doi: 10.4087/FOUNDATIONREVIEW-D-09-00011

Using Community-Based Participatory Evaluation (CBPE) Methods as a Tool to Sustain a Community Health Coalition

Leslie Aldrich, M.P.H., Daniel Silva, B.A., Danelle Marable, M.A., and Erica Sandman, M.A., Massachusetts General Hospital Center for Community Health Improvement; Melissa Abraham, Ph.D., Massachusetts General Hospital Department of Psychiatry

Key Points

- Participatory evaluation has set the standard for cooperation between program evaluators and stakeholders. Coalition evaluation, however, calls for more extensive collaboration with the community at large.
- Integrating principles of community based participatory research and the Substance Abuse and Mental Health Services Administration's Strategic Prevention Framework, which guides much coalition work, into coalition evaluation has proved useful to foster community affiliations and support reciprocal relationship building. The resulting evaluation method, named community based participatory evaluation (CBPE), takes time, money, and skilled personnel but can lead to more accurate results and coalition sustainability.
- The CBPE method has proved essential in sustaining two substance abuse coalitions in and around Boston: Revere Cares (RC) and The Charlestown Substance Abuse Coalition (CSAC).
- CBPE can help sustain coalitions by providing a degree of formality, assuring appropriate leadership and membership satisfaction, supporting conflict resolution, and strengthening relationships with external organizations. Broad-based participation allows coalition members greater access to create organizational and community change. Furthermore, it increases the capacity to collaborate because if one person quits the coalition, the affiliation with the organization may still be robust.
- Challenges to implementing CBPE include the cost, the amount of time required, and the need for a skilled evaluator who is organized, engaged, and knowledgeable about all aspects of coalition work.

Introduction

Coalitions, defined as "inter-organizational, cooperative, and synergistic working alliances," have become popular vehicles for addressing community-wide health needs (Butterfoss, Goodman, & Wandersman, 1993). A common complaint from funders and researchers, however, is that there is a lack of consistent empirical evidence that validates this form of collaborative undertaking (Butterfoss, 2006; Butterfoss et al., 1993; Kreuter, Lezin, & Young, 2000; Zakocs & Edwards, 2006). This may be due in part to the impractical expectations of traditional researchers and funders as well as to the lack of a formal evaluation method for coalition work.

Evaluation of a coalition is essential to maintaining the continued support of both funders and the community. In the current climate of health care, a lack of evidence that coalitions are effective in achieving their goals may jeopardize their future support. Evaluating the effectiveness of coalition interventions is complicated by a number of factors.

1. Coalitions do not lend themselves to conventional approaches to evaluation, which seek quantifiable, rapidly available information attractive to funders.
2. Coalition effectiveness is often determined by both internal functioning and long-term, external community change, making process indicators as important as outcome indicators.

3. Coalitions often rely on public data sources that are unreliable and are not always up to date.
4. Coalitions often use a combination of strategies simultaneously, making it difficult to isolate which specific effort is related to observed changes.
5. There is no list of evidence-based coalition-building factors that have been linked to indicators of coalition effectiveness.

Although evaluating coalitions is complicated, a coalition itself presents a committed group of stakeholders and can be a valuable resource for evaluators, both in providing wide-ranging perspectives and in conducting evaluation activities themselves. Coalitions have been described as catalysts to bring community issues to the forefront (Butterfoss, 2006). Increasing participation and institutionalizing evaluation activities within a coalition creates abundant opportunities for community members to be involved and be vocal about pertinent health issues. As a result, a number of different forms of participatory evaluation may be effective in assessing coalition work, such as empowerment (Fetterman, Kaftarian, & Wandersman, 1996), stakeholder-based (Bryk, 1983), and practical participatory evaluation (Cousins & Whitmore, 1998), among others. For a review of these methods see King's *Making Sense of Participatory Evaluation* (2007b). The aim of this article is to identify aspects of these various forms of evaluation that are useful when evaluating coalitions, and to present how systematically putting these principles into practice has sustained a community substance abuse coalition and enabled it to demonstrate effectiveness and create change.

Sustainability Factors

The first step to sustaining a community based substance abuse coalition is deciding what should be sustained. Coalitions are vehicles for interorganizational collaboration and can direct their efforts toward a number of community health interventions. Of particular interest to funders, policymakers, and community leaders are the functional attributes of a coalition: ability to engage in mutually beneficial relationships, convene disparate community segments, and provide neutral ground to discuss community-wide issues (Alexander et al., 2003). Although community health interventions come and go, sustaining the capacity to collaborate means the community will always have a durable resource with which to address common concerns. Detailed below are what we call "sustainability factors" for a community coalition, which have been shown to sustain collaborative capacity, and how evaluation can be designed to reinforce these factors.

