health of Kansans, provided the funding for this Initiative. Each community received approximately $400,000 over the 4-year period to implement the Initiative. The university research and support teams combined received approximately $700,000 over a 5-year period (1992–1997) to support and evaluate the three community Initiatives. The university teams were also brought in early to assist with the grant-making process. Grant funds were used primarily to cover personnel to implement the projects at the community level as well as provide technical assistance and evaluation support.

The mission of the Initiative was to reduce adolescent pregnancy through implementation of the school/community model (Koo et al., 1994; Paine-Andrews et al., 1996, 1999; Vincent et al., 1987). The broad health objectives were to reduce adolescent pregnancy, postpone the age of first intercourse, and for those young people who chose to be sexually active, increase use of contraceptives. Community alliances among different sectors within the community formed the foundation for the Initiative. The major components of the intervention consisted of comprehensive, age-appropriate K–12 sexuality education, sexuality education for teachers (e.g., graduate training in sexuality education, teacher inservices, and workshops), access to health services (e.g., extending clinic hours to accommodate student schedules, increasing the number of free condoms distributed by the local health department), involvement of the faith community (e.g., implementing "True Love Waits"), use of mass media (e.g., billboards, radio public service announcements), peer support programs (e.g., support groups and mentoring programs), parent-child communication about sexuality issues (e.g., workshops, special events), and alliances among all sectors of the community to create programs, policies, and practices to reduce risk for adolescent pregnancy.

Preliminary findings from the evaluation of the Initiative from 1993 to 1997 suggest positive changes in reported sexual intercourse and use of condoms and estimated pregnancy and birth rates among adolescent females (Paine-Andrews et al., 1999). Although significant changes have taken place since the termination of grant funds from Kansas Health Foundation, the Initiative remains in place in each community (Paine-Andrews, Fisher, Campuzano, Fawcett, & Berkley-Patton, 1999).

This article describes recommendations with illustrative examples associated with implementing, supporting, evaluating, and sustaining the School/Community Initiative for preventing adolescent pregnancy. We close with implications for multicomponent school and community partnerships.
TABLE 1
Fifteen Recommendations Associated With Implementing, Supporting, Evaluating, and Sustaining Community Initiatives for Preventing Adolescent Pregnancy

1. Engage people with life experience in the problem of teen pregnancy in local efforts.
2. Hire a skilled, knowledgeable, and committed team to oversee the support and evaluation of a community initiative for prevention of adolescent pregnancy.
3. Ongoing staff development sessions and education/awareness for community members are necessary to heighten understanding of sexual growth and development needs of children, adolescents, and families (i.e., repetitive, sequential, and continuing education, especially for key leaders).
4. When possible or feasible, involve the originator of a successful model for prevention of adolescent pregnancy in defining key components and elements of the initiative to promote model fidelity in a replication effort.
5. Search for, and build on, indicators of community readiness to address prevention of adolescent pregnancy.
6. Expect and counteract resistance to controversial prevention efforts.
7. Facilitate project implementation through planning for small wins.
8. Seek common ground while finding complementary contributions.
9. Tailor implementation of model components to reflect local needs, assets, and concerns.
10. The lead agency should recruit collaborators to implement program components when political pressure or policy restrictions limit their involvement.
11. Take a broad view in addressing adolescent health and development.
12. Become a resource for school personnel and work together to create acceptable changes in the school environment.
13. Gather information and provide feedback to promote progress toward objectives and inform local decision making.
14. Use community-level indicators, intermediate outcome, and qualifications about the data to help understand (and improve) the work.
15. Provide ongoing technical assistance for planning for and securing financial sustainability of community initiatives.

RECOMMENDATIONS FOR THE WORK
This section provides recommendations associated with implementing, supporting, and evaluating an initiative for the prevention of teen pregnancy. It is based on our experiences and lessons learned from working with each other and with the three sites of the Initiative. The recommendations described in this article (and outlined in Table 1) are those most closely linked with work in teen pregnancy prevention.

Process of Generating Lessons Learned
The experiential lessons and associated recommendations were captured during small group retreats and individual meetings among representatives of community initiatives, foundation staff, and a university research team. In addition, semistructured interviews were conducted with site staff, key partners, and other volunteers. These meetings and semistructured interviews were part of the technical assistance and evaluation process. The process involved open discussion around several broad areas of experience, including leadership, planning and implementation, and evaluation and technical assistance. University research staff encouraged and facilitated discussion around each of the areas. Semistructured interviews with key partners involved questions around events that were critical in the development of the initiative, strengths and challenges, lessons learned, and future directions. Written summaries and illustrative examples of lessons learned were generated by and shared among coauthors. This report is a culmination of these discussions, conversations, and draft reports.

Some Specific Recommendations
Recommendations associated with implementation, evaluation and technical assistance, and sustainability are described below.

Recommendation 1: Engage people with life experience in the problem of teen pregnancy in local efforts.

Personal experience with adolescent pregnancy, or the factors that put individuals at risk for it, brings a needed level of understanding to the work and those it serves. In one community initiative, the assistant director was a former teen mother. She was able to relate to many of the issues the young women were facing and
give them advice and assistance based on her experiences. If project staff do not have these types of life experiences, it is important to recruit mentors and role models with relevant life experience. It is also very important to provide models for youth with which they can identify. All three sites formed teen panels that included teens who practiced abstinence and teen parents. Teen panelists talked with their peers about their choices and the outcomes. One site included teen parents on their steering committee to help maintain youth focus and perspective.

Recommendation 2: Hire a skilled, knowledgeable, and committed team to oversee the support and evaluation of a community initiative for prevention of adolescent pregnancy.

The Kansas Health Foundation, the funder of the Initiative, also invested in a university-based research and support team to provide technical assistance and implement a comprehensive evaluation for the Initiative. This foundation investment provided a structure of support for the Initiative, which included a projectcodirector (the project originator served as the other codirector), one full-time staff person (coordinator for site development), and three part-time graduate research assistants. The project codirectors, full-time staff, and graduate students maintained communication with the sites through personal visits, phone, fax, and frequent e-mail contact. The project codirectors also kept the Technical Review Committee (an expert panel that reviewed proposals and semiannual site status reports) and the foundation informed of the status of the project. The support team provided technical assistance in a variety of areas, including leadership, planning, implementation, and institutionalization. The team established strong relationships with site staff that provided a foundation on which to build on current knowledge and skills and make suggestions for model implementation. Among the responsibilities of the support team was to organize bimonthly meetings among staff from all three sites. These meetings were used as an opportunity for information or idea exchange, support, and mini-in-services. Furthermore, monthly onsite visits with individual site staff provided an opportunity for specific consultation on current successes, issues, and challenges.

The project codirectors and full-time coordinator for site development played a unique role in the Initiative because they worked with all three sites. This allowed for greater exchange of information, resources, and lessons learned among sites, the support and evaluation team, the foundation, and the Technical Review Committee.

Recommendation 3: Ongoing staff development sessions and education or awareness for community members are necessary to heighten understanding of sexual growth and development needs of children, adolescents, and families (i.e., repetitive, sequential, and continuing education especially for key leaders).

Americans are inundated with sexual messages and in reality receive vast quantities of sex education. Yet, few citizens have received formal sexuality instruction, and too many are misinformed about the sexual growth and development needs of children, adolescents, and families. In addition, much of the learning conveys a sex-sin connection, creates guilt feelings, and promotes self-gratifying exploitative relationships with others (Calderone, 1966).

Each initiative worked diligently to promote understanding among all citizens about the normalcy and goodness of human sexuality as a significant positive aspect of life. Consistent with guidelines from the Sexuality Information and Education Council of the United States (SIECUS), understanding human growth and development, relationships and commitments, interpersonal skills in communication and decision making, sexual behaviors, sexual health problems, and the sexual values, societal and cultural influences on human sexuality were deemed by the support and evaluation teams as important educational content (National Guidelines Task Force, 1991; Vincent & Pfefferkorn, 1994). Each initiative provided educational sessions in community forums, special classes for adults and parents, small group sessions with youth, and training sessions for agency and school professionals to meet the mission and objectives of the Initiative. Project staff received training in human sexuality prior to their work with community members, including completing graduate level courses in sexuality with local teachers. Staff must have a solid grasp of sexuality content and the comfort level to facilitate learning with individuals of all ages, school personnel, agency stakeholders, and the community at large.

