PROCESS EVALUATION FOR COMMUNITY PARTICIPATION

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Key Words: coalition, partnership, participatory evaluation, community-based participatory research

Abstract: This review provides a synthesis of published public health and social science literature to determine how process evaluation has been used to examine community participation and its intermediary role in health and social change outcomes. Community participation is defined, and its relationship to other community-development principles and evaluation and research methods is described. Then, case studies and research initiatives help answer questions such as who participates and why? What are the benefits and challenges of community participation? What qualitative and quantitative methods are used in process evaluations to measure community participation? What measures are used to help define the influence of community participation in community-based interventions? A better understanding of these issues is needed to ensure that community participation is valued and used effectively to plan and implement health-promotion initiatives and evaluate their processes and outcomes.

INTRODUCTION

The rationale for community participation in health-promotion research and interventions has been clearly articulated (5). First, communities shape behavior through a system of exchange and influence. Second, communities themselves may be engaged or mobilized to act as change agents to achieve social and behavioral outcomes. Finally, early and sustained participation by community members and leaders is needed to realize community ownership and sustain programs (5, pp. 20–21). The general experience of practitioners and limited evidence from participatory evaluations suggest that, when organizers and researchers seek out and involve community members in their efforts, health outcomes are better realized, and maintenance of programs is enhanced. However, studies of community participation show promising short-term results but have a mixed record of long-term success.

Classic large-scale, community-based prevention trials focused on community organizing but did not evaluate actual participation by community members (54, 62). Since the 1980s, the public health community has witnessed a shift from a model of practice and research on the community to one of practice and research
with the community. This change has increased demands for accountability and
shared control by community members who participate in partnerships and coalitions that engage in collaborative research and interventions (64, 65). Researchers have come to value the inclusion of priority community members in planning, implementing, and evaluating research (37). However, community health-promotion research usually focuses on the outcomes of capacity-building interventions and not on the facilitators or barriers of the interventions (38). This lack of attention results in poor understanding of community participation and other factors that may affect program implementation and their relationship to program outcomes (9, 10). Clarifying these factors may help public health practitioners implement more effective community-based interventions (10, 28).

Process evaluation is valued by practitioners and researchers as a means of discovering the extent, fidelity, and quality of health-promotion and disease-prevention interventions (37). Process evaluation encourages refinement of constructs during implementation (30) and focuses on program operations and how outcomes are achieved, as opposed to outcome evaluation, which studies the program’s influence on health outcomes (37). Notably, community participation has been measured both as a process (who, how, when, why, how many, and how much community members participate in an initiative) and as a program outcome. This review builds on previous assessments of community participation and partnership building and shows how process evaluation has been used to examine community participation and its role in health and social-change outcomes (9, 10, 36, 40, 50, 60, 61). The review is limited to literature that specifically addresses participation in community-based interventions and research projects and not recruitment and engagement of participants in clinical trials, a voluminous literature by itself.

To begin, community participation and its interrelationship with other community-development principles and evaluation research methods are described. Then, case studies and research initiatives are used to help answer questions such as, Who participates and why? What are the benefits and challenges of community participation? What qualitative and quantitative methods are used in process evaluations to measure community participation? What measures are used to help define the influence of community participation in community-based interventions? and What are the results of community participation? Answering these questions may ensure that community participation is used effectively to plan, implement and evaluate health-promotion initiatives.

REVIEW METHODS AND LIMITATIONS

This review covers selected studies of community partnerships or coalitions (e.g., county, city, or neighborhood level) that addressed health issues and collected data on participation of members representing community organizations. Studies described quantitative and/or qualitative data about processes attributed to the partnerships. The literature search relied on electronic journal databases (i.e., PUBMED,
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MEDLINE, and PSYCHLIT), bibliographies of previous reviews, and descriptive articles about community participation and evaluation of community coalitions and partnerships. Interpretations and conclusions based on this review are limited by a focus on studies of partnerships that clearly targeted a health-related concern rather than broad social concerns and those studies that specifically measured community participation. Although numerous studies focused on coalition effectiveness, many did not specifically address community member participation factors in detail and were not included in this review.