Although community health interventions come and go, sustaining the capacity to collaborate means the community will always have a durable resource with which to address common concerns.

Community Ownership

Community ownership, defined as active participation and buy-in from community members and organizations, is integral to coalition sustainability. Evaluation can play an important role in assessing the readiness of the community to move forward with strategies, thus responding to the realities of the community rather than imposing interventions that might not be supported.

Coalition Infrastructure

Coalition infrastructure, including staffing, board functioning, technical assistance, transparency, and effective leadership, contributes heavily to sustainability (Feinberg, Bontempo, & Greenberg, 2008; Gomez, Greenberg, & Feinberg, 2005). Few coalitions have the resources to support full-time staff, and mostly rely on volunteers. Evaluators can provide feedback to members to ensure fidelity of interventions and strategies and to play an

essential role in maintaining the transparency of coalition infrastructure, leading to more trust by members of the coalition.

Reciprocal Relationships

Reciprocal relationships, defined as mutually beneficial affiliations between individuals, institutions, and community organizations, are at the crux of how a coalition "does business." Coalitions are by definition collaborative endeavors, and their most useful asset is the relationships they create. Evaluation can highlight these relationships and point to instances when both parties benefit from such relationships so that they are strengthened over time.

Collaboration

Collaboration includes recognizing the inherent value in the perspective of all partners, equitable division of power and resources, and sensitivity to community realities such as limited resources and time constraints (Israel et al., 2006). These principles encourage trusting relationships, foster transparent communication, develop common goals, and help to resolve conflicts.

Focusing on these sustainability factors can lead to increased community interest and can provide the evaluator with a reliable resource for useful insights into the public health issues facing the community. The coalition will also be more likely to maintain a robust constituency that is representative of the community, creating potential to recruit new partners as the need emerges and to sustain collaboration between various sectors.

Participatory Evaluation for Health Initiatives

Participatory and empowerment evaluations, in their many forms, have set the standard for cooperation between program evaluators and stakeholders. Various types of evaluation approaches (practical, stakeholder-based, empowerment, etc.) were derived, as their names suggest, with particular evaluation goals in mind. For example, participatory evaluation (PE) primarily serves to inform decision making, while empowerment evaluation, although participatory, focuses on the transfer of skills and the building of evaluation capacity (Suarez-Balcazar & Harper, 2003). Evaluation of community health initiatives, however, does not fall neatly into any of these categories, but rather employs attitudes and standards from a number of them.

"Community health initiatives provide a rich context for understanding and improving the practice of empowerment evaluation" (Fawcett et al., 1996,p. 163). Such initiatives also present ripe opportunities for community members to make positive change and gain expertise in addressing public health concerns. In order to maximize their potential, both the evaluator and the community member have to appreciate the benefits brought about by reciprocal relationships (Fawcett et al., 1996).

Community coalitions that address public health issues employ a socio-ecological approach (addressing issues on an individual, family, community, institutional, and societal level) (Butterfoss et al., 1993; Fetterman et al., 1996; Zakocs & Edwards, 2006) and execute various efforts concurrently in order to act on several social and behavioral determinants of health, such as income, shelter, race, community norms, social capital, and family. Additionally, throughout the life span of a coalition, adaptation and revision are the norm and are necessary to address the variety of community-defined needs and foreseeable changes (Fawcett et al., 1996). Evaluations of such strategies must be as dynamic and comprehensive as the initiative itself.

There is no recognized model, however, for a type of participatory evaluation that intentionally integrates community-wide participation while providing evidence-based decision making and empowering participants. This could be due to the limited capacity of outside evaluators or lack of community interest, and often evaluations are focused on timeliness and include only the most influential stakeholders.

In order for coalition evaluation to be both participatory and empowering, it must create and/or retain the capacity and skills in community

members that are necessary to do so. If evaluation is incorporated into all levels of coalition work, it can help to institutionalize an evaluative mindset that complements the framework and that guides coalition work.

One framework that is commonly used to guide coalition work is the Strategic Prevention Framework (SPF). SPF was developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a guide for substance abuse community coalitions. It has been adopted by community health coalitions focused on other issues. The SPF is a five-step process based on the risk and protective factors present in the community. The five steps are assessment of population needs and required resources, capacity building, planning a comprehensive strategy, implementation of the prevention plan, and evaluation of program practices and impact. The SPF was designed for coalitions working across programs and systems and emphasizes multidisciplinary collaboration, empowerment, participation, equity, and capacity building.