Staff also used the media to create additional educational opportunities. The preparation of monthly newsletters, published newspaper columns, public service announcements, the reporting of special events and/or
services, and participating in national campaigns (e.g., Teen Pregnancy Prevention Week) encouraged greater community awareness and understanding of the issue. Consistent with the emphasis of the initiative on community alliances, media resources consisted of local donations and in-kind support. Overall, there was a very positive response from media representatives. Educating the community about sexuality and the purpose or intent of the intervention is a never-ending and continuing aspect of a community-based teen pregnancy preventing intervention.

Recommendation 4: When possible or feasible, involve the originator of a successful model for prevention of adolescent pregnancy in defining key components and elements of the initiative to promote model fidelity in a replication effort.

As a project codirector, the originator of the school/community model was actively involved throughout all phases of the Initiative. His assistance in drafting the Request for Proposals, clarifying the components and elements of the model, and identifying the dimensions of successful implementation allowed for informed implementation and replication of the model in Kansas. Throughout all phases of the Initiative, regular consultation with Dr. Vincent permitted ongoing conversations about how the model was implemented in South Carolina, the lessons learned, and strategies for implementation in Kansas. His expert counsel allowed for more informed and educated implementation (and adaptation) of the Initiative. As noted earlier in this article, Vincent also received resources from Kansas Health Foundation to help guide the Initiative and promote fidelity to the school/community model for prevention of adolescent pregnancy.

Recommendation 5: Search for, and build on, indicators of community readiness to address prevention of adolescent pregnancy.

The leadership skills of project staff and local acknowledgement (and data) of the problem of adolescent pregnancy were key variables in implementation and evaluation of the Initiative. The enthusiasm, commitment, and focus of site staff were critical in engaging local communities to form alliances necessary for implementation of a comprehensive school and community initiative for prevention of adolescent pregnancy. Staff teams at each site had complementary skills—although staff turnover resulted in gaps at certain points throughout the initiative—which fostered the community engagement needed for model implementation.

The availability of local data on the level of the problem (e.g., estimated pregnancy rates and reported sexual activity among young people) not only allows for a reasonable evaluation of the impact of the Initiative but suggests that community members recognize the problem and may be willing to take action. For example, it is likely that in communities where local data on risk and protective factors for adolescent health issues are not available or are limited, readiness needed to take substantial action to address current levels of adolescent pregnancy may not exist (Hawkins & Catalano, 1992).

Recommendation 6: Expect and counteract resistance to controversial prevention efforts.

Some strategies to prevent adolescent pregnancy often elicit opposition from community members and organized groups at both local and national levels. For example, although strategies that support abstinence seem to be widely accepted, those for increasing contraceptive access among sexually active youth may be vigorously opposed. It is important to expect, plan, and prepare for opposition when working with a program to decrease teen pregnancy. Each initiative faced opposition to their prevention efforts. Three prominent opposition tactics (deflection, denials, and deception [Altman, Balcazar, Fawcett, Seekins, & Young, 1994; Nagy, Fawcett, & Berkowitz, 1998]) and responses from the sites are described below.

Deflection was used to oppose efforts in each site. Deflection is an action or event intended to mislead someone. Groups opposing the projects' prevention efforts tried to turn the debate to other issues, such as from contraceptive access to family values. Staff responded by reframing in terms of common ground: Keeping our young people safe and healthy is consistent with strong family values. Staff also used personal contacts with project supporters to affirm the project’s commitment to family values.

Denials of the potential benefits of the project were also very common. Groups opposing enhancement of school K-12 sexuality instruction, for example, consistently voiced the concern that providing more information about sex and contraceptives would actually have negative effects, making sexual intercourse more likely. Deception tactics attempted to confuse people by misrepresenting current evidence for prevention
research. To counteract denial and deception, staff of one site secured data about the issue and community support for addressing pregnancy prevention. For example, a telephone survey showed that 91% of community members surveyed were in favor of sexuality education in the schools (Lewis, Paine-Andrews, & Custard, 1997). Survey results helped to shatter myths about widespread support for K-12 sexuality education. It countered local opponents who asserted that the majority of people did not want sex education in their schools and felt that it would increase sexual intercourse among young people. In another community, staff recruited supportive community members to attend school board meetings to defend improvements in the sexuality education curriculum. Staff familiarity with current prevention research and associated strengths and weaknesses of studies helped in attacks on various sexuality education curricula.

It is also important to plan for how to decrease the threat of opposition toward the projects' more controversial prevention strategies. Staff must be skilled in working with opposing groups, including being able to engage in positive and meaningful discussions, defend their cause, and communicate what prevention interventions can and cannot do. Furthermore, it is important to engage informed supporters from the community to speak out against those opposing the project. Finally, using a variety of innovative strategies will help to deflect some of the opposition. For example, despite support from some students and teachers, the schools tried to limit staff discussions about contraceptive use and making condoms available on school grounds. Because one of the model components included increasing access to contraceptives, project staff had to be innovative in how they increased access. One site worked with the school-linked clinic, and the staff nurse made school presentations; another site collaborated with Planned Parenthood; and the third engaged the county health department and pharmacists (Fisher, Ransom, Harris, Paine-Andrews, & Pulliam, 1998) to increase access to contraceptives and health services. Forging alliances among key partners concerned about adolescent pregnancy prevention, including alliances among young people and project staff, helped soften the impact of opposing forces.

Recommendation 7: Facilitate project implementation through planning for small wins.

Implementing modest but successful projects early in the life of an initiative can motivate collaborators to invest energy in bringing about more difficult changes. These early successes—or small wins—may be particularly important with comprehensive efforts because implementing some model components (e.g., K-12 sexuality education) may be time consuming and controversial. In one site, for example, implementing a youth survey of reported sexual activity proved to be extremely controversial; project staff and volunteers spent approximately 18 months to secure support from the four school districts in the county. Staff and volunteers were drained and pessimistic. Fortunately, they implemented a number of other program components simultaneously. For example, site staff started support groups, created a bike safety program to teach young children decision-making skills, and hosted a number of after-school activities. At the community’s request, another site started to address other salient adolescent health issues such as gang violence. Each accomplishment helped the project and staff to gain credibility and acceptance in the community. Early successes can demonstrate to community members the project’s potential for furthering broadly held purposes and intentions of the project (i.e., enhancing the health and wellness of young people, their families, and the community at large).

Recommendation 8: Seek common ground while finding complementary roles.

Adolescent pregnancy is an issue that surfaces fundamental differences in the values and beliefs about what is healthy adolescent development and how best to support it. Less controversial program components, if made highly visible, can demonstrate the project’s compatibility with local community values. For example, in one site, a small minority of community members wrongly accused the project of performing abortions in the project office. Regular communication of small positive contributions, such as publishing a monthly newsletter with family communication tips or hosting community meetings and an open house helped alleviate community members’ fears about the project and its purposes. Using the mass media to publicize project goals, activities and values helped to gain project acceptance. When public meetings deteriorated into a competition of whose values and beliefs are moral,
project staff sought common ground by reminding people that their ultimate goal was the same: to reduce teen pregnancy as part of a larger effort to improve health and development among young people.

Project staff also used public debates and private conversations (with supporters and opponents) to remind community members that every person—no matter their particular values and beliefs—has something important to contribute to adolescent health and development. One project encouraged those individuals who believed in abstinence-only options to implement abstinence-based programs and worked with other allies to increase access to contraceptives for young people who are sexually active. For example, in one community, a local church implemented abstinence-only sexuality education, while the local youth clinic increased efforts to provide access to contraceptives for sexually active young people.

