Australian health promotion practitioners’ perceptions on evaluation of empowerment and participation

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SUMMARY

Although participation and empowerment are hallmarks of the WHO vision of health promotion, it is acknowledged that they are difficult to evaluate. Devising adequate study designs, indicators and methods for the assessment of participation and empowerment should consider the experiences, concerns and constraints of health promotion practitioners. The aim of this study was to investigate health promotion practitioners’ perspectives on general and methodological aspects of evaluation of empowerment and participation. Semi-structured interviews were conducted with 17 experienced practitioners in community-based health promotion in New South Wales, Australia. The interviews covered benefits of and barriers to the evaluation of participation and empowerment, key indicators and methodological aspects. Interview transcripts were examined using thematic content analysis. The idea of evaluating empowerment and participation is supported by health promotion practitioners. Including indicators of empowerment and participation in the evaluation could also emphasise—to practitioners and citizens alike—the value of involving and enabling community members. The interviews highlighted the importance of a receptive environment for evaluation of empowerment and participation to take root. The resistance of health authorities towards empowerment indicators was seen as a challenge for funding evaluations. Community members should be included in the evaluation process, although interviewees found it difficult to do so in a representative way and empowering approach. Qualitative methods might capture best whether empowerment and participation have occurred in a programme. The positive experiences that the interviewees made with innovative qualitative methods encourage further investment in developing new research designs.

Key words: health promotion practice; empowerment; evaluation; qualitative study

INTRODUCTION

The concepts of participation and empowerment

Since the Alma Ata Declaration and the Ottawa Charter, the principles of participation and empowerment have been a hallmark of the WHO vision of health promotion (World Health Organization, 1978, 1986), particularly in interventions with and in socioeconomically disadvantaged communities or populations (Heritage and Dooris, 2009). However, the operationalization and measurement of these concepts have proved to be challenging to health promotion practice and research.

Experts have yet to agree upon one conceptualization of participation and empowerment. Participation and empowerment express value orientation in health promotion and can serve as conceptual framework. Even though participation is often described as a prerequisite of or a strategy for empowerment (Rappaport, 1987;...
Christens et al., 2011), the terms are frequently used alongside each other. With both participation and empowerment, the processes and the outcomes are equally relevant. The following definitions demonstrate the breadth and comprehensiveness of participation and empowerment as they are used within the field of health promotion.

There are many definitions of participation (Arnstein, 1969; World Health Organization, 1978; Bracht and Tsouros, 1990; Minkler and Wallerstein, 1997; Ritchie et al., 2004). One of the most comprehensive and detailed definitions describes participation as the process by which members of a community, either individually or collectively, (i) develop the capability to assume greater responsibility for assessing their health needs, (ii) plan and then act to implement their solutions, (iii) create and maintain organizations in support of these efforts, and (iv) evaluate the effects and bring about necessary adjustments in programmes on an ongoing basis (Zakus and Lysack, 1998). This implies that participation is an essential precursor to individuals and communities building their capacity; thus, they can act collectively to achieve their own goals—thereby linking participation with the concept of empowerment (Minkler and Wallerstein, 1997). Empowerment can be defined as a multi-level process of gaining understanding and control over personal, social, economic and political forces in order to take action to improve one’s life situations (Wallerstein, 1992; Israel et al., 1994; Zimmerman, 1995). Community empowerment is made up of several components: a raised level of individual (‘psychological’) empowerment among its members, a political action component in which members have actively participated and the achievement of some redistribution of resources or decision-making favourable to the community (Israel et al., 1994; Rissel, 1994; Laverack and Wallerstein, 2001; WHO Commission on the Social Determinants of Health, 2007).

In the following manuscript, we will treat participation and empowerment as highly overlapping concepts that represent the core values of health promotion.