Evaluation of community health coalitions has often focused on process measures that are indicators of these ways of working together. However, funders and policymakers often view this focus as being in opposition to evidence-based decision making and accountability. From the community members' perspective, evaluation activities that focus on evidence and accountability can seem as though they are being imposed by funders who don't appreciate the uniqueness of their community or program. The different perspectives of funders and community members can create tensions that put the sustainability of partnerships at risk. Although the SPF could potentially provide a way to bridge these evaluation expectations, because it requires communities to systematically evaluate outcomes it is not clear from the framework when and how this should be done.

The SPF framework can be adapted to meet the evaluation interests of both the community and funders if evaluation is incorporated into each step, rather than treated as an add-on to the framework. By combining SPF with community based participatory research (CBPR) principles (Israel, Schulz, Parker, & Becker, 1998), funders, community members, and evaluators can ensure both that a representative pool of participants is involved in the decision-making process and that all aspects of coalition work are evaluated.

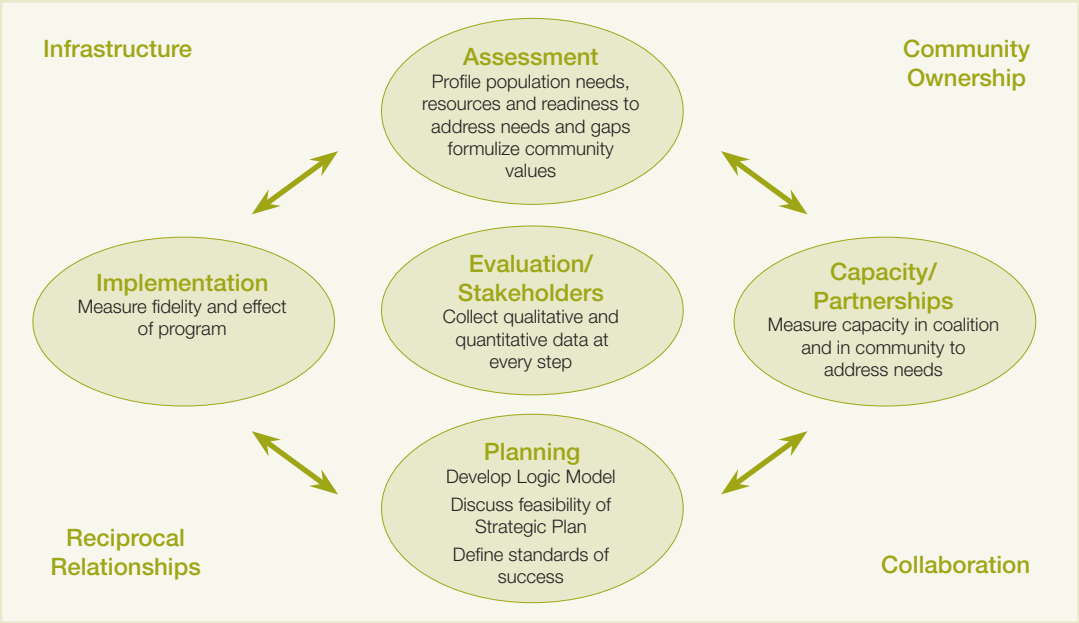
CBPR's main principles include

- recognizing community as a unit of identity,
- building on strengths and resources within the community,
- facilitating collaborative partnership in all phases of research,
- integrating knowledge and action for the mutual benefit of all partners,
- promoting co-learning and an empowering process,
- addressing health from both positive and ecological perspectives,
- disseminating findings and knowledge gained to all partners.

If evaluation is incorporated into all levels of coalition work, it can help to institutionalize an evaluative mindset that complements the framework and that guides coalition work.

Applying these principles to an evaluative mindset reinforces the limits of "value free" science and encourages the evaluator to be engaged and self-critical; improves the quality and validity of findings by connecting it to local knowledge; joins together partners with diverse knowledge, skills, and sensitivities; acknowledges that knowledge is power and can be used for the benefit of the community; overcomes distrust from communities that have historically been treated as "subjects"; and ideally can provide funds and possible employment for community partners (Israel et al., 1998).