Recommendation 9: Tailor implementation of model components to reflect local needs, assets, and concerns.

Although the major components of the school/community model were implemented, the elements of each component differed in each community. Varied implementation reflected differences in local contexts. Although the original school/community model was demonstrated in a rural South Carolina community, the Kansas sites offered a quite different set of urban, rural, and military communities.

Each project necessarily adapted core components, such as contraceptive access, to fit local needs. For example, in the original model (Vincent, 1987, in press) Medicaid reimbursement was used to help provide enhanced access to health services for young people, including counseling for use of contraceptives. During replication, the economic and political climates made it necessary to try a different approach to providing health services. All three sites strengthened relationships with local health providers, such as Planned Parenthood and county health departments to provide enhanced access to contraceptives and related information for young people. One site worked with staff of a school-linked clinic to change clinic policies in response to student concerns about privacy at the clinic.

Another controversial component of the model was administration of an annual survey of reported behaviors associated with sexual activity and contraceptive use among young people. All three communities had members who greatly opposed the content and phrasing of questions on the original survey. Thus, the survey that was first proposed (Vincent, 1982) was replaced with the Youth Risk Behavior Survey (1993). This survey was more acceptable to the community because it measured other locally important health behaviors, such as substance use, violence, and nutrition. The results of the survey appealed to the general community, not just those interested primarily in sexual activity and contraceptive use; it also reflected community members’ more holistic view of adolescent health. School personnel in one site used the broader array of survey data to secure additional grants in other areas of adolescent health.

Recommendation 10: The lead agency should recruit collaborators to implement program components when political pressure or policy restrictions limit their involvement.

The choice of lead agency for the project affected strategies for implementation. Political pressures and policy restrictions discouraged implementation of some model components. For example, in one community, the lead agency was the school district. Because school board members expressed concerns about the content of sexuality education, especially with regard to use of contraceptives, an abstinence focus was encouraged. To help ensure implementation of the full school/community model, project staff enlisted the support of the school-linked clinic to convey information and enhance access to contraceptives for young people. Board member concerns were further alleviated by creating a process by which community members could provide feedback and guidance on the development of the new sexuality education curriculum (Fisher, Anderson, Paine-Andrews, & Lewis, 1998).

In another site, the lead agency was an African American, grassroots family preservation organization. This community-based effort site found more challenging securing permission from school authorities to administer a survey of reported youth behaviors associated with sexual activity. By contrast, the grassroots community base allowed for innovation in enhancing access to contraceptives.

Recommendation 11: Take a broad (noncategorical) view in promoting adolescent health and development.

Youth at risk of becoming pregnant or fathering a child are also often at risk for other adolescent health
concerns such as substance abuse or violence. Thus, it is important that project staff and funders understand that it is prudent to address broader societal determinants of health and related development concerns (Fawcett et al., 1998). For example, in two of the communities, youth violence became a central issue after two youth were killed and project staff learned that female gang initiation involved group sex. Many of the students who attended support groups or educational sessions during the weeks that followed the shootings did not want to discuss teen pregnancy but instead wished to talk about youth violence. Because many of the risk factors and societal determinants overlap, project staff addressed the immediate concerns and continued discussions around teen pregnancy when youth were ready to readdress the issue. Also, all three communities found it necessary to work with teen parents to reduce secondary pregnancies. One site, for example, spawned a program in collaboration with the local hospital to prevent secondary pregnancies among teens. This type of secondary prevention is also necessary because some of the target population for new pregnancies may already be teen parents. Although focus on a targeted mission contributed to success, attention to related issues may be necessary to retain project support and credibility as advocates for comprehensive youth health and development.

Recommendation 12: Become a resource for schools and other key partners and work together to create acceptable changes in the environment.

Schools are often asked to do a variety of things for which they do not receive funding, and those choices about initiatives require a lot of time to carry out. Accordingly, to reach young people through the schools, it is important to gain support of school leadership (superintendent, principals, board members) and teachers early on and continue to seek support as leadership changes. At two sites, project staff attended in-services with school personnel to help build relationships with teachers and learn more about school policies and reporting standards. Another site collaborated with teachers to track instances of student sexuality education and keep the school board informed of the project. Political pressures may prevent schools from participating in a program that is not “abstinence only,” even if the primary objective is abstinence. Two sites struggled with school principals and school boards to allow support groups to take place during school hours and to administer a behavioral survey. Once projects showed the benefits of the survey results and support groups, along with ensuring confidentiality of the students, school personnel and parents were more accepting and supportive of project efforts.

Long-term improvements in rates of adolescent pregnancy require sustained changes in the environment that support healthy adolescent sexuality and development. Project staff worked with school personnel to create changes in the school environment that supported prevention of teen pregnancy. For example, one site director worked with teachers to implement changes in their classrooms as a model for how other teachers in the school could teach sexuality issues without offending parents. In all three sites, staff met regularly with school principals to keep them informed of project activities and about community feedback on program changes implemented in the schools.

Recommendation 13: Gather information and provide feedback to promote progress toward objectives and inform local decision making.

Two major sources of information were used to help assess progress of the Initiative, celebrate successes, and inform local adjustments. First, the comprehensive formative evaluation implemented by the university-based research team used an empowerment evaluation approach (Fawcett et al., 1996, in press). Through this evaluation site, staff gathered ongoing information about how the Initiative was functioning (e.g., member satisfaction), early accomplishments or intermediate outcomes (e.g., new or modified programs, policies, and practices consistent with the mission, sexuality education, provided to students), and changes in the bottom line (e.g., estimated pregnancy rates among females ages 10 to 19). This information was shared with the evaluation team, summarized, and discussed with site staff on a monthly basis to inform site progress. Second, a six-member team (Technical Review Committee) of national and state experts in teen pregnancy prevention and community health initiatives provided semiannual recommendations to sites based on evaluation data and narrative provided in status reports prepared by site staff. The formative evaluation provided an information base from which the expert team could acknowledge successes and make recommendations for strengthening local efforts.
Recommendation 14: Use community-level indicators, intermediate outcomes, and qualifications about the data to help understand (and improve) the work.

Many teen pregnancy prevention efforts look at estimated pregnancy rates (EPR) as their benchmark or “bottom line” indicator. Reports of progress on this community-level indicator can help initiatives to focus their efforts. Such benchmarks also allow the initiative to be accountable to funders and to the community.

There is a significant delay between implementation of an intervention and effect on bottom-line indicators, however, at best several years. This makes it necessary to secure intermediate markers to detect progress before the initiative is over. Our Work Group evaluation system tracks community and systems changes—new or modified programs, polices, and practices—to detect and feed back evidence of changes in the environment (Fawcett et al., in press).

Because the data are also limited in a number of ways, it is also important to articulate these limitations to help avoid discouragement or premature celebration. First, EPR only measures the number of females who are pregnant. This indicator does not track how many teenage males may have fathered children; although many times, these data are also available. Second, EPR is usually reported for groups of individuals, for example, females ages 15 to 19 in the county. This may be a concern if the project targets an age group outside the reported ranges (e.g., middle school youth) or a region within the reported geographic range (e.g., neighborhood) for which data are not readily available. It may be possible to work with local health departments to obtain such data (e.g., EPR by zip code or age) and discuss the strengths and limitations of the data (e.g., accuracy, changes in data collection methods, extraneous events that may influence the data) to help inform interpretations of the data. Third, EPR includes abortions that may not be consistently reported in the county or state. Although including abortion statistics in the EPR helps to counter the argument that the project “supports abortions to make the data look better,” it does expose variations in abortion levels that can fuel opponents’ criticisms.