COMMUNITY PARTICIPATION DEFINED

Community participation was first espoused as a health-promotion strategy by the World Health Organization (WHO), and we have struggled to define and measure it ever since (47, 72). Although formerly known as citizen participation, this term is used less often now because we recognize that citizenship in its legal sense is not required for participation in community life. Nevertheless, the definition of citizen participation as “the social process of taking part (voluntarily) in formal or informal activities, programs and/or discussions to bring about a planned change or improvement in community life, services and/or resources” easily applies to community participation (5, p. 110). Community participation is also described as a social process in which groups with shared needs living in a “certain geographical area” actively identify needs, make decisions, and set up mechanisms to achieve solutions (3). However, heterogeneous groups and individuals can become a community and collectively take action to attain shared and specific goals (47). Furthermore, individuals may belong to multiple communities at the same time, and the essence of community is that something is “shared” (43, p. 84). Communities may be engaged to use and coordinate their resources of personnel, time, money, goods, and services in a broad range of structures and strategies. Large-scale community-based projects identified factors needed for successful community participation: knowledge of community history, organizational resources, influential structures, and interorganizational networks; early identification and discussion of barriers to community change; clearly stated roles and time commitments for community members; commitment of project sponsors to partnerships and/or local ownership; use of planned reinforcement and participant incentives; and timely use of conflict-resolution strategies (14, 46, 54). Solid leadership, effective organizational structures, and a supportive political climate also help promote community participation (43, 48, 61, 69, 73, 74). Conflict can occur when community participation is engaged for a predetermined health-promotion or disease-prevention purpose rather than letting community members define their own health or social agenda (43, 74). Additionally, people- and community-based organizations often participate at different levels (69). They may have less access to resources than do government institutions and agencies and may view themselves as tokens that make the health-promotion effort look more credible (68).
However, if community participation is seen as a process as well as an outcome some of the tension may be reduced.

Community participation may be seen as a process along a continuum that enables communities to maximize their potential and progress from individual action to collective social and political change (36). Process evaluations of health-promotion programs occur over the short term of the planning and intervention periods, but the community’s experience of participating and being empowered may not be realized until long after the intervention is completed (47). In summary, involving community members can help pretest new programs for feasibility and acceptability; gain access to local resources, skills, volunteers, and leaders; incorporate local values and attitudes into program plans; encourage coordination and reduce conflict among local organizations; develop community capacity and competence; and ensure local ownership and maintenance of programs (6, p. 114; 8).

PARTICIPATION IN COMMUNITY BUILDING
AND COMMUNITY ORGANIZING

A strongly held tenet in public health programs is that community organization is critical to implement community-based health interventions and research successfully (2, 17). Community organization is defined as “the process by which community groups are helped by outsiders to identify common problems or goals, mobilize resources and develop and implement strategies for reaching the goals they collectively have set” (51, p. 26). Related to community organizing is community building, a process in which people in a community engage themselves to focus on reinvesting in the community, building and sustaining social capital, promoting community participation, and strengthening families and neighborhoods (4).

Several key concepts help us understand community organizing and community building. At the heart of each of these concepts is the core principle of community participation.

Empowerment

Empowerment is a multilevel construct that describes a social action process for people to gain mastery over their lives, their organizations, and the lives of their communities (7, 52, 65). By organizing and mobilizing, communities can be empowered to achieve the social and political changes needed to address their powerlessness (36, 42, 43, 74). Nine factors that influence community empowerment are participation, leadership, problem assessment, organizational structures, resource mobilization, linkages to other individuals and organizations, inquisitiveness, program management, and the role of outside agents (36, pp. 180–81). As an outcome, community empowerment is limited by the long time frame required to see change and its dependence on community contextual factors (2, 15). As a process, community empowerment measures the interactions between capacities, skills,
and resources at both individual and organizational levels during a program intervention, as well as community changes in networks, institutional policies, and health indicators (36). Legacy Foundation’s Statewide Youth Movement Against Tobacco Use describes youth empowerment as the outcome of active community participation in local efforts by youth (35, 36). Community participation is related to empowerment since, by participating, members expand their power from within to create needed changes (51, p. 35).