Evaluation of participation and empowerment
In order to develop successful health promotion interventions, it is essential to determine (i) if the components of an intervention are effective, (ii) if the intervention is appropriate for the target audience and (iii) if the setting for intervention has been adequately taken into account (Linnan and Steckler, 2004). An evaluation of the processes as well as of the intermediate and ultimate effects can help to determine how programmes work (Nutbeam, 1998; Potvin and Richard, 2001). So far, evaluations of community-based programmes have focused mainly on the measurement of health behaviours and health outcomes. Some authors suggest assessing the extent to which the community has the capacity to take action to promote and maintain their health, and thus to explore the roles of participation and empowerment in promoting the health of communities (Israel et al., 1994; Laverack and Wallerstein, 2001; Minkler et al., 2005; Wallerstein, 2006). Experts have suggested various indicators for measuring empowerment and participation. Rifkin et al. (Rifkin et al., 1988), for example, proposed to analyse five dimensions (needs assessment, leadership, organization, resource mobilization and management) and rate them in a semi-quantitative fashion in terms of the degree of community members’ participation in each dimension. A similar procedure has been suggested by Laverack and Labonte (Laverack and Labonte, 2000), which includes nine domains that represent the influences on the process of community empowerment. In terms of empowerment, proposed indicators include multiple subjective dimensions: perceptions of knowledge, skill development, self-worth, competence, self-efficacy, willingness to participate in collective actions, community connectedness as well as control over decisions and resources (Zimmerman and Rappaport, 1988; Wallerstein, 1992; Israel et al., 1994; McMillan et al., 1995; Rissel et al., 1996b; Wallerstein, 1999). In addition, actual accomplishments and improvements in environmental or health conditions have been suggested as variables, e.g. new or modified programmes, policies or practices and increases in control over resources (Rissel, 1994; Fawcett et al., 1995). Little has been published about the best way to collect the data. Some survey instruments have been put forward to be used by task force members as well as citizens, while some studies have used qualitative approaches such as semi-structured or in-depth interviews (Israel et al., 1994; McMillan et al., 1995; Rissel et al., 1996a; Roger et al., 2011). Many of these approaches, however, have been criticized for not sufficiently
capturing the multi-level concepts of empowerment and participation (Israel et al., 1994; Naylor et al., 2002). Standardized recommendations as to the source of data (participants, random community members, community representatives, health promotion workers, etc.) are not available to date either.

In her literature review on the effectiveness of empowerment, Nina Wallerstein (Wallerstein, 2006) pointed out that more effort should be invested in evaluation methods and in the refinement of measurement tools. Practical experience in measuring empowerment or participation is still scarce.

In every intervention, practitioners of health promotion are confronted with the challenges of defining, measuring and establishing the concepts of empowerment and participation. Through the experience of health promotion managers and practitioners, it may be possible to gain insight as to the facilitators and barriers to the evaluation of these concepts in everyday practice. This qualitative study is part of a research project to design indicators and measures of empowerment and participation, and thus to identify ways to improve practice in the evaluation of empowerment and participation.

Thus, the aim of this study was to investigate the perspectives of health promotion managers and practitioners on:

(i) the benefits of and barriers to including empowerment and participation in the evaluation of community-based health programmes;
(ii) the indicators and measures of empowerment and participation;
(iii) the study design, data collection methods and data sources in the assessment of empowerment and participation.

METHODS

Sample

The study was performed in Australia, where many states, e.g. New South Wales, have developed systematic and detailed strategy papers or framework programmes on health promotion (NSW Department of Health, 2001, 2003). In addition, it is a well-implemented political practice in Australia to involve citizens in the decision-making process within the community (Baum et al., 1996; McMeeking and von Kolpakow, 2002; Clavarino et al., 2004). It is also a characteristic of Australian health promotion policy that evaluation is an essential and integrated part of programme management. Systematic sets of indicators, e.g. for different levels of capacity building, have already been developed years ago (NSW Department of Health, 2001). Many Australian researchers focus on methodological aspects of evaluation, including evaluation of empowerment (Harvey et al., 1998; Rowley et al., 2000; Schofield et al., 2003; Watson et al., 2004). Therefore, health promotion practitioners in Australia usually dispose of sound competencies and experience in the field of evaluation, including the evaluation of empowerment. Their views and perspectives can potentially provide insight for practitioners in other countries as well.