Fourth, some older teens may be married and may not be part of the target group. If the community’s goal is preventing pregnancy among teens only if they are unmarried, consider how to tailor data to inform progress on this concern. Finally, when using EPR, remember that there will be a lag between when the project begins and when effects may be seen due to the nine months allotted for pregnancy. In addition, project start-up takes time. Staff must be hired and trained, collaborations formed, and interventions developed and implemented—often taking a year or more—before effects should be anticipated. When using EPR as an indicator, an understanding of limitations of the data will help project staff better communicate the possible effects of the project to the community. Furthermore, finding reasonable intermediate markers, such as new or modified programs, polices, and practices (Fawcett et al., 1996) consistent with the mission of the project may make possible tracking progress toward—and improving—ultimate health outcomes for young people.

Recommendation 15: Provide ongoing technical assistance for planning for and securing financial sustainability of community initiatives.

Securing financial sustainability for community initiatives is challenging. Planning for financial sustainability early on may even be more daunting. As part of our technical assistance role, the support team provided ongoing encouragement, gathered pertinent information, brought in expert consultants, linked sites with possible sources of support, and established incentives (e.g., an extra year of funding) for attention to financial sustainability. Our attempts to support local efforts to sustain the projects may have contributed to the continued implementation of initiatives at each site (Paine-Andrews et al., 1999). However, bringing the issue of long-term sustainability to the forefront remains challenging. Many individuals, organizations, and communities are used to, and perhaps comfortable with, working from grant to grant. Enhanced technical support might enable community-based organizations to institutionalize their efforts through grant funds, line item budgets of other agencies, or other strategies for institutionalization.

SUMMARY AND SO WHAT?

This article outlined 15 recommendations associated with planning, implementing, supporting, evaluating, and sustaining multicomponent comprehensive school and community-based initiatives for prevention of adolescent pregnancy. These recommendations were based on field experiences associated with an Initiative that had substantial resources for implementation at the community level as well as technical assistance and
evaluation support. When implemented with modification to suit community contexts and available resources, this guidance could help strengthen community efforts to prevent adolescent pregnancy. Furthermore, many of these recommendations may also help inform initiatives addressing other health areas such as prevention of substance abuse, chronic diseases, or HIV/AIDS. Given the controversial nature of teen pregnancy prevention and many other health issues, it is important to have insight, draw on the experiences of others, and avoid pitfalls associated with this important and challenging work.

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Empowering Community Health Initiatives Through Evaluation

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Empowerment evaluation is an evolving connection between apparently conflicting ideas. Traditional evaluation methods contribute to

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understanding (and perhaps improvement), with less emphasis on whether the capacities of those studied are enhanced by the inquiry. By contrast, empowerment evaluation offers the promise of using evaluation concepts and methods to promote self-determination (Fetterman, 1994a).

Empowerment is a core concept in the fields of community psychology (e.g., Rappaport, 1981, 1987; Rappaport, Swift, & Hess, 1984) and action anthropology (e.g., Tax, 1952, 1958). Its roots and application are also apparent in education (Freire, 1970), community organization (Mondros & Wilson, 1994), and public health (Eng, Salmon, & Mullan, 1992). Empowerment refers to the process of gaining influence over events and outcomes of importance to an individual, group, or community (Fawcett, White, et al., 1994). This construct highlights the value of individual strengths and competencies, natural helping systems, and social change (Zimmerman, in press; Zimmerman, Israel, Schulz, & Checkoway, 1992). Empowering processes and outcomes have been examined in a variety of contexts, including with children and youth (e.g., Mithaug, 1991), people with disabilities (e.g., Fawcett, White, et al., 1994), health care of minority populations (Braithwaite & Lyncott, 1989), low-income elders (Minkler, 1992), and low-income and disadvantaged communities (Fawcett, Seekins, Whang, Muiu, & Suarez de Balcazar, 1984).

Empowerment evaluation as a capacity-building process is grounded in the tradition of participatory inquiry, research, and evaluation (Choudhary & Tandon, 1988; Whyte, 1991). This tradition reflects the core values of critical theory (Gitoux, 1983), feminism (Lichtenstein, 1988), qualitative evaluation (Fetterman, 1988, 1989; Guba & Lincoln, 1989; Patton, 1980), and action anthropology (Fetterman, 1993; Stull & Schensul, 1987). Its aims are to legitimize community members' experiential knowledge, acknowledge the role of values in research, empower community members, democratize research inquiry, and enhance the relevance of evaluation data for communities. In participatory evaluation and empowerment evaluation, and some forms of intervention research (Fawcett, Suarez-Balcazar, et al., 1994), those studied help set the agenda for research, participate in collecting and analyzing data, and determine the use of the results.

Evaluation may enhance (or reduce) capacity to influence the environment, and to varying degrees. On one end of a continuum of evaluation, nonparticipatory evaluation can be completely coercive
and proscribed, without input from those whose efforts are being appraised. At the other extreme, fully participatory (or participant-controlled) evaluation can be completely initiated, designed, and administered by the community initiative. Empowerment evaluation seeks to balance the legitimate interests of the field in promoting understanding with those of communities in fostering improvement and self-determination.

Community health initiatives provide a rich context for understanding and improving the practice of empowerment evaluation. These initiatives have attempted to build community capacity to address a variety of citizen concerns, including violence (Wilson-Brewer, Cohen, O'Donnell, & Goodman, 1991), substance abuse (Falco, 1992), injuries (Davidson et al., 1994), mental disorders (Fawcett, Paine, Francisco, Richter, & Lewis, 1994), and adolescent pregnancy (Nezlek & Galano, 1993). Community health initiatives often adopt a public health framework (Fawcett, Paine, Francisco, & Vliet, 1993; Green & Kreuter, 1991), using technical assistance and evaluation to help build local capacities to address identified community concerns.

This chapter explores the concept of empowerment evaluation in the context of several community health initiatives. First, we describe a conceptual framework that our Work Group uses to guide efforts to facilitate empowerment through evaluation. Second, we identify the contexts for case studies with community health initiatives with which we have collaborated: community coalitions for prevention of adolescent pregnancy and substance abuse in Kansas and a tribal partnership for prevention of substance abuse in New Mexico. Third, we outline and illustrate the evaluation process used to empower these coalitions (a) assessing community concerns and resources, (b) setting a mission and objectives, (c) developing strategies and action plans, (d) monitoring process and outcome, (e) communicating information to relevant audiences, and (f) promoting adaptation, renewal, and institutionalization. Finally, we conclude with a discussion of the challenges and opportunities of empowerment evaluation.

Framework and Context for Empowerment Evaluation

This section outlines a conceptual framework used to guide our efforts to empower community initiatives through evaluation. We also
describe the community health initiatives that serve as the context for using this methodology for empowerment evaluation. These serve as the basis for the several case studies of the process of empowerment evaluation that follow.

FRAMEWORK FOR EMPOWERMENT EVALUATION

Guided by models of community health and development (Fawcett et al., 1993) and enabling systems for community empowerment (Fawcett, Paine-Andrews, et al., 1995), we outline a framework for empowerment evaluation. Table 8.1 displays this framework and its four distinct elements: (a) agenda setting (assessing community concerns and resources), (b) planning (establishing or setting the mission, objectives, strategies, and action plans), (c) implementation (facilitating and monitoring processes and outcomes), and (d) outcome (documenting community competence and community outcomes). Enabling activities of the support team permeate every element of this conceptual framework—agenda setting, strategic planning, implementation, and outcome. Beginning with agenda setting, an outline of each follows.

Agenda Setting. Controlling the agenda—determining the problems and solutions for consideration and possible action—is the most potent form of citizen participation (Cobb & Elder, 1972). Community initiatives set the agenda by assessing community concerns and needs, and available resources for addressing them. The community’s chosen agenda will create the context for its more specific planning efforts. To maximize community control of the initiative, the support team may prompt and provide technical assistance with assessing community concerns and resources, and gathering epidemiological data related to the identified concerns. Assessments of concerns and resources may include informal listening sessions as well as community surveys and community forums (Paine, Francisco, & Fawcett, 1994). Such agenda-setting efforts are often community-wide, with emphasis on involving underrepresented and marginalized parts of the community (Fawcett, Seekins, Whang, Muiu, & Suarez-Balcazar, 1982).

