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Developing Culturally Competent Evaluation Tools With Tobacco Control Program Practitioners

Jeanette Treiber, PhD

Aiming to develop a utilization-focused evaluation approach, this article presents the process of developing culturally competent evaluation guidelines for Tobacco Control programs with American Indian/Alaska Natives, African Americans, Asian/Pacific Islanders, Hispanic/Latinos, LGBT, low-socioeconomic status populations, and rural populations. Through literature reviews and an interactive process that engages tobacco control program practitioners throughout the state of California, a UC Davis evaluation center developed a series of culture-specific guidelines for use in process and outcome evaluations. The norm change approach of the California Department of Public Health is contrasted with the norms of the priority populations it serves to determine why these populations are less responsive to the strategy than mainstream populations and points to ways in which evaluation activities can contribute to achieving greater inclusion of minority populations in tobacco control program efforts.

Keywords: culturally competent evaluation; priority populations; norm change; evaluation guidelines; tobacco control

Cultural diversity influences the validity of data in disease prevention research and evaluation efforts, if the tools to collect data do not adequately account for cultural specificity. The need for culturally adapted tools became apparent to the Tobacco Control Evaluation Center (TCEC) when assisting tobacco control grantee organizations in the State of California with their evaluation work. Many of these grantees work with new immigrants and culturally diverse populations; they expressed that assessments, surveys, and interviews were difficult to conduct with available standardized instruments. In California, cultural difference in tobacco control programs is particularly pronounced because of the comparatively high number of recent immigrants with diverse ethnic backgrounds, generational differences within ethnic groups with wide ranges of cultural retention and assimilation, the multifaceted nature of cultural identity building, and the various social and political meanings that tobacco use and tobacco control issues have for the various stakeholders involved in tobacco control programs. As a capacity-building organization, TCEC wanted to acquire and pass on relevant values, behaviors, knowledge, and skill sets and went in search of culturally competent evaluation guidelines for use in tobacco control work. It did so by first conducting a literature review and then engaging practitioners in developing practical guidelines.

The result of TCEC’s effort is a series of how-to documents for tobacco control evaluation in communities with diverse populations, which is available on TCEC’s website at http://programeval.ucdavis.edu/. Although the tools and guidelines are the major outcome of the research effort, the focus of this article is not the tools themselves but rather the process of

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developing them with the help of program practitioners in a collaborative manner and lessons learned in the process. Following a brief literature review on culturally competent evaluation, this article relates the development of culturally competent evaluation guidelines relevant for tobacco control and other health program evaluation efforts while engaging tobacco control program practitioners in the guidelines development process. It discusses the need for culturally competent evaluation using the California tobacco control example, and it outlines the steps TCEC took to help tobacco control programs conduct culturally competent evaluation.

Philosophically, this article aligns itself with utilization-focused evaluation, which emphasizes “intended use by intended users” (Patton, 1997). Utilization-focused evaluation stresses “situational responsiveness” that guides the evaluation process. By extension, situational responsiveness includes cultural responsiveness as an equally important element to give evaluation the intended purpose.

**BACKGROUND**

What is culturally competent evaluation? This article proposes a definition that is derived from various sources and that encompasses three levels: *culture*, *cultural competency*, and *culturally competent evaluation*. Those who have defined *culture* struggle to find the balance between culture’s specificity and its fluidity. In its *Practical Guide for Evaluators*, the Colorado Trust (n.d.) names religion, history, rituals, social class, concepts of beauty, notions of leadership, etc. as characteristics of culture. Cross, Bazron, Dennis, and Issacs (1989) stress that culture indicates the desirability of certain behaviors, interactions, or values. The National Center for Cultural Competence (2001) defines culture as “an integrated pattern of human behavior which includes (but is not limited to) thought, communication, language, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of racial, ethnic, religious, social and political groups” that is transmitted to succeeding generations yet is dynamic in nature. Sayre (2002) points out that cultural groups can have a wide range of heterogeneity, and Botcheva, Shih, and Huffma (2009) emphasize that “culture and cultural boundaries are unstable, fluid entities under constant reconstruction and revision,” whereas Chouinard and Cousins (2007) identify social transformation, social conflicts, and power relations as factors in the shaping and changing of culture; SenGupta, Hopson, and M. Thompson-Robinson (2004) add economic, ecological, and political forces as influential. Combining these various suggestions, we are defining culture for the purpose of this article as a distinct group’s pattern of behavior and set of values that are fluid and often overlapping with other group’s behaviors and values.