FIGURE Community-based participatory evaluation



As stated by Zakocs & Edwards (2006), "Community coalitions present ripe opportunities for adopting recommended community participatory action research principles, where community members work in partnerships with researchers to collectively define local problems, identify and implement solutions to them, and evaluate their impacts" (p. 352). The combination of SPF, with evaluation integrated throughout, and CBPR leads to a new method of participatory evaluation for coalitions called community based participatory evaluation (CBPE). This combination approach creates evaluation designs that reflect community contexts and are supported by funders, policymakers, and key community stakeholders (Judd, Frankish, & Moulton, 2001). CBPE combines multiple methods and participatory evaluation approaches so they take place simultaneously, are ongoing, and are action-oriented.

Community-Based Participatory Evaluation

The CBPE model (see the Figure) represents the basic work cycle a coalition goes through to respond to a community issue. It places evaluation with stakeholders in the center in order to illustrate how evaluation should be incorporated into each step rather than treated as a last step. The bidirectional arrows indicate that the life cycle is not always linear and may involve backtracking to ensure a sustainable and effective response. The four sustainability factors are essential coalition outcomes that evaluation can measure and enhance through this CBPE model. CBPE does not employ new tools or methods, but rather it describes the participatory and empowering nature of evaluation processes for coalitions that follow the SPF. Stakeholders include community members, health care professionals, employers and businesses, the media, academia, and government and public health officials. Diversity of potential stakeholders increases the potential funding opportunities because of the broad skill set available to apply for funds from multiple streams. Furthermore, broad-based participation ensures community representation, encourages coalition members to appreciate evaluation, and makes explicit the necessity of everyone's involvement.

CBPR and PE look similar in practice but it is essential to understand the distinction. The latter is a cyclical process that is reliant on community-defined, value-laden *standards* (Butterfoss, 2006),

while CBPR relies upon ongoing, broad community participation. CBPE builds upon both by employing a cyclical process (as in SPF and PE), while maintaining a mindset that stipulates broad-based participation (as in CBPR). In doing so it ensures that all steps of coalition work are monitored and evaluated with maximum stakeholder involvement and that data is interpreted and shared at every step. Bringing together multiple perspectives, a coalition can agree on strategies that are acceptable by all participating parties. Such intensive participatory evaluation practices allow for accurate gauging of both process and outcome measures, both of which are equally important to a coalition's sustainability (Butterfoss, 2006). In particular, empowerment, which is typically viewed as a process, can be conceptualized as an outcome for a coalition in its first years. CBPE challenges the evaluator and coalition to continually reassess their capacity and plans along the way while keeping an eye on community change.

A formalized evaluation plan is integral to maintaining the interest and participation of key stakeholders. Because CBPE works within the SPF model, it is relatively straightforward to outline both the process and outcome evaluation activities that fit under each step and to review how stakeholders should be involved. Once outlined, though, the amount of evaluation activities may be overwhelming for the evaluator, and it will be immediately apparent that coalition members will have to conduct some activities in order to achieve success. In this model the evaluator must play the dual roles of (1) teacher by training coalition members to conduct surveys, focus groups, and so forth, as well as (2) facilitator by providing an outsider lens to guide decision making. The transfer of evaluation skills to coalition and community members is the basis of empowerment evaluation (Fetterman et al., 1996). CBPE actively relies on these "rookie evaluators" to help design evaluation tools so they are culturally appropriate and to refine interventions so they are more effective.

Butterfoss (2006) has outlined process methods to measure community participation, which include participant surveys, key informant interviews, focus groups, and observation of meetings. Such methods can be conducted by coalition members themselves, and can be extended to include community surveys to assess needs and resources or capacity for a particular intervention. There are various necessary skills and organizational contexts that promote the use of process measures to increase evaluation capacity (King, 2007a). For example, the evaluator must be purposeful in the role of facilitator and must be able to communicate effectively and identify teachable moments. Under fortunate circumstances, there might be participants that are more committed to the evaluation process, so called "evaluation champions" who can support evaluative thinking. Identifying or creating organizational infrastructure is challenging for an evaluator, but an established experiential learning cycle of planning an evaluation activity, conducting it and collecting data, and then reflecting and planning next steps increases evaluation and intervention capacity with every round (King, 2007a).

CBPE actively relies on these "rookie evaluators" to help design evaluation tools so they are culturally appropriate and to refine interventions so they are more effective.