Planning. Planning is essential for an initiative to reach its goals, providing the grounding for the evaluation and related enabling
### TABLE 8.1 Framework for Empowerment Evaluation and Related Enabling Activities

<table>
<thead>
<tr>
<th>Component</th>
<th>Related Enabling Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Setting</td>
<td>1. Assessing community concerns and resources</td>
</tr>
<tr>
<td></td>
<td>2. Collecting epidemiological data (i.e., incidence and prevalence of identified problems)</td>
</tr>
<tr>
<td>Planning</td>
<td>3. Facilitating development of a vision, mission(s), objectives, and strategies</td>
</tr>
<tr>
<td></td>
<td>4. Helping develop an action plan that specifies changes in programs, policies, and practices to be sought in relevant sectors of the community</td>
</tr>
<tr>
<td>Implementation</td>
<td>5. Monitoring and providing feedback on process and outcome (e.g., rate of community change)</td>
</tr>
<tr>
<td></td>
<td>6. Helping communicate information to relevant audiences (e.g., grantmakers)</td>
</tr>
<tr>
<td>Outcome</td>
<td>7. Assessing community competence (e.g., in implementing interventions; evaluation)</td>
</tr>
<tr>
<td></td>
<td>8. Detecting community outcome (e.g., community-level indicators of impact)</td>
</tr>
<tr>
<td></td>
<td>9. Collecting qualitative information (e.g., about critical events and their meaning)</td>
</tr>
<tr>
<td></td>
<td>10. Assessing adaptation, renewal, and institutionalization of the initiative and successful components</td>
</tr>
</tbody>
</table>

Enabling activities may focus on creating a vision, setting (or adapting) the mission, establishing objectives, and developing strategies and action plans. With extensive community input, action plans specify the changes in programs, policies, and practices to be sought in relevant sectors of the community such as schools or religious organizations (see, e.g., Fawcett, Francisco, Paine-Andrews, Fisher et al., 1994).

**Implementation.** Empowerment evaluation should also facilitate implementation of the initiative's plan for achieving intended outcomes. Monitoring processes and outcomes and arranging ongoing feedback are critical enabling activities of the support team that can empower the initiatives by allowing participants to make more informed decisions and identify where to focus efforts for maximum impact (Francisco, Paine, & Fawcett, 1993). The support team also assists in communicating information about the initiative’s accomplishments (and
challenges) to relevant audiences, including community members, trustees, and current and prospective grantmakers.

**Outcome.** The community initiatives with which we collaborate strive to (a) enhance community competence to address health issues, (b) have a positive impact on health outcomes, and (c) create a structure that allows for adaptation, renewal, and institutionalization of the initiative. For example, collaboration with the original Project Freedom, a nationally recognized substance abuse coalition in Wichita, Kansas, resulted in enhanced competence in conducting interventions such as citizen-led “stings” on merchants who sold alcohol to minors (Lewis et al., 1994). The coalition facilitated community changes and improved community-level indicators related to the mission, adapting its strategic plan to reflect new opportunities and a change in leadership (Fawcett, Lewis, et al., 1994).

**Enabling Activities of the Support Team.** To maximize resources for capacity building, we join the often separated roles of technical assistance and evaluation in an integrated support system. The support team engages in a number of technical assistance and evaluation activities to enhance the capacity of community initiatives to influence valued outcomes throughout the development of the initiative. To enhance experience and competence of members of the community initiative, such as in collecting evaluation data, the support team may use informational materials, on-site consultation, or other modes of assistance. To enhance group structure and capacity, the support team may assist in developing a strategic plan, for example, using a planning retreat, regular on-site assistance, or other forms of facilitation. The support team may also enhance coalition capacity by conducting intervention research examining the effectiveness of specific interventions, such as a peer support program, using the results to strengthen the initiative (Fawcett, Suarez-Balcazar, et al., 1994). To remove social and environmental barriers to achieving intended outcomes, such as to building evaluation capacity, the support team or granting agency may provide computer systems to enable better and more efficient communication between sites and evaluators. Finally, to enhance environmental support and resources, the evaluation and support team may assist with obtaining grants and other potential resources.
and linking the initiative with local, state, and national informational resources.

The ongoing support provided to leadership and staff is often dynamic and individualized. In addition to providing information and skills building on topics that have been critical to previously successful endeavors, such as strategic planning, the support team responds to the needs of each leader and group. For example, a leader may schedule working phone calls with support team members to complete tasks she finds daunting, such as writing action plans. The support team listens to and learns from leaders, groups, and community members. Reciprocal relationships are formed. This type of support empowers leaders and initiatives to maintain progress toward achieving objectives consistent with their mission.

These elements—agenda setting, planning, implementation, outcome, and related enabling activities—outline a framework for empowerment evaluation. The process is interactive: The initiative’s objectives affect the evaluation system, and data from a system for monitoring coalition activities and outcomes may suggest the need to modify the action plan. The process is also iterative: Success (or challenges) in attaining outcomes should influence the enabling activities of the support team, and enabling activities should contribute to agenda setting, planning, implementation, and outcome. Collaboration among community leadership, the support and evaluation team, and grantmakers should contribute to the mission and to the adaptation, renewal, and institutionalization of the initiative.

COMMUNITY HEALTH INITIATIVES AS CONTEXT

We have applied our methodology for empowerment evaluation with 17 different community initiatives for health and development (Fawcett et al., 1993; Fawcett, Lewis, et al., 1994; Francisco et al., 1993). Two case studies provide the context for this report: community coalitions for prevention of adolescent pregnancy and substance abuse in Kansas and a tribal partnership for prevention of substance abuse in New Mexico.

Community Coalitions for Prevention of Adolescent Pregnancy and Substance Abuse. Three Kansas communities—one rural (Franklin
County), one urban (northeast Wichita), and one military (Geary County)—received a grant from the Kansas Health Foundation to replicate a community-wide approach to prevent adolescent pregnancy first conducted in South Carolina (Koo, Dunteman, George, Green, & Vincent, 1994; Vincent, Clearic, & Schluchter, 1987). The three sites shared the mission of involving a variety of sectors of the community such as schools, health organizations, and religious organizations in modifying programs, policies, and practices related to reducing risk for adolescent pregnancy (Paine-Andrews et al., 1994). Their main objectives were to reduce unwanted pregnancies among adolescents, postpone the age of first intercourse, increase abstinence, and, for those who chose to be sexually active, increase use of contraceptives.

Three Kansas communities—one military/prison (Leavenworth), one university (Lawrence), and one military (Geary County)—also received a grant from the Kansas Health Foundation. This was to develop and implement community coalitions for prevention of adolescent substance abuse modeled after Project Freedom of Wichita, Kansas. The three sites shared the primary mission of reducing substance use among adolescents aged 12 to 17 years. Each coalition involved key influencers and grassroots groups from different community sectors including law enforcement, schools, health, and businesses in facilitating community change related to the prevention of substance use among adolescents.

Tribal Partnership for Prevention of Substance Abuse. The Decade of Hope Coalition was developed by several members of the Jicarilla Apache tribe on their reservation in Dulce, north-central New Mexico. The Jicarilla Apache number about 3,500 and live on approximately 1 million acres of land in the San Juan Mountain range. Although the community is traditionally agrarian (raising sheep, horses, and cattle), there is currently a very high level of unemployment, with the tribe being virtually the only employer. After oil and natural gas were found on the reservation in the early 1960s, funds from their sale were distributed to tribal membership, with a resulting decline in local agriculture. Many of the tribal elders have died from alcoholism, often from exposure during the long winters.

The coalition began its work in 1989, following a rash of suicides among young tribal members. Mothers of these teens and young adults
decided that something needed to be done about the problem beyond the limited efforts of the Tribal Council. We began our involvement with this coalition near the end of 1991 when we were contacted by them to help with evaluation for a successful grant proposal to the Community Partnership Program of the U.S. Center for Substance Abuse Prevention (CSAP).