Community capacity is defined as the “characteristics of communities that affect their ability to identify, mobilize and address social and public health problems” (31, p. 259). Dimensions of community capacity include citizen participation and leadership, skills, resources, social and organizational networks, sense of community, understanding of community history, community power, community values, and critical reflection (31). Collaborative capacity refers to the conditions needed to promote effective collaboration and build sustainable community change (30). Further, researchers suggest that collaborative capacity is needed at four levels in the coalition: within members, within member relationships, within the organizational structure, and within the programs that coalitions sponsor (27). Community participation is related to community and collaborative capacity in that members actively participate in the life of their community through leadership, social networks, and access to power (27; 51, p. 36).

Community competence occurs when various parts of the community collaborate to identify its problems and needs, reach working consensus on goals and priorities, agree on ways and means to implement those goals, and collaborate effectively (19, p. 199). The dimensions of community competence are commitment; participation; self-other awareness and clarity of situational differences; conflict containment and accommodation; management of relations within society; skills for facilitating participant interaction and decision making; articulateness; and communication (19). Community competence is described as skillful application of community capacity, and community participation is central to its accomplishment (31).

Social capital is defined as the relationships and structures within a community, such as civic participation, networks, norms of reciprocity, and trust, that promote cooperation for mutual benefit (57). In essence, social capital is a bonding relationship between community members that results from their participation, trust, and reciprocity (39, 51, 57).

PARTICIPATION IN COMMUNITY PARTNERSHIPS AND COALITIONS

Do all health problems or social issues require a community-participative approach? The simple answer is not if an easier way exists to get the work done and achieve community goals. Mobilizing community members to comprehensive action is difficult; it must be deliberate, persistent, coordinated, and funded. However,
if community stakeholders in collaboration with public health, medical, human service, and political leaders decide to engage community members to participate in research and intervention projects, many structures exist to accomplish this end, including leadership boards or councils, citizen panels, networks, grass roots organizations, and consortia (5, 9). In recent years, the vehicle most widely used in public health to promote citizen participation is the community coalition. Community coalitions are defined as groups of individuals, factions, and constituencies who agree to work together to achieve a common goal (22). Coalitions are types of partnerships that coordinate existing prevention and health-promotion efforts in communities and encourage or sponsor new ventures. Coalitions strive to improve, change, and introduce innovative solutions to health problems by using existing and potential resources in effective ways (8, 73). The key asset of any coalition or partnership is its members, and the role of the coalition is to mobilize effectively members’ commitment, talents, and assets to effect change. Participation of coalition members is prerequisite to goal accomplishment for any partnership. The main aspects of community participation that are measured in coalitions are member roles, expectations, actual hours spent in and outside of coalition meetings and activities, benefits and challenges of participation, and influences in decision making (8). Partnership synergy is a multifactorial concept influenced not only by coalition members’ levels of participation, but also by the partners’ diversity and their ability to leverage material and financial resources, trust, and power relationships and governance (44). Member engagement is a related term that encompasses commitment, satisfaction, and participation of coalition members (11). Critics of coalition approaches maintain that, although popular, they often do not show effects on primary outcomes, e.g., levels of substance abuse (2, 32, 40, 60). This is not surprising given the amount of time and effort needed to show these kinds of health status changes (2, 9, 11, 48, 61, 69). However, coalitions do need to evaluate their intermediate process outcomes, such as community participation, and link them to realistic, corresponding community outcomes such as new indoor air policies (26, 32).

PARTICIPATION IN COMMUNITY-BASED PARTICIPATORY RESEARCH AND PARTICIPATORY EVALUATION

Community-based participatory research (CBPR) in public health focuses on social, structural, and physical environmental inequities through active involvement of community members, organizational representatives, and researchers in all aspects of the research process (50). Partners contribute expertise to enhance understanding of a given phenomenon and to integrate the knowledge gained with action to benefit the community involved (50). CBPR shares several fundamental characteristics with other types of participatory research; namely, it is participatory, engages community members and researchers in a joint process in which
both contribute equally, is a colearning process, involves systems development
and local capacity building, empowers participants to increase control over their
lives, and balances research with action (36). Community participation is central to
CBPR—community members are involved at every level from recruitment of other
community members to designing the research, collecting data, and interpreting
the results and data feedback to the community for decision making.