Semi-structured, face-to-face interviews were conducted with 17 experts in community-based health promotion in New South Wales, Australia, from September 2005 to January 2006. Purposive and snowball sampling were used to recruit the sample. The participants worked in responsible positions in different Area Health Services, or at the University of Sydney or University of New South Wales, or in the New South Wales Health Department. Academic interview partners were only included if they had substantial practical experience in the field of community-based health promotion, i.e. had implemented several health promotion projects in close contact with communities before or during their academic career. The health promotion programmes that had been or were managed by the interview partners covered a wide range of health issues, e.g. food security, healthy nutrition, cancer prevention, HIV/AIDS prevention and substance abuse, and they focused on different respective communities, e.g. senior citizens, young homosexuals, students, culturally and linguistically diverse groups, aborigines or populations of disadvantaged neighbourhoods.

Recruiting of interviewees continued until saturation (the process by which no new themes were appearing). In addition, three health promotion experts were interviewed first in order to pre-test the interview guide; they provided comments on the interview guide (for the final interview guide, see Table 1). These interviews are included in the analysis, as only minor
revisions were consequently made. All participants agreed to being interviewed and recorded. To ensure confidentiality of information, only the researchers were involved in the transcription, analysis and presentation of data. The analysis and presentation of data could not be traced back to individual participants.

Data collection
The interviews addressed the following topics: the benefits of and barriers to including empowerment and participation in an evaluation of community-based health programmes, the key indicators for empowerment and participation, and suggestions as to further methodological aspects of the assessment of empowerment and participation (research design, data sources, data collection method, role of evaluator). There was no definition of empowerment and participation given to the interviewees. The interviewee could answer according to his/her idea of the concepts. One of the authors (J.L.) conducted all the interviews, each of which was recorded and lasted 60–120 min.

Analysis
Interview tapes were transcribed verbatim and examined using thematic content analysis (Patton, 1990). Themes were identified using a grounded conceptualization process (Pope et al., 2000). Transcripts were repeatedly read before and after coding to ensure proper categorization of data. Categories were initially developed in line with the main domains covered in the interviews, but this changed following a more detailed reading of information under each category to identify emergent themes and sub-themes. To assess the validity and credibility of the findings, the interviewees were invited to an interactive workshop during which the results of the analysis were presented and discussed. Ten of the 17 interviewees participated in the workshop. The reactions of the study participants to the analysis were then incorporated into the study findings, a technique known as respondent validation (Mays and Pope, 2000). As the presented findings corresponded with the perceptions of the interviewees, there were only minor corrections and additions that had to be made after this workshop.

RESULTS
Evaluation of empowerment and participation: benefits and barriers
All interviewees agreed that assessing empowerment and participation is important or has interesting potential in order to provide additional measures of the quality of a health promotion intervention. One benefit frequently mentioned referred to distinguishing meaningful participation from tokenistic participation.

[Evaluation] does help you study different degrees and types of participation...
least understand the spectrum of participation and understand where it is empty, and where it’s not.

Furthermore, the assessment can provide positive feedback to health promotion workers which can be measured earlier than health outcomes.

People shouldn’t be disappointed because they haven’t changed a whole universe of health behaviours or health outcomes, I think it’s really important that we clock those aspects [empowerment and participation], to feed them back to ourselves, rather than say: “O, I can’t measure if I prevented falls for another 10 years, I’m feeling helpless, I don’t know if my program worked”.

Table 2 lists all benefits named in the interviews.