**Process of Empowerment Evaluation**

This section describes the process used to empower community initiatives through evaluation. Following Fettersman (1994b) and the framework described above, we outline six elements of the process of empowerment evaluation: (a) assessing community concerns and resources; (b) setting a mission and objectives; (c) developing strategies and action plans; (d) monitoring process and outcome; (e) communicating information to relevant audiences; and (f) promoting adaptation, renewal, and institutionalization. This is an interactive and iterative process by which the community, in collaboration with the support team, identifies its own health issues, decides how to address them, monitors progress toward its goals, and uses the information to adapt and sustain the initiative. Each aspect is described and illustrated with case examples.

**ASSESSING COMMUNITY CONCERNS AND RESOURCES**

In empowerment evaluation, the support team assists local initiatives in the initial and ongoing task of assessing local concerns and resources for change. Listening to community concerns should precede taking action; securing community input, ownership, and involvement is critical to sustaining initiatives. Support teams provide workshop sessions and on-site consultation to build the capacity of staff, leadership, and volunteers to hold listening sessions. Support teams also provide assistance with more formal needs assessments and inventories of community strengths and resources.

**Case Study With Kansas Coalitions.** Each local coalition for preventing adolescent substance abuse and pregnancy conducted listening
sessions to assess community concerns and resources for addressing their missions. The listening sessions consisted of informal public meetings in which participants identified (a) problems or issues, (b) barriers or resistance to addressing the problem, (c) resources for change, and (d) potential solutions. The listening sessions were designed to involve key leaders, people affected by the problem, and people who could contribute to addressing the problem throughout all sectors of the community. For example, the listening sessions for
the inner-city pregnancy prevention initiative in northeast Wichita involved grassroots leaders and people of color from this predominantly African American community. This included religious leaders, youth, parents, teachers, health officials, representatives from informal neighborhood groups, and other community organizations. Listening sessions continued to be held throughout the initiative to meet empowerment aims of (a) maintaining community involvement in setting (and adapting) the goals and objectives and (b) attracting volunteers to help implement the action plan.

*Case Study With a Tribal Coalition.* The coalition began its work with a social reconnaissance (or information-gathering process) conducted by local residents in conjunction with representatives from the U.S. Indian Health Service. This process involved conducting meetings with all tribal offices, as well as general meetings with community members. It resulted in identifying a number of goals and objectives for change. Members for the emerging Decade of Hope Coalition were solicited from the more vocal persons attending the town meetings, and they began to set priorities for action. With a grant from the Community Partnership Program of CSAP, a community mobilizer was hired from outside the community who took responsibility for implementing the objectives identified in the grant and mobilizing support for those activities in the community.

**SETTING A MISSION AND OBJECTIVES**

Although the mission of a community initiative may be largely defined by the granting agency, its form should be tailored to the community’s own unique vision and circumstances. The support team assists community initiatives in identifying or adapting the mission and objectives. For example, a substance abuse initiative might modify its mission and objectives to include prevention of gang-related activity; an adolescent pregnancy initiative might do the same to include reducing risk for HIV/AIDS or sexual violence. Support teams facilitate workshop sessions with staff and membership of initiatives and provide on-site consultation to review and, if necessary, adapt these aspects of the strategic plan.
Case Study With Kansas Coalitions. For the community coalitions to prevent adolescent substance abuse and adolescent pregnancy, the mission and objectives were predefined by the funding agent, the Kansas Health Foundation. The initiatives were replications of previous community initiatives that showed some success in reducing adolescent pregnancy (Vincent et al., 1987) and community-level indicators related to substance abuse (Fawcett, Lewis, et al., 1994). Each grantee agreed to adopt the mission and objectives of the initiatives upon acceptance of the grant award. As the coalitions mature, the mission statements may be modified to embrace emerging community issues. For example, following a shooting in one community, the coalition modified its objectives and action plan to reflect community concerns about youth violence and associated substance use.

Case Study With a Tribal Coalition. The Decade of Hope Coalition emerged in response to community concern about suicides among youth of the Jicarilla Apache tribe. With support from CSAP and community concern about alcoholism and related issues, the coalition expanded its embryonic mission to include prevention of substance abuse. Its specific objectives, such as to establish a reward system for tips leading to arrests for drug sales and bootlegging, flowed from this mission. Information from community-wide surveys and listening sessions helped initiatives to modify established missions and objectives and adopt new ones.

DEVELOPING STRATEGIES AND ACTION PLANS

An important task for a community initiative is to develop strategies—the general approaches, such as coalition building or advocacy, by which it achieves its mission. Action planning, that is, identifying specific community changes to be sought in each relevant sector of the community, may be particularly critical to success. We developed action planning guides to support this process with community health initiatives, including those for prevention of substance abuse (Fawcett, Paine-Andrews, Francisco, Richter, Lewis, Williams, et al., 1994), adolescent pregnancy (Fawcett, Paine-Andrews, Francisco, Richter, Lewis, Harris, et al., 1994), youth violence (Fawcett, Francisco, Paine-Andrews, Fisher et al., 1994), and chronic disease (Fawcett,
Harris, et al., 1995). These planning guides enable community initiatives to identify changes in programs, policies, and practices to be sought in schools, businesses, and other relevant sectors that are consistent with known or suspected risk factors for the concern.

*Case Study With Kansas Coalitions.* The strategies for both initiatives were, in part, predefined; the initiatives replicated a model that emphasized coalition building as the dominant strategy. Both initiatives adopted a community coalition approach and involved key influentials and grassroots leadership from different community sectors such as schools, religious organizations, and law enforcement (for the substance abuse initiative). The adolescent pregnancy prevention initiatives, however, also were required to put in place several program components that were part of the replication effort (Paine-Andrews et al., 1994). These included a K-12 comprehensive and age-appropriate sexuality education curriculum, graduate training for teachers in sexuality education, parent-child communication about sexual issues, and enhanced access to contraceptives. Strategic planning emphasized how to get the core components in place, including dealing with opposition from those who do not support sexuality education or enhanced access to contraceptives.

With support from the Work Group, each site developed action plans specific to the community, the mission, and the core program components (if appropriate). The action plans listed proposed changes in programs, policies, and practices to be sought in each sector. For example, for an adolescent pregnancy prevention initiative, the following change was proposed for the school sector: “By September 1994, adopt and implement a comprehensive K-12 age-appropriate sexuality education curriculum.” We used surveys inviting community input on the importance and feasibility of proposed changes to build consensus and set priorities for the action plan. The action plan also noted the specific steps needed to create the change, including who would do what by when. The action plans were used by coalition staff, leadership, and volunteers to keep them focused on working toward their mission. The action plans also contributed to the evaluation, identifying potential changes in the environment that served as early markers for the success of these prevention initiatives. Outside of the
proscribed core components, coalitions were free to determine their own strategies and community changes for reducing pregnancy and substance abuse among adolescents.

*Case Study With a Tribal Coalition.* We collaborated with coalition staff to involve the Dulce community in more formal strategic planning, including identifying community changes to be sought and action steps for each objective. The staff, largely members of the tribal community, led a process that was sensitive to their predominantly Jicarilla Apache culture. Coalition staff first identified appropriate community sectors, such as the Tribal Courts, schools, and health services, through which the coalition could address its mission. They then used their experiential knowledge and the planning guide for substance abuse prevention to identify potential changes to be sought in programs (e.g., develop a wilderness experience program for at-risk youth), policies (e.g., establish a preferential hiring policy for tribal members for an oil and natural gas production facility), and practices (e.g., enforce mandatory age checks for purchasing tobacco and alcohol). After an initial draft of the action plan, staff worked with the community in identifying additional changes to be sought in all relevant sectors. Through this process, the coalition gained further acceptance as a catalyst for change in the community. Evidence of its enhanced capacity was an invitation to assist the Tribal Council in developing their strategic plan for dealing with alcohol and suicide problems in tribal government and the community.