The most commonly referred to definition of *cultural competency* mentioned in evaluation literature comes from Cross et al. (1989), who define it as a “set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations” (in Endo, Joh, & Yu, 2003). Shui (2003) requires awareness and acceptance of differences to be culturally competent, and Botcheva et al. (2009) see it not as a skill set but rather an attitude of ongoing reflection and reaction. Some also stress the need to gain specific cultural knowledge (Botcheva et al., 2009; Cross et al., 1989; Shui, 2003). TCEC defines cultural competency as the ability to understand, validate, and respond to distinct cultural groups’ patterns of behavior and sets of values.

The literature on *culturally competent evaluation* is growing; however, it is predominantly conceptual rather than prescriptive. This can be attributed in part to the definition of culture itself—culture is fluid, not static. Making recommendations for evaluation strategies and practices with a specific group risks essentializing that group, possibly even stereotyping it. There is therefore an understandable tendency to limit recommendations to overall guidelines that are applicable cross-culturally rather than narrow the recommendations to specific groups. Because the evaluator’s own culture is present in the evaluation process, culturally competent evaluation requires a certain amount of self-reflexivity, including an awareness of the evaluator’s own position in the power dynamics of the evaluation process (Chouinard & Cousins, 2007; Endo et al., 2003; Hopson, 2003; SenGupta et al., 2004). Moreover, culturally competent evaluation applies principles of cultural competency to the entire evaluation process, which includes inclusiveness of stakeholders and their perspectives (Botcheva et al., 2009; Endo et al., 2003; SenGupta et al., 2004; Shui, 2003), flexibility in adjusting to cultural contexts (Botcheva et al., 2009; Shui, 2003), and knowledge and skills that are specific to the cultural group or groups that are part of the evaluation process.
A number of sources provide guidelines for various phases within the evaluation process, in particular for the development of indicators and data collection instruments (Botcheva et al., 2009; Cowles, 2005; Hopson, 2003; Sayre, 2002). In summary, the literature makes three main recommendations for culturally competent evaluation: (a) acknowledging and taking into consideration the political culture in which evaluation takes place, including power relations among stakeholders; (b) including stakeholders with their perspectives into the evaluation process; and (c) taking cultural specificities into consideration to generate useful data and make evaluation relevant.

Attempting to develop useful guidelines for California’s tobacco control programs, TCEC followed the same recommendations for the process of developing culturally competent evaluation guidelines. Therefore, TCEC engaged in the following steps:

1. Analyzing the political and power relations involved in California Tobacco Control
2. Including stakeholders in the development of the tools and encouraging their involvement in the local evaluation process
3. Developing tools that include multicultural principles of evaluation as well as specific guidelines for evaluation with the groups that the California Tobacco Control Program has identified as high-need populations.

**METHOD**

TCEC needed to learn from program practitioners what barriers prevented priority populations from achieving the same health behavior norm changes that other populations had already achieved, and how evaluation approaches could be made more culturally specific and relevant. In August 2007, TCEC brought together a number of project directors and program evaluators from California Tobacco Control projects for a 1-day facilitated discussion on the cultural challenges and possible strategies in tobacco control program evaluations. All Tobacco Control Section grantees serving priority populations were invited to attend the day-long workshop. Fifty-four people attended. This included project directors and/or evaluators of 12 Local Lead Agencies, 3 Competitive Grantees, and 19 Priority Population Grantees. In addition, 12 staff members from the California Department of Public Health, Tobacco Control Section, and 8 staff members from TCEC also attended. Dr. Rodney Hopson, Professor at Duquesne University, presented an introduction to culturally competent evaluation and then led the group through a discussion of a case study. Later, small groups discussed different challenges and solutions to culturally competent evaluation. Attendees were split up into smaller roundtables to begin collecting challenges, tips, and guidelines for conducting evaluation with the following groups: African American, Hispanic, LGBT, Native American, low–socioeconomic status (SES) populations, and rural populations. Participants shared stories, challenges, insights, and cultural specificities that came directly from their evaluation work in communities around the state. TCEC staff members that were assigned to each round table took notes, which later became the starting point for guidelines of conducting tobacco control evaluation with the various groups.

Following the workshop, evaluation associates at TCEC conducted additional research to validate and complement the information gathered from practitioners. The research was based on literature findings as well as on correspondence and conversations with cultural experts in the respective communities. For instance, the California Rural Indian Health Board (http://www.crihb.org/) acted as a sounding board for guidelines developed for working with Native American and Alaskan Native Communities. The African American tool was developed with the help of a consultant, who had many years of experience conducting program evaluation with African American communities, and the low-SES tool was reviewed and commented on by local evaluation experts, NGOs serving low-SES populations, and a poverty policy research group. TCEC understands the resulting documents that are available on its website as living documents, meaning that they are open for discussion and will be revised as more insight and information will be brought to the attention of the evaluation associates that function as primary authors.