Participatory evaluation is a cyclical process based on the action research cycle
that involves a series of decisions in which all stakeholders participate. As the
name suggests, community participants are actively involved in participatory eval-
uation. The evolving nature of community initiatives (whether led by a coalition
or not), the complexity of the community, and the multiple levels of change that
are expected make traditional evaluation less useful than participatory approaches
(23). For example, empowerment evaluation is a participatory and iterative process
by which the community, in collaboration with a support team, identifies its health
issues, decides how to address them, monitors progress toward goals, and uses the
information to adapt and sustain the initiative (19, 23). Involving participants at
each stage of evaluation generates innovative ways to measure process, impact,
and outcome, even though maintaining participants’ enthusiasm and interest is
challenging (62). Although they both use some of the same tools and methods,
participatory evaluation differs from research in that community values drive the
evaluation, and program activities are measured against standards that are often
value laden. However, when participatory activities of research and evaluation take
place during the same initiative, little difference is observed (23).

PROCESS EVALUATION OF COMMUNITY
PARTICIPATION

Now that the relationship of community participation to community building and
organizing principles and concepts has been clarified and the role of community
participation in coalitions and partnerships and in participatory research/evaluation
has been defined, we review the methodologies, measures, and results of process
evaluations of community participation itself.

PROCESS EVALUATION METHODS TO MEASURE
COMMUNITY PARTICIPATION

Participant Surveys

Written questionnaires for members and leaders (and often staff as well) are the
most common method used by coalitions and partnerships to assess participa-
tion. Valid and reliable instruments have been developed and refined such as the
Block Booster Survey (56), California Tobacco Control Coalition Member Survey
Community Team Member Survey (59), Rhode Island Community AOD Task Force Survey (24), Fighting Back Committee Member Survey (10), North Carolina Project ASSIST Coalition Effectiveness Survey (39), South Carolina Adolescent Pregnancy Prevention (AAPI) Key Leaders’ Survey (58), Questionnaire for Partnership Members (written and online formats) (44), and Smokeless States Coalition Self-Assessment Survey (CSAS) II (63).

Event or Activity Logs

Event logs are maintained by key informants in the community coalitions and are used to document the history of the coalition’s accomplishments and occurrences related to the coalition’s goals and objectives. The entries describe program objectives, actions taken by members and those outside the group, targets of action, actors’ names, dates of action, and locations of action (20, 21, 26). The logs document members’ actual levels of participation in coalition activities better than does recall alone.

Key Informant Interviews

Many coalitions use structured interviews with members, leaders, and key community stakeholders (in and outside of the coalition) to develop subsequent quantitative member surveys or elucidate the findings of previous surveys. Structured interviews provide a rich source of contextual information about the coalition; its formation, structure, and operation; resources (personal, organizational, and financial); linkages with other organizations; perceptions of provided assistance; anticipated future needs; and value added to the work by the coalition. The Rhode Island Community AOD Task Force Leader Interview (24), Minnesota Statewide Association for Family Planning Interview (33), East Side Village Health Worker Interview (1), Project ASSIST Interview (39), AAPI Member Interview (58), and RWJF Allies Against Asthma Interviews (18) are examples of structured interviews that were used to gather information about member, leader, and staff participation and perceptions. The University of Kansas Work Group used structured interviews to clarify and check for completeness of event logs (21, 26).

Focus Groups

Focus groups are used to collect data about special populations served by community coalitions. However, as coalition members are often part of the population being studied, they have been used to clarify their perceptions of barriers to participation, their role in the coalition, and the involvement of community members in coalition activities (8, 12).

Observation of Meetings

Because most partnerships convene meetings to plan and evaluate their work, systematically assessing the quality, participation, and productivity of member interactions is critical. A meeting effectiveness inventory (MEI) was used to rate...
the level of participation, balance of leadership between leaders and staff, cohesiveness, and quality of decision making, organization, and productivity of quarterly coalition and committee meetings (30). Postmeeting debriefing sessions were held between staff and leaders to review results and problem solve to improve various aspects of participation. Similarly, a project insight form (30) was used as an open-ended discussion tool after the meeting to discern factors that facilitated or hindered meeting effectiveness and to plan for improvement.