Some of the interview partners viewed participation and empowerment as process measures rather than outcomes, whereas others saw participation and empowerment as independent indicators of success. One interviewee described his problem of distinguishing between the classical

Table 2: Benefits of and barriers to evaluating empowerment and participation, as viewed by the interviewed health promotion practitioners

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Barriers</th>
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<tr>
<td>The involvement of the participant is appreciated</td>
<td>Unambiguous and objective definitions for empowerment and participation are lacking.</td>
</tr>
<tr>
<td>When empowerment and participation are classified as ‘health promotion outcomes’, they can be measured earlier than health outcomes and provide an earlier (positive) feedback to health promotion workers and communities</td>
<td>There is no reference available for judging the findings.</td>
</tr>
<tr>
<td>It can be ensured that participation is implemented in a meaningful, not tokenistic way (quality assurance)</td>
<td>There are many confounding factors.</td>
</tr>
<tr>
<td>The understanding of steps in delivering programmes that meet the needs of communities can be improved (identifying best practice)</td>
<td>It is difficult to find measures that are meaningful for the community as well as for the funding body</td>
</tr>
<tr>
<td></td>
<td>The actual cost–benefit relation is unclear (high expenses needed for the evaluation).</td>
</tr>
<tr>
<td></td>
<td>Support from funders/decision-makers is lacking</td>
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‘process’ and ‘outcome’ indicators when it comes to measuring empowerment and participation:

[Empowerment and participation] are process measures… But those things will tell us more about the success of the program, because they’re the things that we need to build in for sustainability in the long term. So, in a way they’re sort of process indicators, but they’re important outcomes in themselves… The participation and empowerment of those people would definitely be an indicator of the success to me. It always links back to the sustainability.

Empowerment and participation were also described as ‘outcomes along the way’ or ‘rungs on the ladder’ in the process to achieving health outcomes.

It was repeatedly mentioned that participation and empowerment should not be routinely measured. The interviewees expressed that it depends on the theoretical underpinning of a project as to whether or not it would be useful to evaluate these principles. The assessment of empowerment and participation is seen as important mainly when they are explicitly part of the programme logic. There is no need to assess these concepts if the community initiative is only a small-scale or short-term project, or about social marketing or policy development.

I think we should do it [evaluation of empowerment]. But … as the manager, I don’t want people doing it all the time, because then they’re not getting their project work done, so you need to have sort of a balance here.

I wouldn’t routinely measure it [empowerment and participation] … But where it is important in the logic of the program or where it’s part of the theory of what’s going to happen, then yes.

If indicators of empowerment and participation are part of the evaluation, this would also stress the value of involving and enabling community members and demonstrate the importance of these aspects to those who are running the programme, as well as to the community members.

Interviewees expressed that they see the lack of objective definitions and references, the potential lack of acceptance and support in funders and community members and the unclear benefit as the main barriers to measuring empowerment and participation (see Table 2). The many ambiguous definitions for
empowerment and participation were frequently pointed out as a challenge for the evaluation.

I think the first barrier [to measuring empowerment and participation] is: I feel like I don’t really have a definition, and I can’t measure something I can’t define. I can’t measure something that’s diffuse.

Another main barrier is that the evaluation of empowerment and participation would not be supported by the funders and health authorities. Interviewees have experienced that those outcomes are usually not considered as relevant to programme success as health outcomes.

In health, people want the health outcomes.

The community says, “For me it’s about... that I feel like people listen to me, and I now feel confident to say things. So that means I’m healthier, happier, more connected to the community.” You speak to your mayor, and your mayor says: “O, that’s all well and nice, but, – what can I do with that?”

Indicators/measures for empowerment and participation
Numerous indicators were named for empowerment and participation. For empowerment, the suggested indicators referred to subjective perceptions of self-esteem, autonomy and confidence. The more objective dimension of power and control over resources was mentioned by some interviewees as well.

