NINA WALLERSTEIN, DRPH

A Participatory Evaluation Model for Healthier Communities: Developing Indicators for New Mexico

SYNOPSIS

Participatory evaluation models that invite community coalitions to take an active role in developing evaluations of their programs are a natural fit with Healthy Communities initiatives. The author describes the development of a participatory evaluation model for New Mexico's Healthier Communities program. She describes evaluation principles, research questions, and baseline findings. The evaluation model shows the links between process, community-level system impacts, and population health changes.

Dr. Wallerstein is an Associate Professor and Director of the Master's in Public Health Program of the University of New Mexico School of Medicine, Albuquerque.

Address correspondence to Dr. Wallerstein, MPH Program, Dept. of Family and Comm. Med., UNM School of Medicine, 2400 Tucker NE, Albuquerque NM 87131; tel. 505-272-4173; fax 505-272-4494; e-mail <nwall@unm.edu>.

New Mexico's health statistics are among the worst in the nation. New Mexico is often last in access to health care, use of prenatal care, and fatalities from drunk driving crashes per capita, and is third worst in teen pregnancy rates. One-fourth of New Mexico's children live in poverty, compared with 20% nationally.[1] To tackle these problems through community-based decision-making and improved service coordination, in 1992 the state legislature launched New Mexico's Healthier Communities initiative with a $200,000 initial appropriation.

NEW MEXICO'S HEALTHIER COMMUNITIES INITIATIVE

Successful lobbying efforts for legislative funds for New Mexico's Healthier Communities initiative came from child advocacy groups and from communities that demanded a broader approach than the traditional

funding of categorical health problems, building on the earlier successes of state-funded maternal and child health councils.

At the same time, private and public agencies, community groups, schools, higher education, and tribal entities organized to form the New Mexico Partnership for Healthier Communities (NMPHC, or Partnership). In developing a set of principles, the Partnership adopted the World Health Organization's Healthy Cities framework, which calls for multisectoral collaboration, community participation, equity, and healthy public policy.[2] In New Mexico, the Partnership added new principles tailored to the state's specific demographic needs: community ownership, prevention, respect for cultural differences, and conflict as an opportunity for positive transformation.

In 1992 the legislature further contributed to the effort by creating a new Department of Children, Youth and Families (CYFD) to redress fragmentation of services. Funding CYFD out of the budgets of other state agencies, the legislature mandated that the Governors' Cabinet Secretaries form a high-powered Interagency Council to consolidate redistribution of agency resources and better coordinate services to families.

The New Mexico Healthier Communities initiative was an opportunity to challenge the way state government operated in communities. The Department of Health took this challenge seriously. First, the Department, which had the original authority to administer the Healthier Communities funding, issued a Request for Proposals (RFP) as a four-year noncompetitive bid, enabling communities to plan a longer-term process than allowed by the usual one-year contract. The RFP asked communities to start or strengthen community coalitions based on Healthier Communities principles. Second, the health department proposed that the Partnership serve a mediating role in articulating policy needs from communities to the new Interagency Council. Third, the health department allocated funding for the creation of an Action-Learning Center, a participatory technical assistance group that would act as an intermediary between the communities and the state funding agency. Finally, the initiative challenged all community and state partners to adopt Healthier Communities principles within their organizations.

Initially, the health department funded four communities, three counties, and one tribal social service agency serving eight sovereign nations. Twelve additional communities were funded the next year with a further legislative appropriation.

THE PARTICIPATORY EVALUATION MODEL

An evaluation was conducted to describe the impact of the Healthy Communities process on the structure and system of community initiatives in New Mexico and on the communities themselves.

The projects initiated under the New Mexico Healthy Communities program were aimed at improving family health and lowering rates of domestic violence and substance abuse. The focus of the Participatory Evaluation Model, however, was not on achieving those goals but on the process, structure, and systems by which the projects themselves unfolded. The fundamental issue in question was: Using Healthy Communities strategies to improve health, what changes would occur in community organizing, collaborative processes, and structural conditions that would maintain changes to sustain health improvement?