CBPE in Practice

In addition to the abundance of evaluation activities needed in coalition work, complexity is added due to the multiple purpose each activity may have. As described above, implementing an intervention can involve teaching, building, and formalizing relationships, as well as conducting the actual activity and collectively reflecting on its results. Clear examples of this are illustrated in the development of community surveys designed by two Drug-Free Community Grantees in and outside of Boston, Mass.: Revere Cares (RC) and the

Charlestown Substance Abuse Coalition (CSAC). Both coalitions are supported by Massachusetts General Hospital's Center for Community Health Improvement that strives to meet the needs of the underserved and vulnerable populations by collaborating with and building relationships in the communities served by the hospital. Thus, indicators of coalition effectiveness are measured not only by community behavior changes, such as decreased substance use, but also by change in community knowledge, attitudes, and reciprocal relationship development.

During its fourth year of funding, RC worked with the evaluator to design a community survey to measure the attitudes, experiences, and knowledge around youth substance use in the community. Questions were modeled after the Youth Risk Behavior (Centers for Disease Control and Prevention, n.d.) and Monitoring the Future (Johnston, O'Malley, Bachman, & Schulenberg, 2008) surveys and were pretested by coalition members to ensure appropriateness for the community. The survey was sent out to 1,500 randomly selected residents along with a letter of endorsement from the mayor, community health center directors, and coalition director. A 30% response rate was obtained. Survey results (basic frequencies) were presented to the coalition steering committee, which proposed ideas for a more in-depth analysis. Findings were then reported to the whole coalition and the community at large, leading to increased community awareness of substance abuse issues, modification of coalition strategy, and a trusted relationship between the community and the health center. Sharing data with the community showed the coalition's ability to listen and respond to their needs, which cultivated greater commitment from community groups participating in the coalition. As a result, the school system fully opened its doors to the evaluator and asked for assistance in analyzing student health data. The survey has been implemented two more times since its collaborative creation and is now an ongoing tool used for both assessment and evaluation purposes.

In CSAC, the evaluator worked with coalition members to design a similar community survey to measure attitudes and beliefs around community substance use. However, due to this community's historic mistrust of outside agencies and the coalition's age (first year), the survey was administered very differently. With few resources and an abundance of energy, the coalition decided to mobilize the community by recruiting volunteers to deliver the survey door to door. There was no control over who in the household should complete the survey, no follow-up was offered, and the survey was offered on-line to those who had internet access. To supplement the low response rate (12%), focus groups and interviews were conducted by coalition staff who were trained by the coalition's internal evaluator. Although this method for collecting data was not scientifically rigorous, the benefits were enormous. Because the coalition controlled the survey design and distribution process, the data was trusted. In addition, the process of collecting the data engaged community members that were not initially attracted to the coalition and increased the visibility and capacity of the coalition. The collected data helped the coalition create its initial strategic plan, obtain the Drug-Free Communities Award from SAMHSA, and develop a relationship with the school system, which later asked the coalition and its internal evaluator for assistance collecting and analyzing local student data. CSAC's community survey not only increased community awareness of substance abuse and its visibility in the community, it also was an outreach tool to engage new members, obtain funding, and formalize relationships. Thus, coalition evaluation had a direct role in fostering reciprocal relationships that extend beyond the coalition into the community

Benefits and Challenges

CBPE instigates, and actively supports, community organization/building, which researchers agree is critical when implementing community-based health interventions (Berkowitz, 2001; Berkowitz & Wolff, 2000; Butterfoss, 2006). CBPE can help sustain coalitions by providing a degree of formality, assuring appropriate leadership and membership satisfaction, maintaining a positive organizational climate (conflict resolution), and strengthening relationships with external organizations. Broad-based participation with a

focus on empowerment allows coalition members greater means to create organizational and community change. Furthermore, it increases the capacity to collaborate because if one person quits the coalition the affiliation to his/her organization may still be robust.

Designing evaluation techniques to serve multiple purposes often challenges an evaluator who strives to guide coalitions toward using best practices. However, when evaluation processes are adaptable to the context of a unique community, it can help build and sustain coalitions and add to the validity of the data, as illustrated in the examples above. It is important to review the relevance of the standards of acceptability in order to make sure it is in tune with the community contexts. *This requires that evaluation be flexible and function in terms of suitability rather than scientifically.* The benefits of being an internal evaluator familiar with the community and the coalition's inner workings and multiple strategies are indispensable in this respect.

Evaluation is often needed, but not provided, in community agencies involved in health promotion, and as a result many community groups may solicit help from coalition evaluators once relationships are formed. This is illustrated in the examples above in which both of the school systems requested coalition evaluators to help develop and administer student surveys and assist with data analysis. It is positive and necessary to bring together community agencies and share evaluation knowledge and skills. However, the coalition evaluator must be cautious and stay focused on the various evaluation activities of the coalitions they serve.