**THE CULTURE OF CALIFORNIA TOBACCO CONTROL**

The California Department of Public Health’s antitobacco campaign can be understood as a political movement that promotes distinct norms and values. Its strategies are based on the Social Norm Change Paradigm promoted by the Centers for Disease Control and Prevention (California Department of Health Services, Tobacco Control Section, 2006; Centers for Disease Control and Prevention, National Institutes of Health, 2005). The theory promotes the idea that human behavior such as tobacco use is largely influenced by an individual’s surrounding social norms and that consequently strong antitobacco sentiment and policies in communities will
reduce tobacco use. CDPH therefore concentrates its efforts on promoting grassroots community activities such as gaining support among community members for local tobacco control policies. Policies are pursued in three main areas: countering protobacco influences (e.g., through limitation of advertising), reducing exposure to secondhand smoke (e.g., through smoke-free housing and public areas), and reducing availability of tobacco (e.g., through local tobacco licensing ordinances). Even though cessation services are also promoted, fewer resources are invested in this approach. Program emphasis is determined through local needs assessments, and the state allows local programs to choose from a wide menu of program objectives.

The approach has been having great success: California has been among the leading U.S. states in reducing smoking rates. The adult smoking rate of Californians was 14.3% in 2005 (C-Stats, 2008). This is down from 20.1% in 1990. The funds for the various tobacco control programs come from the state tobacco tax. A high portion of this tax goes to the 50 county health departments and some metropolitan areas in California to establish tobacco control programs. In addition, about 25 to 50 (depending on the funding cycle) programs are run by nongovernmental organizations.

**BARRIERS TO NORM CHANGE**

Although the cultural norms and values of California’s health authority have been quite influential in reducing overall smoking rates in the state, suggesting that a large part of the population has been ready to accept this change or adopt new norms as part of its culture, the smoking prevalence in some demographic groups or in subgroups of these demographics remains particularly high. The latter suggests that these groups’ cultures do either not as readily conform to the norms and goals of the State’s Health authority or that the promotion of the new norms has used communication strategies that have not been effective with these cultures. This is true in particular of the following groups: African Americans, American Indians, Asian/Pacific Islanders, Hispanic/Latinos, LGBT (lesbian, gay, bisexual, transgender), those of low SES, military personnel, and rural populations. The California Tobacco Control Program calls these “Priority Populations,” indicating that targeting these groups is of priority to future program efforts. Its explanation for the higher smoking rates and the associated health disparities among these populations reflects the challenge for tobacco control programs: “The reasons for tobacco related disparities are numerous, complex, and diverse: Lack of access to culturally competent medical care, limited community resources, competing priorities, limited tobacco control infrastructure, cultural traditions, and targeting by the tobacco industry all contribute to greater tobacco use in these communities” (California Department of Health Services, 2008).

Recognizing these disparities, the California Department of Public Health’s Tobacco Control Program’s Master Plan states that it aims to “eliminate disparities and achieve parity in all aspects of tobacco control” (“Master Plan,” 2006). The Master Plan specifies that “smoking must be reduced in the population groups in which smoking prevalence is the highest.” This is particularly important because these groups exhibit disproportionately high smoking-related disease rates. For this reason, the Tobacco Control Program requires that County Health agencies and other grantees include these populations in their intervention plans with outreach and program activities. Currently, all state-funded projects are required to include cultural competency objectives. In addition, competitive grants are made available to organizations that work exclusively with priority populations.

The CDPH has a mandate to address disparities in its health promotion program. This article and the work that it represents hopes to contribute to the effort of eliminating these disparities (Figure 1).

Because the evaluation component of the California tobacco control program effort includes assessments and offers main points of contact with the populations the program serves, TCEC sees an opportunity to help build the bridge between the culture of the state’s health authority and the culture of priority populations. If needs assessments, population surveys, key informant interviews, and other methods of interacting with and reaching the intended population are culturally inappropriate because they do not conform to the norms of that population, then health promotion efforts and norm changes will have little chance of occurring. The following section explains how evaluation comes into play in California’s tobacco control.