**MONITORING PROCESS AND OUTCOME**

Our Work Group’s evaluation system is used to help understand and improve how community health initiatives engage the environment and facilitate intermediate and ultimate outcomes related to the mission (Fawcett, Francisco, Paine-Andrews, Lewis, et al., 1994). Core components of the measurement system include (a) a monitoring system to assess process and intermediate outcomes (Francisco et al., 1993), (b) constituent surveys of process and outcome, (c) behavioral surveys, (d) measures of community-level indicators such as estimated pregnancy rate (for adolescent pregnancy initiatives), and (e) interviews with key participants to obtain qualitative information about
critical events. All measures are refined, collected, and interpreted in collaboration with staff and leadership of participating community initiatives.

**Case Study With Kansas Coalitions.** Both initiatives used logs to keep track of how well the initiatives were being implemented and their accomplishments. Process measures included units of service provision and actions taken to create or modify programs, policies, and practices related to the mission. The primary measure of intermediate outcome was community change: new or modified programs (e.g., peer support groups), policies (e.g., a no-smoking ordinance), or practices (e.g., expanded clinic hours) related to the mission. In addition, surveys were used to obtain data on reported behaviors related to the mission such as use of tobacco and alcohol (for substance abuse coalitions) and age of first intercourse and use of contraceptives (for adolescent pregnancy coalitions). Archival records are used to assess community-level indicators, such as estimated pregnancy rate (for adolescent pregnancy) and nighttime single-vehicle crashes (for substance abuse).

The monitoring information was collected by coalition staff and sent to the evaluators. The evaluators coded and summarized the data and fed them back to staff and leadership on a regular basis. The monitoring system allowed initiatives to track activities and outcomes related to their mission, and provided a record of key actions taken to implement a particular outcome or community change. For example, one of the substance abuse coalitions used the monitoring data on community change to inform a new community mobilizer about previous coalition activities and outcomes. The data also enabled the coalitions to be accountable to their funding agents and the community. Because the data provide evidence of accomplishment, they can be used by the initiative staff to secure additional resources. Finally, as part of the participatory or empowerment evaluation, some tailoring of the monitoring system took place to meet the needs of individual coalitions better.

The behavioral surveys were collected by coalition staff or school officials and summarized by the evaluators. Data about the level of early sexual activity, for example, were used to help increase awareness about the problem and show improvement toward the coalition’s broad health objectives. In response to community concerns, the
proposed behavioral survey for the pregnancy prevention initiative was replaced with a more palatable survey that minimized explicit references to anatomy and put sexual risk in the context of other risky behavior of adolescents. This substitution of a more acceptable survey illustrates the interactive nature of empowerment evaluation.

*Case Study With a Tribal Coalition.* Early in our work with the Decade of Hope Coalition, we agreed to provide training and support for coalition staff and leadership in methods of community development and evaluation. Some of the evaluation budget was returned to the coalition to hire a tribal member to serve as on-site research coordinator. This local evaluator collected community-level impact data, such as emergency medical transports, and was the main contact person for completing logs for tracking process and outcome measures, such as community actions to change local policies, and community changes, such as change in the policy of a local bar to ban customers involved in fights. This monitoring system, and interviews with key members of the coalition and community, helped document the local nature and meaning of coalition process and outcomes.

**COMMUNICATING INFORMATION TO RELEVANT AUDIENCES**

Regularly sharing accomplishments and keeping constituents informed of progress are important to maintaining community support, obtaining additional resources, and ensuring accountability. Support teams provide data reports and training to enable coalition leadership and staff to communicate their data to coalition membership, boards of directors, current and prospective funding agents, and other important constituents.

*Case Study With Kansas Coalitions.* Data were shared with coalition leadership, grantmakers, and the community at large. The Kansas coalitions regularly provided data in reports to their primary funding agent, the Kansas Health Foundation. It was especially important to communicate data to the foundation given that annual renewal of grant funds was contingent on evidence of progress. The data on community change served to demonstrate progress, providing early indication of coalition success.
Coalition leadership, with support from the evaluation team, also reported the data to steering committees and coalition members. Keeping the coalition membership informed of progress helped to recognize contributions of members and other volunteers as well as maintain focus on and momentum for community change. Sharing data with committees and the community contributed to accountability to local constituents. Several coalition leaders presented their work at regional conferences and national conventions. This provided them with the opportunity to share their progress and to network with other initiatives with similar missions. Establishing networks and sharing information about the accomplishments of the initiative at local, state, and national levels are important for securing resources and commitments to sustain the initiative.

Case Study With Tribal Coalition. Feedback was provided to coalition leadership and membership in the form of cumulative graphs documenting the number of actions taken and community changes facilitated each month. Accompanying these graphs were printed reports itemizing those actions and accomplishments. In addition to monthly reports, quarterly reports were generated for the funding agent (CSAP). We discussed the evaluation data with staff, and trained them in how to use the data themselves during working sessions in Dulce. Data were used in subsequent grant applications to the Indian Health Service, Kellogg Foundation, and Robert Wood Johnson Foundation. Data in the hands of staff and coalition members proved to be instrumental in obtaining an award for excellence from the Indian Health Service and additional financial and community support.

PROMOTING ADAPTATION, RENEWAL, AND INSTITUTIONALIZATION

In the life span of community initiatives, adaptation and renewal may be necessary to address a variety of predictable changes, including those in leadership, goals and objectives, and community conditions and concerns. Institutionalization of valued components of the initiative, including evaluation, may also be important to community initiatives. Support teams facilitate training and provide regular consultation to this end, but the ultimate success may be unknown for years after the evaluation.
Case Study With Kansas Coalitions. The monitoring data helped the coalition recognize accomplishments and redirect energies when necessary. For example, for one coalition for prevention of substance abuse, a high level of service provision and low levels of community action and change indicated to leadership, staff, and the funding agent that the coalition was becoming a service agency rather than a catalyst for community change. These data helped redirect the energies of coalition staff, leadership, and members away from service provision and toward creating community change. This adaptation was important and empowering because prevention initiatives may be more effective as catalysts for change than as new service agencies.

Changing leadership in another coalition for prevention of substance abuse required some reenergizing and refocusing of coalition members. The evaluator for this site worked closely with new leadership and the steering committee to share with them the intended purpose of the coalition, that is, to serve as a catalyst for change. This renewal of the coalition was necessary to reestablish and maintain its focus on facilitating community change related to the mission.

Similarly, the evaluation team provided training and consultation in strategies for promoting institutionalization of the initiative and its successful programs, such as securing personnel positions in city or county budgets or developing leadership in collaborating organizations. Initiatives gave consideration to sustainability as they designed project components. For example, one pregnancy prevention coalition used local data about the level of the problem to help initiate a new group at a local college that would assist in preventing unwanted pregnancies among college students and adolescents.

Case Study With a Tribal Coalition. The monitoring system, with regular reporting about key events, allowed the funding agents, staff, and local influential persons to keep track of and adjust activities of the coalition. Staff and coalition members were able to detect the immediate effects of their actions, such as a new program or policy change, and could suggest adjustments that would improve implementation. This process engaged all parties in the evolving process of evaluation and community development.

Major and repeated turnover in virtually all leadership and evaluation positions made renewal and institutionalization particularly
critical issues with the Decade of Hope Coalition. Perhaps technical assistance with new staff, particularly with action planning and monitoring, would be helpful in coalition renewal and institutionalization of valued community changes.

Challenges for Empowerment Evaluation

There are a number of significant challenges to the practice of evaluation in service of empowerment. First, the ambiguous quality of the concept of "empowerment evaluation" may make it difficult to detect good practice. Empowerment remains a vague concept, referring to both a process and a goal (Swift & Levin, 1987; Zimmerman, in press). Outcomes of empowerment evaluation, such as community competence to conduct evaluations, and community outcomes such as securing grants with evaluation data, may be difficult to attribute solely to the process of empowerment evaluation rather than empowerment evaluation and other intervention processes. Conceptual analyses of the process of empowerment evaluation, such as those offered in this book, may help explicate this important construct.