Review of Existing Documents

Coalition evaluators commonly review coalition documents such as meeting agenda, attendance rosters, minutes, and annual reports to determine how, when, where, and how often members participate (13, 26, 29, 39, 58).

MEASURES OF COMMUNITY PARTICIPATION

Indicators of community participation include the opportunities and levels of decision making, amount and duration of time devoted to goal activities, degree of local ownership perceived and/or achieved, representativeness of member and leader groups, satisfaction with the process of participation and achievement of long-term goals (5, p. 11). Similarly, the following indicators have been widely used by researchers and practitioners who rely on community participation to achieve project goals:

1. diversity of participants/organizations,
2. recruitment/retention of new members,
3. role in the coalition or its activities,
4. number and type of events attended,
5. amount of time spent in and outside of coalition activities,
6. benefits and challenges of participation,
7. satisfaction with the work or process of participation, and
8. balance of power and leadership.

Measures represent items taken from surveys that have been continually enhanced and refined as more is learned about how members function in their roles as community partners (1, 8, 9, 13, 16, 18–21, 25, 26, 30, 31, 34, 39, 41, 45, 49, 53, 55, 58, 59, 63, 67, 68, 70). Granner & Sharpe have produced an extensive inventory of tools for evaluating community coalitions that contain these and other relevant measures (31a, 31b).

Individual and Organizational Diversity

Earlier studies found that active participation does not appear to be related to demographic characteristics such as ethnicity, gender, or age of members but is
related to member satisfaction, expectations about outcomes, skills, and training (15, 16, 24, 56, 66–68, 73). Nevertheless, the coalitions reviewed strived to achieve diversity at all levels and evaluate the impact of diversity on other coalition factors and outcomes. Other than the usual demographic items, one survey asked members whether the coalition was actively recruiting new members and to identify (from a list) which sectors were not well represented (53). Members were asked which single group was not well represented and which would be most important to add. When asked why that group was not well represented, choices of responses included coalition never tried to involve them, they were invited but chose not to participate, they used to participate but dropped out, coalition could not obtain access to this group, coalition is not sure that this group should be recruited, resources are lacking to recruit, or members do not want to share power with this group (53).

**Member Recruitment and Retention**

Recruiting and retaining a diverse membership are the goals and mandates of most funded coalitions. A stable membership is often observed in coalitions after a significant turnover of organizations in the first few months of the effort. Once established, the core membership often gels into a cohesive unit where the members experience mutual support and a sense of belonging (18). All coalition studies reviewed used questionnaires or structured interviews to query how long respondents had been members of the partnership (categories from >6 months to >5 years) (10, 59) or asked members to write the number of years and/or months of membership (39, 63, 70). In one survey (a) coalition coordinators were asked to estimate how many partners had left and joined the partnership since its formation; and (b) members were asked how much having different kinds of partners led to new/better ways of thinking about how to achieve goals, enabled the partnership to plan activities that connected multiple services, programs, or systems, and incorporated priority population perspectives into their work (70).

**Role in the Partnership**

The degree of community participation may be discerned by the number and kind of active roles that members and organizations assume, as well as the amount of time they contribute to the organization. Some of the roles measured include serving as a coalition, work group, or task force leader; serving as a coalition representative to other groups or coalitions; recruiting new members; serving as a spokesperson; training or mentoring others; acquiring funding or other resources for the coalition; advocating for policy or law; getting outside support for coalition positions on key issues; designing evaluation; collecting data; or refining findings (39, 44, 58, 63). Several surveys asked members to rate whether they knew their role and what was expected of them (5, 58) and whether they had a choice of the activities in which they were involved (58). One questionnaire asked to what extent their roles
and responsibilities in the partnership reflected their interests, skills, or resources; to what extent they were asked to take on roles or responsibilities better suited to other partners; and to what extent their involvement affected the partnership’s goals, plans, and activities (a lot, some, a little, not at all) (44).