So, to be honest, you need to be measuring: what are you doing about power. Has power shifted? Are the groups that have now influence on the project the groups that should be influential on the project? These are the sort of questions that we should be asking, because otherwise, you have a project that is gross in size, gross in reach, gross in budget, but the same five people are in charge.

Furthermore, it became clear that the indicators have to be specific for (i) the type of programme and (ii) the community context. The participants should be involved in the development of indicators and evaluation design as much as possible.

The key characteristic of such an approach would be that the participants, as far as possible, have a lot of influence on the design of the approach. Because otherwise, the more the approach is designed by the service providers, the more likely it is to be biased in the favour of them, whereas it should be designed in such a way that it is biased towards the participants, and having the participants speak.

Some interviewees raised the concern that empowerment and participation cannot only be measured on the individual or community level, but one also has to track its actual impact, because ‘empowerment for sake of empowerment doesn’t mean anything but I’m feeling good about myself, but everything around me is still the same’.

Participation is about whether they feel like they’re being listened to, but it’s also about whether they are listened to.

Tracking the impact of empowerment and participation can mean, according to the interviews:

- to follow if concrete suggestions are taken up, e.g. after a committee meeting;
- to analyse the impact on institutions, e.g. government, schools, churches;
- to monitor the impact on environmental changes, e.g. new policies, changes in the physical and social environment.

Methodologically, the impact and pathway of participation can be followed by comparing whether a programme did actually meet the objectives of the community, or by tracking which processes take place once a community member has expressed an opinion or made a suggestion to a committee.

In terms of, say, aircraft noise...[you can ask:] Can the community members talk to other people, are they getting influence? Yes/no, you can measure that. And did they make a difference, have they changed the routes? So empowerment actually has concrete measures. So are they actually shifting policy settings, or are they actually re-routing the traffic?

It was pointed out that one has to distinguish between the individual level and the community level.

It’s just important to keep the distinction clear between the individuals and the community, or organization. The question is, does that qualitative feedback apply more generally to the whole community, or is it just a few people that feel great about the whole thing, and no one else has been really touched by it.
Study design, data collection methods and data sources for evaluation of empowerment and participation

It became clear throughout the interviews that qualitative and interactive methodologies were favoured in order to measure empowerment and participation, mainly because empowerment and participation are complex, subjective ideas depending on the social context and cannot be sufficiently captured in questionnaires.

These are very socially rich ideas, and I don’t think a questionnaire would necessarily unpack and explore that adequately, and only talking to people would get that for you.

If you just count it, you lose what participation might really mean.

[Evaluation of empowerment and participation] …It’s about making things count, not counting things.

Checklists designed for use by health promotion practitioners were rejected by most of the interview partners for the evaluation of empowerment and participation, because (i) they are too objective and rigid for the contextual concepts of empowerment and participation and (ii) are under the control of the experts and might be biased in their favour. Due to these conditions, checklists might fail to distinguish between tokenistic and meaningful participation, or to reflect the dimension of power.

I think that if you have instruments [like checklists], you will increase the probability that you end up with an “empty ritual”. Because the instruments are like liturgy.

The interview partners suggested a variety of qualitative approaches they had found useful or considered suitable for evaluating empowerment and participation. There are some assessment measures which can be carried out by the project staff themselves (e.g. facilitated self-reflection), but the majority of suggested evaluation measures are aimed at involving the intended beneficiaries of the programme (Table 3).

Qualitative assessments of participation …[like] theatre…are a very useful tool, because it’s about community articulation. The community gets to speak up. So the thing to do as a health promotion worker is to amplify the way the community gets to speak up. And of course then you’re obliged to listen.

One main barrier associated with qualitative evaluation methods is that the funders or authorities usually prefer quantitative outcomes, according to the interview partners.

And qualitative, no matter how well you do it, no matter how good your rationale and your criteria and the evidence is, that this is really valid and useful, – there’s a natural “What are the numbers?” …In health we’re still competing, in Australia, against this paradigm of evidence-based medicine.