CBPE is guided by the community and should be practical and appropriate so that it will more easily be sustained and incorporated into a coalition's work plan and infrastructure. This will inherently lead to more timely, useable, and meaningful data that coalitions can use to make quality-driven improvements and achieve positive outcomes. These improvements and positive outcomes can lead to increased infrastructure, community ownership, reciprocal relationships, and collaboration.

As one may imagine, *time* is a major factor when considering using the CBPE method with coalitions. Each step can take several months, with rapid decision making at one end and standstills at the other. In addition, evaluation activities might be taking place simultaneously on separate initiatives, which can fatigue stakeholders and evaluators alike. Thus, it is important to identify at the onset the most important pieces of coalition work to document and evaluate. This can help to prevent stakeholder apathy during the process.

When evaluation processes are adaptable to the context of a unique community, it can help build and sustain coalitions and add to the validity of the data.

Funding for this intensive type of evaluation can be hard to find; thus, coalitions resort to the easiest and least expensive evaluations that fit within grant budgets. Funders should take into consideration the importance of thorough documentation of the activities and outcomes of coalitions and should reflect this in their RFPs and budget requirements. Coalitions must not be shy about requesting additional funds for evaluation, as well as identifying and establishing "evaluation champions" within their membership. "Providing extensive evaluation support for our two substance abuse coalitions has been invaluable," states Joan Quinlan, the Director for the MGH Center for Community Health Improvement. "Outcomes for many community health programs are not easily measured and can take years. Providing evaluation personnel who have the unique skills to listen, work and engage with communities over time have helped bridge trust between the community and the hospital and to show positive community outcomes which have helped advance our work."

Coalitions tend to have multiple initiatives running at once, and generally live in crisis-response

Sample Community Survey Questions

1. Some people believe that once a child becomes a teenager parents have very little influence over their decisions on things like whether they will smoke, drink, or try illegal drugs. How do you feel about this opinion? (Check one box only.)

   ☐ Strongly agree
   ☐ Somewhat agree
   ☐ Somewhat disagree
   ☐ Strongly disagree
   ☐ Don't know

2. Overall, in your opinion, how big of a problem is substance abuse* in COMMUNITY?

   ☐ Not a Problem
   ☐ Small Problem
   ☐ Medium Problem
   ☐ Large Problem

3. How much of a problem, if any, do you think the following are among teenagers in COMMUNITY? (Check one box for each line.)

	Not a Problem	Small Problem	Medium Problem	Large Problem
Underage drinking	☐	☐	☐	☐
Drinking 5 or more drinks in a row	☐	☐	☐	☐
Marijuana use	☐	☐	☐	☐
Ecstasy use	☐	☐	☐	☐
Cocaine/Crack use	☐	☐	☐	☐
Heroin use	☐	☐	☐	☐
Inhalant use	☐	☐	☐	☐
Steroid use	☐	☐	☐	☐
Methamphetamine use	☐	☐	☐	☐
PCP use	☐	☐	☐	☐
Oxycontin use	☐	☐	☐	☐
Other prescription drug use	☐	☐	☐	☐

4. How easy or difficult do you think it is for a person to get each of the following drugs in COMMUNITY? Please give your best guess. (Check one box for each line.)

	Very Easy	Easy	Difficult	Very Difficult
Marijuana	☐	☐	☐	☐
Ecstasy	☐	☐	☐	☐
Cocaine/crack	☐	☐	☐	☐
Heroin	☐	☐	☐	☐
Steroids	☐	☐	☐	☐
Methamphetamine	☐	☐	☐	☐
PCP	☐	☐	☐	☐
Oxycontin	☐	☐	☐	☐
Other prescription drugs	☐	☐	☐	☐

5. Have you ever allowed a teen to drink alcohol (other than a few sips) in your home?

   ☐ Yes
   ☐ No
   ☐ Don't know

6. How much influence do you think you have over your child(ren)'s decision to...
   (Check one box for each line.)

	No Influence	Small Influence	Medium Influence	Large Influence
Drink alcohol	☐	☐	☐	☐
Smoke cigarettes	☐	☐	☐	☐
Use marijuana	☐	☐	☐	☐