**EVALUATION ACTIVITIES**

All grantees are required to evaluate their programs through process and/or outcome evaluations using an empowerment evaluation–related approach (Tang et al., 2002). An online system helps programs design their evaluation plans, and it allows some flexibility by choosing from menu options of evaluation activities. Process evaluations are mainly used to document and analyze a policy adoption process, whereas outcome evaluations are conducted to proof and evaluate the policy implementation. For instance, a local program will conduct a community assessment activity. Based on the assessment, it may decide to work on a campaign for a
citywide policy to require apartment complex owners to set aside a certain percentage of housing units as smoke-free. The grantee has several options to conduct the campaign, and accordingly, to choose among different evaluation activities. To achieve the policy adoption, the program will try to find support among the general population, among apartment renters, among policy makers on the city council, etc. To help with these efforts and to document and learn from this process, the program can choose from a number of process evaluation options such as public opinion surveys at public events; tenant surveys at large apartment complexes; key informant interviews with city council members and with apartment managers; key informant interviews with city council members in other cities where such policies have passed; and document reviews to shape policy language. If implementation is part of the objective, it will be measured using outcome data. Outcome evaluations can use observation, key informant interviews, document reviews, and other methods to document compliance with the adoption of the policy. The following section indicates how culturally competent evaluation activities are crucial in the success or failure of tobacco control efforts.

THE NEED FOR CULTURALLY COMPETENT TOBACCO CONTROL EVALUATION STRATEGIES

In the above example of a nonsmoking housing policy objective, we begin to understand that the evaluation activities are not easy to carry out in a multicultural context. Multiunit housing complexes in California have great numbers of residents that fit the criteria of Priority Populations, as described above. Programs with this type of policy adoption routinely conduct interviews and surveys with multiunit housing residents. To yield valid data, interview and survey instruments must be designed for accurate assessment of the opinions and needs of all residents. Because many standardized survey instruments are tailored only toward a generic audience, the resulting data collection often becomes either exclusive or skewed. Without culturally specific data collection instruments, some informants are not sampled because of their cultural, linguistic, and/or economic characteristics, or if they are, they may misinterpret or not understand the survey questions. Data collectors encounter barriers related to language and cultural norms that if not overcome, limits program effectiveness.

In “Theory at a Glance: A Guide for Health Promotion Practice” (Centers for Disease Control and Prevention, 2005), the U.S. National Institutes of Health points out that most health behavior theories (and social norm change theory is among them) “can be applied to diverse cultural and ethnic groups, but health practitioners must understand the characteristics of target populations (e.g., ethnicity, socioeconomic status, gender, age, and geographical location) to use these theories correctly.” It goes on to say that morbidity and mortality, as well as risk and health behaviors, vary among these groups. In the experience of TCEC, communication
patterns and strategies rank equally high among the factors influencing success or failure of health promotion campaigns. In accordance with one of the identified strategies for achieving cultural competency, TCEC decided to listen to the voices from “the field,” meaning from those coming from and working with priority populations. It invited tobacco control practitioners to the table to discuss experiences and suggestions.

OUTCOMES

The tools developed with the help of practitioners may be viewed and used by going to the TCEC’s website at http://programeval.ucdavis.edu. During the research process, TCEC learned that even though tobacco use in the targeted groups is higher than in the general population, common ground between the norms of the California Department of Health and the groups could usually be found in the interest in preserving and promoting the health of all community members. But some cultural norms could usually be identified as interfering with this common interest, for instance, in Filipino and the LGBT communities.

In a conversation with a Filipino health educator in Filipino town of Los Angeles, TCEC learned that it was common in the culture for men to smoke in the house as long as children were not around. The norm was that tobacco use was okay for adults but harmful to children. What people did not usually know was that the second-hand smoke in the apartment where the family lived was harmful to the children, and that tobacco smoke was also harmful to adults. It was obvious that a standard survey question asking the tenants whether or not they were in favor of smoke-free housing did not take into consideration what the tenants knew about the harms of tobacco and what the social norms were surrounding tobacco use. Moreover, educating the tenants about the harmful effects of tobacco smoke and of secondhand smoke needed to occur long before support for smoke-free housing policy could be expected.

Another example demonstrates resistance to norm change: In the LGBT community, tobacco use takes on a symbolic function for some, as it is a behavior that counteracts mainstream society’s norms. Marginalization of LGBT in the community has led many individuals and subgroups within the LGBT community to appropriate their marginalized status with norm-countering behavior, whereas others use tobacco as a stress releaser to counteract the marginalization. Moreover, the tobacco industry has tapped into this market and used the rebel image heavily in advertisement to the LGBT community. Evaluation activities in this community had to consider for example that health educators and evaluators might be identified with the same institutions that contributed to the marginalization of these groups and that participation in evaluation activities could not necessarily be expected.

TCEC worked the outcomes from the roundtable learning experience into usable guidelines. Each of the tools also has instructions about cultural specificities that might interfere with or influence data collection. For example, Hispanic culture emphasizes the need for behaviors that promote smooth and pleasant social relationships. Giving socially desirable responses to an interviewer’s questions, out of a desire to please, may jeopardize the quality of evaluation data. Knowing this helps shape interview and survey questions in a less direct way. Triangulation by garnering information through different questions also helps improve the reliability of data.