The most significant finding was the uncovering of conflicts that were both internal to the coalitions and between the coalitions and their local power structures and state agencies.

The evaluation consisted of a "baseline" assessment and one-year follow-up with the first four communities and three-year follow-ups for all 12. The evaluation committee of the Partnership, consisting of researchers, state agency workers, and community representatives and led by the present author, developed the evaluation instrument and standardized the questions across all participating communities.

The evaluation committee adopted several participatory values:

- Engaging community coalitions to identify key indicators that would measure the success of their Healthier Communities programs;
- Providing regular feedback to communities to enhance their decision-making; and

- Using process and short- and long-term outcome measures.

In most communities, the baseline assessment was conducted at about the same time as coalitions were being formed. At baseline, the evaluation focused on two questions: (*a*) How does a community express the characteristics and principles of a healthier community (such factors as vision, levels of collaboration and participation, coalition diversity, conflict resolution skills, political leadership, healthy policies, and addressing inequities)? (*b*) What are the barriers to and facilitators of change? The assumption underlying these questions was that changes in community infrastructure and collaboration would lead to improvement in health and social status.

The overall evaluation involved: a community profile of population health statistics and existing collaborations and leadership; a process evaluation of leadership and coalition changes; an impact evaluation of programs, systems, or policy changes; and an outcome evaluation of economic, health, or social welfare indicators.

To generate community profiles, four graduate students were hired to conduct interviews with informal and formal community leaders. For the baseline community profile, the graduate students interviewed informal and formal leaders, observed coalition meetings, and compiled population-based statistics. In each community, they conducted interviews with key informants from social and health services, public education, law enforcement, religious organizations, local, county, and state elected officials, and informal community leadership. Their questions addressed the community's recognition of the Healthier Communities principles, its levels of participation and collaboration, the forces that promoted or inhibited collaborative processes, and how state agencies needed to change to respond effectively to communities.

BASELINE FINDINGS

The findings documented common themes across all communities. Interviewees generally expressed community pride and their visions for healthier communities, but the most significant finding was the uncovering of conflicts that were both internal to the coalitions and between the coalitions and their local power structures and state agencies.

Conflict One: Lack of Awareness of Process/Conflict of Missions. The majority of leaders interviewed were not aware of the Healthier Communities grants at the outset. Even coalition members who were aware that a grant proposal had been submitted did not understand the implications of adopting the Healthier Communities principles. For example, in several communities, it was difficult for coalition members to work out the dynamics between the coalitions' existing missions and the new visions brought by the Healthier Communities grant process. This conflict was heightened when the initiative was seen by some coalition members as one project among many, instead of as an overarching perspective for the coalition's community work.

Conflict Two: Abstractness of Principles. The abstractness of the principles of Healthier Communities created uncertainty. While people agreed in theory that there should be equity, diversity, multisectoral participation, and grassroots and policy maker participation, conflicts surfaced with people having different ideas about how to implement these principles in practice. Two of the coalitions expressed a belief that their internal organization should not be evaluated on these principles at all, especially the leaders who felt that this was a separate project among many others.

Conflict Three: Diversity/Racism/Sexism. Diversity was one of the more difficult principles to assess either because of denial on the part of coalition members of the importance of building linkages with people from underrepresented groups or because of frustration with this process. When the graduate students shared key informants' dismay about lack of diversity, some coalition leaders took offense. They believed that their coalitions had diverse representation on board, even if the people of color did not represent their constituencies.

Conflict Four: Risk When Challenging Power. An unexpected concern at baseline was the fear expressed by community coordinators in challenging the power structures within both their communities and their coalitions.

Conflict Five: Service-Driven vs Organizing Agenda. The key players in the coalitions were most often service providers who operated well within a provider culture, yet did not necessarily understand how to engage in community organizing. Though providers understood the need to increase grassroots involvement, service collaboration and integration require very different skills from organizing.

