



## Swimming upstream: The challenges and rewards of evaluating efforts to address inequities and reduce health disparities

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### ABSTRACT

Racial and ethnic disparities in the health of Americans are widespread and persistent in the United States despite improvements in the health of Americans overall. Increasingly, strategies for reducing disparities have focused on addressing the factors that contribute to – if not fundamentally underlie – health disparities: social, economic, and environmental inequities, which limit access to resources and cause unhealthy exposures. As public health shifts to interventions that seek to improve the circumstances of disproportionately affected populations and achieve equity through policy change, alternative methods to evaluate these efforts are also required. This paper presents an example of such approaches to addressing asthma disparities through Regional Asthma Management and Prevention's (RAMP) programmatic efforts and an evaluation of these activities. The paper describes RAMP's targets and strategies, as well as the specific evaluation methods applied to each, including activity tracking, observations, surveys, key informant interviews, and case studies. Preliminary evaluation findings are presented, as are lessons learned about the efficacy of the evaluation design features – both its strengths and shortcomings. Findings discussed are intended to contribute to the growing literature that provides evidence for the application of emerging approaches to evaluation that reflect non-traditional public health and support others interested in expanding or replicating this work.

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### 1. Introduction and background

Racial and ethnic disparities in the health and well-being of Americans by are widespread and persistent in the United States despite improvements in the health of Americans overall (Liao et al., 2011). Health disparities, in turn, are tied to social, economic, and environmental conditions which affect access to resources (such as healthy food, safe housing, quality education, health care, and employment) and unhealthy exposures (to environmental toxins and violence, for example) (World Health Organization, 2008). Indeed, the social and economic conditions in which a person is born, lives, and works are important determinants of health status (World Health Organization, 2008). As the consistency and strength of these relationships have been better documented and more widely acknowledged (Berkman & Kawachi, 2000; Brownson, Haire-Joshu, & Luke, 2006; World Health Organization, 2008), strategies for reducing disparities have increasingly focused on the root causes of health disparities: social, economic, and environmental inequities (Koh et al., 2010; Thomas, Quinn, Butler, Fryer, & Garza, 2011; Williams, Costa,

Odunlami, & Mohammed, 2008; World Health Organization, 2008). These approaches seek to affect the social determinants of health which are defined as the social, economic, and environmental circumstances that produce unhealthy living, school, and work conditions and limit opportunities for quality education, jobs and other means of access to resources and self-determination (World Health Organization, 2008). In a departure from traditional strategies for improving health which tend to focus on “downstream” causes of poor health by attempting to ameliorate the effects of inequity, efforts to eliminate disparities increasingly also incorporate “upstream” interventions that seek to address inequity, often through policy change (Buckner-Brown et al., 2011; Liao et al., 2011; World Health Organization, 2008).

In 2008, the World Health Organization's Commission on Social Determinants of Health issued its final recommendations based on three years of research and deliberation. Among the chief recommendations in this groundbreaking work were calls for immediate action to ameliorate unhealthy conditions among disproportionately affected populations and for the adoption of policies to “assure more equitable distribution of resources, money and power” (World Health Organization, 2008). The report also called for all sectors of society – governments, the private sector, and research institutions – to support and/or undertake efforts to advance knowledge about the social determinants of health, as

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well as to know “what works effectively to alter health inequity” (World Health Organization, 2008). This appeal for additional study can be met, at least in part, by evaluations of health disparity initiatives. While often utilized primarily for accountability purposes, evaluation is also a critically important tool for identifying effective strategies, determining what specific components of a strategy contribute most directly to success (or failure), and how successful models are best disseminated and replicated.

However, given the importance of policy change in addressing inequities and disparities, traditional program evaluation methodologies, which seek to systematically measure the impact of specific inputs on predetermined outputs and goals, within specified periods of time, are not always suitable in this context. The stages of policy change developed by Ferris and Mintrom (2002) – problem definition, agenda setting, policy adoption, policy implementation, and evaluation – illustrate the multilayered and iterative process that is involved with affecting policy (Ferris & Mintrom, 2002). Yet even this model suggests a linearity in the process that rarely exists. Policy making can be extremely complex, with its multiple players and influences, some of which are known and others which are unknown (Teles & Schmitt, 2011). In addition, the policy making process is always subject to change, in part, because, it occurs within a political context that is itself multi-dimensional and ever changing. Investments in any one stage of the policy chain can result in diametrically different outcomes: rapid results which propel the effort to the next stage; little or no movement requiring more time for progress than anticipated; unexpected results that call for major shifts in the strategy; or a full stall in progress that requires that the effort be altogether abandoned.