7. How often do you know who your child is with after school or on weekends?

   ☐ Never
   ☐ Hardly ever
   ☐ Sometimes
   ☐ Most of the time
   ☐ Always

8. How often do you know what your child is doing after school or on weekends?
   ☐ Never
   ☐ Hardly ever
   ☐ Sometimes
   ☐ Most of the time
   ☐ Always

9. Now think about your child(ren)'s closest friends. How many of them have you met in person? (Check one box only.)

   ☐ None
   ☐ Some
   ☐ Most
   ☐ All

10. In your opinion, how effective would each of the following be in addressing a drug and alcohol problem in COMMUNITY?

	Very Effective	A little Effective	Not very Effective	Not at all Effective
Education on the consequences of substance abuse*	☐	☐	☐	☐
More police enforcement	☐	☐	☐	☐
More treatment options	☐	☐	☐	☐
Harsher penalties for people who break drug and alcohol laws	☐	☐	☐	☐
Higher taxes on alcohol	☐	☐	☐	☐
Changing attitudes in community	☐	☐	☐	☐

For full survey, please contact Leslie Aldrich, MPH at MGH Center for Community Health Improvement
laldrich@partners.org

mode, which makes *communication* with the evaluator difficult. Also, the evaluator may not be aware of all activities that require evaluation. This challenge can be ameliorated by setting up activity logs to maintain a record of all activities, as well as attending meetings and events. It is incredibly important that the coalition director and evaluator have open lines of communication, a solid work plan, and a protocol in place so that the evaluator is aware of any new initiatives that may arise.

Conclusion

Various tenets of evaluation theory have proved useful in coalition evaluation, but as the coalition model gains acceptance as a valid approach to address community health needs it will necessitate an evaluation method particular to coalition work. CBPE formalizes a system that ensures all areas of coalition work are evaluated with stakeholder involvement, and institutes an evaluative mindset so that process and outcome measures are collected and reflected upon. It is easiest to execute CBPE if you are an internal evaluator, as it allows for deeper understanding of the intricacies of coalition work and clarifies why traditional evaluation methods may be counterproductive. This unique relationship is valuable because there is a shared understanding that everyone is working towards one goal: the evaluator is not solely working with data but also working with people to tell the complete story. There may be concerns that being an internal evaluator may bias outcomes. In coalition work, however, relationships are the basis for successful prevention activities and sustainability. It is important to appreciate that bias can be informative; as Berkowitz has pointed out, "evaluations should be 'appropriate' rather than 'scientific'" (Berkowitz, 2001, p. 223.

CBPE takes, time, money, and skilled personnel and requires the evaluator to be organized, engaged, and knowledgeable about all aspects of coalition work. A minimum of 20% of the entire coalition/project budget should be devoted to evaluation rather than 10% or less, which is often required by funders. For mature coalitions, a part-time employee, or one more full-time employees, may be needed since the coalition is often involved in many areas of work and needs additional assistance. To fund anything less makes evaluators gravitate toward accessible administrative data that does not necessarily lead to evidence for positive coalition outcomes.

Conferring value to community scholarship is an empowering experience for those who have been treated as "subjects" of research in the past. In addition, endowing self-determination may promote institutionalization of evaluation methods (Fawcett et al., 1996). The coalition membership is accessible to the community as well as community agencies and is a convenient, practical, and representative resource of participants. Not to take advantage of this resource would be counterintuitive to the purpose of coalition work: building relationships to sustain interventions that promote health in the community.

References

Alexander, J. A., Weiner, B. J., Metzger, M. E., Shortell, S. M., Bazzoli, G. J., Hasnain-Wynia, R., et al. (2003). Sustainability of collaborative capacity in community health partnerships. *Medical Care Research & Review, 60*(4, Suppl.), 130–160.

Berkowitz, B. (2001). Studying the outcomes of community-based coalitions. *American Journal of Community Psychology, 29*(2), 213.

Berkowitz, B., & Wolff, T. (2000). *The spirit of the coalition*. Washington, DC: American Public Health Association.

Bryk, A. S. (1983). Stakeholder-based evaluation. In Bryk, A.S. (Ed.) *New Directions for Program Evaluation.* (17). San Francisco, CA: Jossey-Bass.

Butterfoss, F. D. (2006). Process evaluation for community participation. *Annual Review of Public Health, 27*, 323–340.

Butterfoss, F. D., Goodman, R. M., & Wandersman, A. (1993). Community coalitions for prevention and health promotion. *Health Education Research, 8*(3), 315–330.

Centers for Disease Control and Prevention. (n.d.). *Youth risk behavior survey*. Atlanta, GA: Author.