Conflict Six: Lack of Policy Maker Involvement. Similar to the lack of grassroots involvement, there was a lack of awareness of the importance of policy maker

involvement. Most of the legislators and county commissioners interviewed were not aware of the project.

Conflict Seven: Need for Economic Development Agenda. The evaluation showed that poverty, lack of job opportunities for youth, and lack of capital in tribal communities were major barriers to developing healthier communities.

Conflict Eight: Critiques of State Government. All communities expressed similar criticisms of state government, among them:

- Unhappiness with the procurement code and reimbursement procedures that made it difficult for small nonprofits to engage in start-up activities;
- Lack of a central clearinghouse or timetable for grants and contracts;
- Lack of communication between community and state personnel; and
- Lack of communication between state agencies. One coalition coordinator, for example, received requests for the same information from four different state agencies, all to be filled out on different forms.

Many community leaders expressed skepticism about whether the state was serious about community decision-making. As one interviewee said, the community group could be set up for failure when it actually came to the state for money to implement projects the community had chosen. Longstanding tribal criticisms of the state were pervasive, with state agencies being viewed as disrespectful of tribal sovereignty.

Conflict Nine: Power Issues: Center vs Periphery Dynamics. The final theme was expressed as a larger power conflict between local communities and state agencies. Interviewees expressed resentment of the lack of community power in two ways: their concern with being out of the communication loop and their frustration with having little or no decision-making authority. Most community coalitions felt that they were not part of the decision-making process, that the "center" (state agencies, the university, the Action-Learning Center) ultimately made the decisions.

Some communities also found the evaluation process itself an unwarranted and unnecessary burden. In the initial scope of work for the first four communities, evaluation was not required, as the evaluation proposal came after the initial funding. As with many community-researcher relationships, community coordinators felt the evaluation process was an unexpected imposition rather than an asset for their own planning.[3]

IMPLICATIONS

Findings from the baseline evaluation clarified that community-level indicators of levels of participation, collaboration, policy involvement, and diversity were important to the communities and showed the difficulties and conflicts inherent in promoting collaborative work and system change. To integrate these findings into ongoing tracking systems and plans for follow-up in the next years, the evaluation committee adapted Fawcett et al.'s community evaluation model.[4] (See Figure 1.) New Mexico's new model proposed monitoring logs and annual assessments of planning and implementation processes, and of intermediate community-level system impacts, as well as assessing longer-term changes in morbidity/mortality at the end of the four-year period.

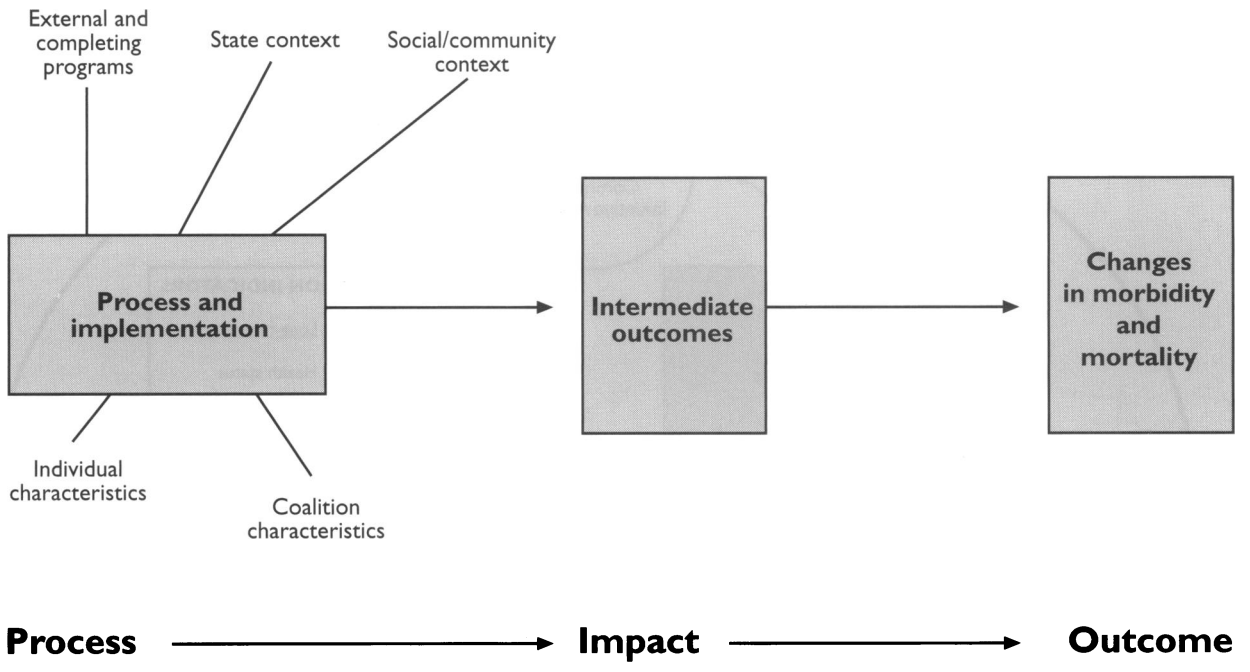
The Year One evaluation, which emphasized community-level system indicators, was conducted through follow-up telephone interviews with coalition coordinators and a few coalition members. Year One questions focused on the processes of development of the Healthier Communities initiative, such as the ability to concretize the principles into specific goals and objectives, a listing of achievements and barriers, and progress on the conflicts indicated during the first year.[5] These included conflicts related to diversity, participation, collaboration, and state relations.