Number and Type of Events Attended

Some evaluators use event logs to measure the actual number of events and meetings that members attend (26). Similarly, Program Reach is an online activity-reporting system that tracks numbers and names of organizations and members that participate in training, educational sessions, and community events on a quarterly basis (8).

Amount of Time Spent in and Outside of Coalition Activities

All reviewed studies tracked the amount of time members and leaders spend in coalition meetings, activities, or community-related events on behalf of the coalition. If not recorded by event logs or reports, this factor is collected via questionnaire recall as hours per month or quarter or calculated as a percentage of time spent in meetings versus out of meetings (58). One survey asks members to determine what the number of meetings they actually attended out of those to which they were invited (all, most, some, a few, none) (44). Some questionnaires or interviews asked members to rate how involved they have been in coalition activities (not at all, a little, fairly or very involved) (63) or to rate their level of participation (not at all, minimally, moderately or very active) (58). A six-point Likert scale had members rate whether they participated consistently over the past year and how committed they were to participating in future activities (58). One study asked participants whether they participated in any of seven “change-related” activities during the past year (1).

Benefits and Challenges of Participation

The following potential benefits for members and their organizations have been measured: heightened public profile; increased utilization of expertise or services; enhanced ability to address an important issue; enhanced ability to affect public policy; development of valuable relationships with other groups; acquisition of useful knowledge about health issues, services, programs, or people in the community; achievement of organizational goals; enhanced ability to meet the needs of clients or constituency; ability to have greater impact by working collaboratively on goals; ability to make a contribution to the community; acquisition of additional financial support; and enhanced access to priority populations (44, 63).

Challenges to participation that were measured include diversion of time and resources away from other priorities or obligations, insufficient influence in partnership activities, insufficient credit for contributing to the accomplishments of the
coalitions, conflicts between job and partnership work, undervalued opinion, misused or misdirected skills and time, competition between coalition and member organizations, and lack of support for member’s viewpoint. Finally, all surveys asked whether the benefits of participation outweighed the costs or drawbacks personally, professionally, and for their organization (yes, no, both are about equal) (44, 63).

Satisfaction with the Work or the Process of Participation

Satisfaction with the work or the process of participation was included in most studies and was often the dependent variable against which other factors were measured. From earlier studies, the global question of whether members are satisfied with the work of the coalition appears to be reliable (10, 24, 59). However, several other areas of satisfaction were assessed, i.e., satisfaction with the way people and organizations work together, with the coalition’s plan, and with the way the partnership implements its strategies (70).

Influence in Decision Making

Most coalition evaluations addressed this question, attesting to the importance of decision-making power. One evaluation simply asked how satisfied members were with their influence in the coalition (70). Many questionnaires included items that asked members to consider whether staff, leaders, or other members had more, less, or the same amount of influence in making decisions. One survey asked whether the decision-making process was clear, followed standard procedures, and was timely and fair (63). Another asked how much influence members have in making certain kinds of decisions, i.e., those that involve setting goals and objectives, selecting coalition activities, setting the budget, or deciding general policies and actions (37).

Balance of Power and Leadership

Balance of power and leadership is related to decision making but is less often included in process evaluations. One survey asks members to estimate the control that members, leaders, and staff had in the previous meeting (30). A member survey asked members to list up to three organizations that have the most power in making decisions (39).

Synergy

Synergy has been used by only one evaluation team but is being widely disseminated (44, 70). Synergy items ask members whether by working together they achieve ten ideal tasks, e.g., identify new and creative ways to solve problems, develop goals that are understood and shared, and implement strategies that are likely to work.
RESULTS OF MEASURING PARTICIPATION IN COMMUNITY INITIATIVES

Measurement of community participation has progressed from merely asking members whether and how much they participate in various activities to actually specifying how they participated and monitoring that participation. The reviewed literature addressed or measured some of the participation factors, but most did not focus on process evaluation of community participation as an end in itself. The measurement of process indicators was most often used to produce a set of recommendations for program improvement, especially related to recruitment and retention of members, development and training of staff and leaders, and improvements in collaborative decision making and governance. Although researchers and practitioners who work with collaborative partnerships would be reassured to find a participation measure that predicted success in reaching their mutual goals, such is not the case. The following results were found.