The unpredictability and complexity of policy making requires that evaluation of efforts to address inequities and disparities take these factors into account as well as build them into the design. Evaluation design, including data collection and analysis plans and definitions of outcomes, must be framed to incorporate:

- Acceptance that the timeframe needed for achieving policy change may be beyond the scope of the project being evaluated (and, hence, beyond the evaluation timeframe) (Guthrie, Louie, David, & Foster, 2005; Teles & Schmitt, 2011);
- Allowance for progress to be assessed in incremental steps, as opposed to a specific long term policy goal, and identification of appropriate incremental outcomes – or even process outcomes, such as capacity building – as benchmarks (Coffman, 2007; Gardner & Geierstanger, 2007; Guthrie et al., 2005);
- Flexibility in the design to permit shifting of the evaluation if the project focus shifts to adapt to changes in the political context (Teles & Schmitt, 2011), and;
- Acceptance that policy evaluation does not always allow for attribution for successes (or failures) to a single individual or entity given the interactions and synergy that can occur with the multiple layers and multiple players involved (Guthrie et al., 2005; Stuart, 2007; Teles & Schmitt, 2011).

Alternative evaluation methods which incorporate these qualities are in formation and many are in practice (Gardner & Geierstanger, 2007; Kreger & Brindis, 2008; Samuels, Schwarte, Clayson, & Casey, 2009), though the field is in the relatively early stages of development. The purpose of this paper is to present the evaluation of an inequities and disparities initiative as a means of illustrating how the guiding principles for such evaluations can be successfully applied.

## 2. REACH and CEED: U.S. approaches to reduce disparities

The U.S. Centers for Disease Control and Prevention, in recognition of the role of social, economic, and environmental

factors in health disparities, established the Racial and Ethnic Approaches to Community Health program (REACH) in 1999 as a cornerstone of its efforts to address racial and ethnic health disparities (Giles et al., 2004). REACH provides funding to projects that incorporate community-based, participatory approaches to identifying community needs and adopting strategies for addressing the social factors that contribute to disparities at the individual, community, societal, cultural, and environmental levels. In this vein, REACH grantees pursue a wide range of intervention approaches, from counseling and education to systems and policy change (National Center for Chronic Disease Prevention and Health Promotion, 2011).

Currently, there are two major funding initiatives of REACH: 22 REACH Action Communities (ACs) which implement and evaluate practice-based and evidence-based initiatives designed to affect the cultural and environmental factors that can influence health disparities and 18 Centers of Excellence in the Elimination of Disparities (CEEDs) (National Center for Chronic Disease Prevention and Health Promotion, 2011). The overall purpose of the CEED initiative is to support local activities to improve the health and well-being of communities which experience disproportionate burdens of poor health associated with inequitable distribution of resources (as protective factors) and harmful exposures (as threatening factors). Among the 18 CEEDs designated in 2007 is Regional Asthma Management and Prevention (RAMP), located in Oakland, CA, which addresses disparities associated with asthma. RAMP's CEED project is in the final year of the five year grant. This paper reflects evaluation findings documented in the first four years of this project's implementation.

## 3. RAMP and its role as a CEED

Established in 1996, RAMP promotes strategies to reduce the burden of asthma in disproportionately affected communities through a socio-ecological approach that touches upon the individual, community, and societal spheres of influence on health. By working across these levels, RAMP seeks to maximize its effectiveness by tending to the array of factors that affect asthma outcomes while also intervening at multiple target points. In an effort to reach root causes of asthma disparities, RAMP's interventions are designed to address the conditions in homes, schools and child care centers, clinical settings, and in the outdoor environment which affect asthma, utilizing a number of means ranging from research and meetings with partners to define a given problem to organizing for policy change. Integral to this work are RAMP's four strategies: (1) expanding knowledge and access to resources; (2) creating linkages; (3) providing technical assistance; and (4) advocating for systems change, all of which are aligned with the principles identified by REACH as successful methods for addressing health disparities in diverse racial and ethnic communities (Centers for Disease Control and Prevention, 2007). RAMP's approach to addressing asthma disparities also involves bringing together diverse partners with common interests, such as public health and community-based organizations, schools, medical providers, and environmental health and justice groups (For more detailed information about the RAMP framework for addressing asthma disparities, see Authors et al., 2011).

As a CEED, RAMP's asthma disparities work is chiefly focused on African American and Latino communities. This emphasis is based on research which indicates that low-income populations and people of color in the San Francisco Bay Area experience the burden of illness more severely than their wealthier, white counterparts (Beyers et al., 2008). For example, African Americans have the highest asthma prevalence rates in the region while the number of Latinos diagnosed with asthma (1.4 million) is greater than any other minority group in California (Center for Health Policy

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