Cousins, J. B., & Whitmore, E. (1998). Framing

participatory evaluation. In Whitmore, E. (Ed.) *New directions in program evaluation* (80th ed., pp. 87–104). San Francisco: Jossey-Bass.

Fawcett, S. B., Paine-Andrews, A., Francisco, V. T., Schutlz, J. A., Richter, K. P., Lewis, R. K., et al. (1996). Empowering community health initiatives through evaluation. In D. M. Fetterman, S. J. Kaftarian, & A. Wandersman (Eds.), *Empowerment evaluation: Knowledge and tools for self-assessment & accountability* (pp. 161–187). Thousand Oaks, CA: Sage Publications.

Feinberg, M. E., Bontempo, D. E., & Greenberg, M. T. (2008). Predictors and level of sustainability of community prevention coalitions. *American Journal of Preventative Medicine, 34*(6), 495.

Fetterman, D. M., Kaftarian, S. J., & Wandersman, A. (Eds.). (1996). *Empowerment evaluation: Knowledge and tools for self-assessment & accountability*. Thousand Oaks, CA: Sage Publications.

Gomez, B. J., Greenberg, M. T., & Feinberg, M. E. (2005). Sustainability of community coalitions: An evaluation of communities that care. *Prevention Science, 6*(3), 199–202.

Israel, B. A., Krieger, J., Vlahov, D., Ciske, S., Foley, M., Fortin, P., et al. (2006). Challenges and facilitating factors in sustaining community-based participatory research partnerships: Lessons learned from the Detroit, New York City and Seattle urban research centers. *Journal of Urban Health, 83*(6), 1022–1040.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health, 19*, 173–202.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2008). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2007* (NIH Publication No. 08-6418). Bethesda, MD: National Institute on Drug Abuse.

Judd, J., Frankish, C. J., & Moulton, G. (2001). Setting standards in the evaluation of community-based health promotion programs — a unifying approach. *Health Promotion International, 16*(4), 367.

King, J. A. (2007a). Developing evaluation capacity through process use. In Cousins, B. (Ed.) *New directions in program evaluation* (116th ed., pp. 45–59). Wilmington, DE: Wiley Periodicals.

King, J. A. (2007b). Making sense of participatory evaluation. In Mathison, S. (Ed.) *New directions for evaluation* (114th ed., pp. 83–105). Wilmington, DE: Wiley Periodicals.

Kreuter, M. W., Lezin, N. A., & Young, L. A. (2000). Evaluating community-based collaborative mechanisms: Implications for practitioners. *Health Promotion Practice, 1*(1), 49–63.

Suarez-Balcazar, Y., & Harper, G. W. (2003). Community-based approaches to empowerment and participatory evaluation. In Y. Suarez-Balcazar & G. W. Harper (Eds.), *Empowerment and participatory evaluation of community interventions* (pp. 1–20). Binghamton, NY: Haworth Press.

Zakocs, R. C., & Edwards, E. M. (2006). What explains community coalition effectiveness? A review of the literature. *American Journal of Preventive Medicine, 30*(4), 351–361.

Leslie Aldrich, M.P.H, *is the director of Evaluation & Research for the Massachusetts General Hospital Center for Community Health Improvement. For more than 10 years, her work has focused on youth and the prevention of risky lifestyle choices and the study of underserved populations and the critical need for access to health care. Questions about this article may be addressed to Leslie Aldrich, M.P.H., Director, Evaluation and Research, MGH Center for Community Health Improvement, 101 Merrimac Street, Suite 603, Boston, MA 02114.*

Daniel Silva, B.A., *is a research assistant for the Massachusetts General Hospital Center for Community Health Improvement. Daniel is a graduate of Wesleyan University where he received his Bachelor of Arts in biology and science in society and was a National Scholars Honor Society Member.*

Danelle Marable, M.A., *is a project manager for the Evaluation & Research Team of the Massachusetts General Hospital Center for Community Health Improvement. Her work is focused on adolescent risk and protective factors, specifically relating to drug use and violence, refugee and immigrant health, and pregnant and parenting teens.*

Erica Sandman, M.A., *is a project coordinator for the Evaluation & Research Team of the Massachusetts General Hospital Center for Community Health Improvement. Ms. Sandman has experience coordinating research projects in the area of alcohol and nicotine addiction and treatment and has expertise in social science research methodology.*

Melissa Abraham, Ph.D., *is a staff psychologist at Massachusetts General Hospital. She is on faculty at the Institute for Health Policy and Harvard Medical School.*