First, in most community collaborative partnerships, substantial sectors of the community were not well represented and not as diverse as the partnerships expected. According to surveys and content analyses of coalition member rosters, sectors that were most often inadequately represented or not represented at all include business and faith-based groups, minority groups, and certain age groups (children, youth, elderly) (8, 10, 13, 19, 24, 25). Recruiting members was relatively easy for most partnerships (other than recruiting partners from the above sectors), but sustaining their participation was difficult. To counteract this problem, partnerships reported spending considerable time communicating with members, promoting positive relationships, and making sure members felt included (13, 18, 21, 25).

Second, in general, the more roles members assumed, the more satisfied they were (25) and the more skills they had to offer, which was, in turn, related to increased participation in coalition work (8, 10, 13, 16, 18, 21, 24, 39, 59). Moreover, more time spent participating in activities in and outside the partnership (especially those geared toward effecting change) was related to higher levels of empowerment (1, 34, 35, 54, 74). Increased empowerment is, in turn, related to member satisfaction.

Third, participants generally reported more benefits than challenges from participating in coalition activities. Early work with formal or voluntary associations, appears to be supported, namely, which found that participation was more likely among those who were concerned about their neighborhood, experienced as community leaders, and believed that able peers could be recruited to support the project (9, 59, 67). Participation was also related to positive cost-benefit determinations (10, 18, 19, 26, 39, 59, 66).

Overall, members reported moderate levels of influence in decision making and balance of power and leadership. Democratic leadership that supports full community-member participation is a key determinant of successful partnerships (9, 42, 43, 45). Results reviewed showed that synergy was highly related to partnership efficiency or the degree to which the organization optimally used the member’s time and financial and in-kind resources (70). This finding emphasizes the need to
plan collaborative activities carefully because the work of the partnership is often not the member’s primary responsibility.

Discussion and Recommendations

In community-partnership interventions and research, process evaluation plays a vital role. The innovative methods, tools, and measures reviewed here reflect the needs and vital input of community participants. We have made real progress in how community participation is measured compared with measurements in the early 1990s. Standard instruments, online surveys, and detailed reporting of program activities use members’ time well (8, 22, 71). Resulting data is more likely to reveal the subtle contexts and variety of information about program implementation (26, 29, 40, 60). Ongoing systematic documentation of progress in participating in activities that lead to community change is essential to the longer-term process of relating significant reach and intensity of programs to achieving changes in health status (17).

Documentation can help assess progress, recognize positive achievements, and refine programs (2). When faced with project timelines of three to five years, process data is helpful in maintaining community interest before longer-term outcome data is available (11, 17, 20, 21, 23, 26, 29–32, 37, 38, 48, 50, 52, 62, 69, 71, 73). Assessment and feedback of process-evaluation results can strengthen programs and reassure community participants that their efforts are worthwhile.

Measurement of process indicators alone, however, is insufficient (2, 15, 32, 40, 43, 50, 61). Researchers and evaluators must learn innovative ways to tie process evaluation to intermediate and long-term goal attainment. Although researchers have begun to demonstrate that link (13, 27, 35), evidence is strong that this task will continue to be a persistent struggle. Public health partners may have to scale back expectations of what can be accomplished though community participation and collaboration (40, 50). Perhaps the best reason to encourage and improve participation in partnerships is that these organizations have proven themselves to accomplish some tasks very well. Coalitions serve as catalysts to bring community issues to the forefront; collect data from hard-to-reach populations about health status and barriers to care; help community groups develop action plans of feasible strategies; test promising and innovative change strategies that may later be adopted by community institutions and service agencies; and serve as forums to connect people with diverse talents, ideas, and capacities.

Finally, this review teaches us that how community is defined and who represents the community are critical factors. Fair and reliable methods and measures are being developed to determine who is left out of community partnerships, how partners relate back to their organizations, and how well community-based organizations represent the actual community (37). Coalitions often recruit less diverse partners than expected or desired with higher proportions of female, middle-age, and majority-race professionals. Perhaps the focus should be to achieve substantive representation where members are selected by and accountable to community interests rather than descriptive representation that mirrors the demographics of the community but has little accountability to it (49).
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DISCLOSURE STATEMENT


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