In 1995, the communities requested a new task force, composed of half of the 12 Healthier Community sites and state agency staff, to work on a shared tracking system for community changes that could result from the Healthier Communities initiative. After a year-long process, this task force identified a participatory model, which was then incorporated into a *Participatory Evaluation Workbook for Community Initiatives* that highlights the importance of community-level system changes, including adoption of Healthier Communities principles.[6] (See Figure 2.)

As a result of this collective work, the Year Three telephone follow-up with community coordinators and other coalition leaders focused more specifically on community-level impacts on leadership, policies, organizational structures, resources acquired, community norms, and any changes in health, education, or economic indicators.[7]

The Year Three evaluation revealed many new policies and policy norms, such as integrated service forms, an

Figure 1. Coalition evaluation model



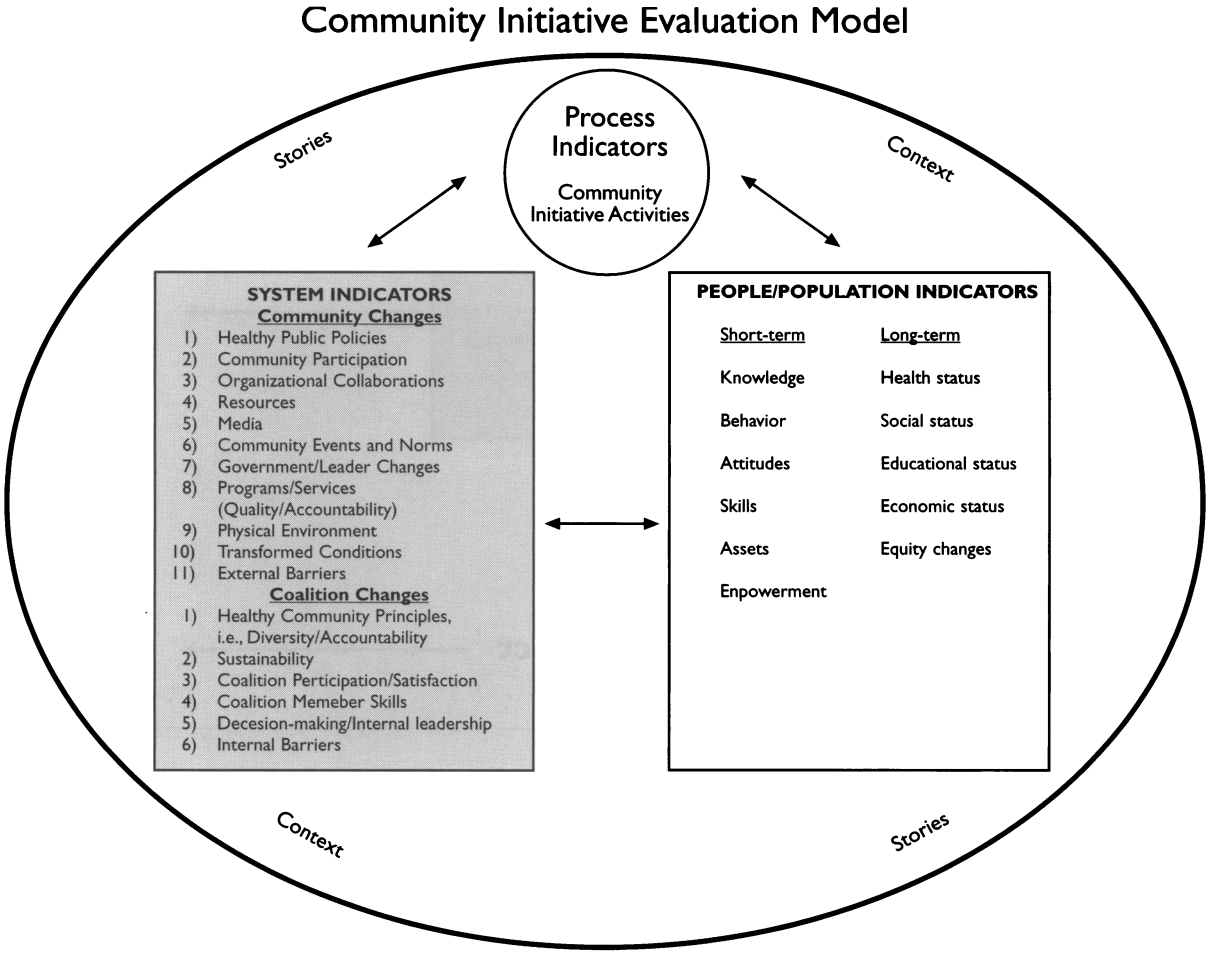
increase in women in leadership positions, inclusion of nondiscriminatory language in county personnel policies, an increased demand for information and counseling referrals, increased cooperation with police, and more openness to treatment options instead of jailing adolescents. Though very few communities claimed any health changes because of the short time period, several reports of health indicators illuminated a broad perspective on health. One county, for example, reported that kids had taken out 214,000 books from the school library the previous year. A few counties reported decreases in dropouts, juvenile arrests, alcohol-related mortality, and repeat offenses and no infant auto fatalities in the previous three years. The search for useful indicators helped communities continue to develop appropriate programs.

After four years of funding 12 communities, the state of New Mexico chose to discontinue the larger funding streams of $30,000 to $40,000 for community coordinator positions, primarily because of political changes and a growing interest in decentralizing funding. These were replaced by smaller project funding administered by District Health Offices. The New Mexico Partnership continues to provide networking, support, and materials. The *Workbook* has continued to be pilot-tested in coalitions working on driving while intoxicated (DWI), health system changes, healthier schools, and other small Healthier Communities projects. As it stands now, the *Workbook* is a useful tool for professional planners and evaluators to use in thinking about and highlighting the framework of community-level indicators and their relationship to processes and health/social status outcomes. It remains cumbersome, however, as a self-management tool for communities because evaluation expertise is often not located in communities. Community members and coalition leaders with evaluation training and time, however, can use the participatory model to identify and evaluate their own indicators of success.

CONCLUSION

This process of an unfolding participatory evaluation model has been instructive. Developing an evaluation model is a dynamic process that requires both a constantly negotiated relationship between the evaluator/researchers and community members and a grounding in indicators, that are useful for community understanding and, ultimately, for people's decision-making for improved health.

Figure 2. Model for tracking community changes, from Participatory Evaluation Workbook for Community Initiatives[6]



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