Second, it may be difficult to optimize the traditional goals of evaluation and empowerment in the same endeavor. As Stufflebeam (1994) noted in a critique of empowerment evaluation, the traditional goal of evaluation (Joint Committee, 1994) is "the systematic investigation of the worth or merit of an object" (p. 323). Empowerment evaluation offers a seemingly orthogonal goal: to promote self-determination. Although these complementary goals may not be easily maximized, creative applications of this process may suggest how the goals of assessing and contributing to worth can be optimized. The relationship has greater clarity when evaluation is viewed as the tool by which self-determination is fostered at every stage (Fetterman, 1995).

Third, empowerment evaluation, like other approaches to evaluation, must protect itself against charges of misuse (Stufflebeam, 1994). When involving community members and other stakeholders in the evaluation, we must acknowledge potential for bias and conflict of interest. To promote such collaborations is not to abdicate responsibility for assessing merit and worth; it is merely to share that duty with those most affected by the outcome. Evaluators can (and should) collaborate with key
stakeholders, including community members and grantmakers, in setting the agenda for research, collecting and interpreting data, and communicating the findings to interested audiences. Evaluations must also meet the field’s standards for propriety and accuracy when communicating findings to professional and other audiences (Joint Committee, 1994). Consistent with the aims of action science (Argyris, Putnam, & Smith, 1985), appropriate collaborations among evaluators and stakeholders can optimize the potential contributions of evaluation to both understanding and improving community initiatives.

Fourth, empowerment evaluation must also guard against potential confusion resulting from conflicting interpretations from various sources (Stufflebeam, 1994). As with qualitative evaluation (Fetterman, 1988, 1989, Guba & Lincoln, 1989; Patton, 1980) and other forms of relativistic evaluation, stakeholders contribute to the process of assessing merit. Although expanding participation always increases risk for conflict, it does not ensure it. If consensus on assessments of merit is valued, cases of differing interpretations of results could enable us to better understand the values that undergird judgments of merit. Such case studies may enable us to understand how evaluation methodologies can foster common assessment (and attainment) of worth.

Fifth, as with other approaches to evaluation, those that would promote self-determination must meet standards for feasibility (Joint Committee, 1994). Increased requirements for effort by either evaluators or communities could limit the practicality of implementation. For example, feeding back information about progress and providing training in communicating the data require time from evaluators. Similarly, if collaborating with evaluators diverts attention from the initiative’s efforts to facilitate change, it may properly be viewed as another “unfunded mandate.” When empowerment evaluations balance the interests of both evaluators and community members, they may be more likely to be judged as having met standards for feasibility and utility.

Benefits of Empowerment Evaluation

There are also a number of opportunities and benefits from evaluation in service of empowerment. First, empowerment evaluation encourages the creative coupling of technical assistance and evalu-
ation. Because empowerment evaluation is designed to foster self-determination, it is essential that community stakeholders understand and can apply the methods. Enabling activities, such as technical assistance and training, are expected features of an integrated set of support activities. For example, in a more traditional paradigm, workshops in strategic planning or communicating evaluation results might be delegated to an outside contractor providing technical assistance. Because building capacity is among the primary ends of empowerment evaluation, an integrated support system, combining the functions of assessment of merit and technical assistance, is a more efficient and appropriate design.

Second, empowerment evaluation may enhance integration of qualitative and quantitative methods. One way in which evaluation processes extend community influence over the initiative is by inviting community members and other stakeholders to assess the value and accomplishments of the initiative. By integrating such qualitative information with quantitative data on accomplishments, we have begun to identify factors, such as action planning or monitoring and feedback, that may affect the functioning of community health initiatives. Such integration of qualitative and quantitative data may enhance the capacity of community initiatives to affect valued outcomes.

Third, capacity-building approaches may help demystify the process of evaluation. Collaboration increases ownership of the evaluation process, making evaluation practices an integral part of leadership activities. For example, community leaders help gather data on community change for the monitoring system and assess its significance for the mission using constituent surveys. Once initiative leadership become familiar with evaluation and recognize its empowerment capacity, they are more likely to understand the data and communicate the findings to relevant audiences.

Fourth, empowerment evaluation supports reinvention of evaluation methods and instruments. In collaboration with evaluators, initiative leadership rejected some proposed assessments as not feasible or useful, specified additional measures to be collected, modified measurement instruments to be used, and adjusted time lines for implementation of evaluation instruments. For example, coalition leadership associated with the Jicarilla Apache tribe rejected traditional survey methods as being too invasive, and staff and leadership
of one of the pregnancy prevention initiatives modified and extended the time line for a consumer satisfaction survey to suit their needs better. When other evaluation standards are upheld, reinvention may enhance the value of self-determination while strengthening prospects for continued use of the evaluation methods after the evaluation team is gone.

Finally, a degree of self-determination in evaluation may promote institutionalization of the evaluation methods. Strategies for promoting institutionalization of evaluation include (a) promoting awareness of the value or need for evaluation data (Eng & Parker, 1994; Lefebvre, 1990; Mittelmark, 1990), (b) encouraging participation in developing the research goals and methodology (Eng & Parker, 1994; Fawcett, 1991; Fetterman, 1994a), (c) building community competence in designing and conducting the evaluation (Eng & Parker, 1994; Fawcett, 1991; Fetterman, 1994a), (d) incorporating evaluation into the structure of the initiative (Eng & Parker, 1994; Fetterman, 1994a, 1994b; Lefebvre, 1990; Price & Lorion, 1989), (e) providing needed resources such as people and materials, and (f) securing champions or change agents within the organization who will take responsibility for the evaluation (Lefebvre, 1990; Rogers, 1983; Seekins & Fawcett, 1984). Such empowerment strategies may facilitate long-term use of functional evaluation methods.

Conclusion

This chapter described the use of a framework and process for empowerment evaluation. The aim of this evaluation is to build community competence; optimize community outcomes; and promote adaptation, renewal, and institutionalization of community health initiatives. We illustrated this approach with case studies involving community initiatives to prevent substance abuse and adolescent pregnancy in Kansas and a tribal partnership to prevent substance abuse in New Mexico.

Although we have considered how to enhance the practice of empowerment evaluation, questions of who should be empowered and for what ends are largely questions of philosophy and ethics (Fawcett et al., 1982; Fetterman, 1994a). For example, evaluations of community initiatives to prevent youth violence may maximize bene-
fits for at-risk youth and their families, or those who fear or resent them. Several questions may help clarify ethical issues in empowerment evaluation: (a) What are the vision, mission, and/or goals of the initiative? (b) Who experiences the health or social concern to be addressed? (c) Are those experiencing the problem among the primary beneficiaries of the initiative? (d) Are those affected by the problem involved in implementing the initiative? (e) Does the evaluation contribute to the community's capacity to address these and other concerns? (f) Does the evaluation contribute to a reduction in problems and other outcomes of importance to the community? Attention to these ethical issues may help maximize benefits for those whom evaluators would enable to help themselves.

Empowerment evaluation with community initiatives poses an apparent paradox: How do we simultaneously maximize the competing ends of community control and understanding of the processes and outcomes of community initiatives? For example, community input and control increase the number of stakeholders and potential competing interests that affect the evaluation. This can create confusion in the implementation of the evaluation and in the interpretation of evaluation results.

Maximizing community control and understanding may be precisely the sort of divergent problem that calls for apparently contradictory solutions (Fawcett, Mathews, & Fletcher, 1980; Fawcett et al., 1984; Rappaport, 1981; Schumacher, 1977). Empowerment evaluation optimizes both self-determination and understanding—even if it may not maximize each of these valued ends. Moreover, the varied forms of action science spawned by these efforts are challenging scientists and practitioners to reconsider how best to serve methodological rigor and relevance (Argyris & Schön, 1991; Fawcett, 1991). Such innovation should be good for action scientists, community practitioners, and the marginalized people and communities who are the intended beneficiaries.

References


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