Each of the tools provided on the TCEC website under “Culture in Evaluation” has a list of guidelines for developing specific instruments such as surveys and interview guides. Some are very specific to the community in question; others are applicable to almost all. For example, a common recommendation for all groups is the need to work with members of the community in the evaluation planning process. A “cultural broker” helps make the connection to important community organizations and known community leaders, provides insider information, can identify translators (in case language is a concern), and is the local eye and ear.

Although many of the characteristics mentioned in the culture-specific documents have great value for data collection, TCEC is aware of the danger that characterizing cultures might have for the possible stereotyping of certain community groups. One of the recommendations made in all tools is therefore to be aware of differences within each group. For example, as mentioned above, many individuals within the LGBT community identify with a rebel image, but many are also affirming and conforming to many mainstream cultural norms and could be offended by being classified or approached with assumptions made about this community as a whole. Data collectors must understand and be prepared to encounter a continuum of identity perceptions and norms from individuals within even specialized communities.

Practitioners found that an understanding of the population composition and the population’s relationship to tobacco, as well as the population’s relationship to health and health services were a prerequisite for conducting any evaluation activities in the community. The tools therefore all have corresponding introductory remarks. The remainder of the tools gives advice on gaining access to the community, on ways to increase
response rates in data collection efforts, and on developing data collection instruments.

**DISCUSSION**

In the process of developing culturally specific evaluation guidelines for tobacco control work with culturally specific groups, TCEC confronted a contradiction: Culture is not an easily definable concept; cultures have loose boundaries and cultural identities overlap. Identifying characteristics about a cultural group easily leads to stereotyping. On the other hand, tobacco control practitioners working with various cultural groups are asking for support in addressing these specific groups. To provide information and guidelines, a certain degree of cultural essentializing is therefore necessary. TCEC addressed this inherent contradiction by fleshing out cultural specificities and making recommendations for a number of cultural groups, while at the same time recommending being prepared for the cultural nuances and differences within groups. One of the most important skills a culturally competent evaluator must gain is to reach a balance between applying specific cultural knowledge and remaining free from cultural assumptions.

TCEC followed recommendations for cultural competency in the development of its guidelines by including many of the California Tobacco Control stakeholders in the process. The most valuable input came from local program staff that work in and conduct evaluation activities with diverse cultural groups. Being in part representatives of the cultural groups themselves, their insights were invaluable in beginning to flesh out program evaluation challenges and recommendations. Many of the observations the practitioners had were confirmed by subsequent literature searches. In the months following the workshop and during the revision of drafts, the members of the respective roundtables were contacted for further feedback through e-mail and some via phone. Although the face-to-face roundtable discussions yielded useful debate and results, the follow-up interactions via e-mail were not always as fruitful. Some tools received more detailed feedback than others. In general, it was difficult to continue the coherence that had been created spontaneously for the different groups at the workshop. TCEC attributed the difficulty of maintaining group coherence beyond the workshop to the limited time groups had had to develop an identity and to the individuals’ more pressing professional demands. In retrospect, the face-to-face meeting at the one-day workshop proved invaluable in generating a meaningful discussion and collecting useful and relevant information.

The Culture in Evaluation tools on TCEC’s website are geared toward tobacco control evaluation, yet the recommendations made in the tools are also applicable to program evaluation in other areas, especially in disease prevention and other health-related programs because they contain practical program evaluation advice. TCEC plans to continue the series in the future to include other groups such as substance abusers, military personnel, and laborers. It also understands the already existing tools as living documents that will undergo periodic revisions as more information and feedback become available.

**NOTES**

1. The following two paragraphs are in part excerpts of the evaluation report produced after the workshop. (Tobacco Control Evaluation Center, 2007).

2. The instrument was developed by Dr. Laura Plybon.


4. In 2007, the former California Department of Health Services was split into two departments: the Department of Public Health and the Department of Health Services. Tobacco Control falls under the care of the Department of Public Health. Some references in this article are to the former California Department of Health Services and some to the current Department of Public Health.

5. Overall smoking rates in demographic groups might be lower than in the overall population, for instance in Asian/Pacific Islanders, but in some subgroups of these demographic groups, for instance in Korean men, the smoking rate is extremely high.


7. For an in-depth study of tobacco use in the LGBT community, see Stevens (2008).

**REFERENCES**


Treiber / CULTURALLY COMPETENT EVALUATION TOOLS