An alternative way that was frequently suggested to convince the funders was to combine qualitative with quantitative approaches.

I’d tend to use preferably two methods rather than one. I mean, I’m coming from a management level as well. Because the funding body, they’re like: “Tick this!”, you might encounter that… Yet, is it meaningful as well, is it not only for the sake of having the set of data, but is it meaningful? …[Therefore] I would use the two hand in hand, focus groups, quantitative data, qualitative, at the same time.

Different data sources were proposed. Whereas interesting contributions can come from health promotion practitioners, most interview partners were adamant that community members be involved in a meaningful evaluation, either by asking involved community groups and community leaders, or by asking ‘everyday’ community people. Some interviewed experts doubted, however, that asking ‘random’ community members could generate significant results. Mostly, the inclusion of several sources was suggested.

You should ask community people, and I would maybe also involve the health promotion workers. Their insights are very different from what the community’s would be…it would give you some sort of comparison.

I wouldn’t ask it like that, asking a few random community members, “Do you feel in control of the project?”. I mean, there’ll be a few that say: “Yes, very much”, and most people will say: “No, not all”.

When asking community members, one should consider the language and terms that are used with the people. Scientific jargon or
Table 3: Suggested methodological aspects for the evaluation of participation and empowerment

<table>
<thead>
<tr>
<th>Level</th>
<th>Indicators</th>
<th>Data collection methods</th>
</tr>
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<tbody>
<tr>
<td>1. Funder</td>
<td>Commitment to participation and empowerment</td>
<td>Screening budget for investment in participation and empowerment</td>
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<tr>
<td>2. Health promotion professionals</td>
<td>Involvement of community</td>
<td>Documentation of process and outcome of participation and empowerment</td>
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<tr>
<td></td>
<td>Influence of community members on project, shift of power dynamics</td>
<td>- Mapping and reporting what has happened</td>
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<td></td>
<td></td>
<td>- Discourse analysis of how community representatives communicate and are listened to</td>
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<td>- When being on a committee</td>
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<td></td>
<td></td>
<td>- Staff self-reflection or reflective diaries regarding empowerment process/shift of</td>
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<tr>
<td></td>
<td></td>
<td>- Power</td>
</tr>
<tr>
<td>3. Community members</td>
<td>Being listened to</td>
<td>Combination of</td>
</tr>
<tr>
<td>a) Individual level</td>
<td>Self-esteem, confidence</td>
<td>- Quantitative methods (questionnaires)</td>
</tr>
<tr>
<td></td>
<td>Advocacy skills</td>
<td>- Qualitative methods</td>
</tr>
<tr>
<td></td>
<td>Influence</td>
<td>- Participatory action research with community members</td>
</tr>
<tr>
<td>b) Organizational level</td>
<td>Group capacity, group potency</td>
<td>- Reflective diaries of community members</td>
</tr>
<tr>
<td>c) Community level</td>
<td>Leadership</td>
<td>- Story dialogue and most significant change,</td>
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<tr>
<td></td>
<td>Shift of power dynamics</td>
<td>- Based on community members’ accounts</td>
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<tr>
<td></td>
<td>Mobilization of resources</td>
<td>- Theatre, developed and enacted by community members</td>
</tr>
<tr>
<td>4. Physical and social</td>
<td>Changes in policy and regulation</td>
<td>Documentation</td>
</tr>
<tr>
<td>environment</td>
<td>Environmental change</td>
<td>- Retracing a chronological link between the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Action and change</td>
</tr>
</tbody>
</table>

Paternalistic approaches have to be avoided as well as giving the impression that the assessment may be more important than the active process.

There are techniques that obviously need to be developed around making it respectful... It’s how you gather that information... in a respectful way. Because it can be very paternalistic.

The term “research” does freak people out... because they go ‘Uh, research?!’. So... you approach it in a way that is not using big terms and not sort of freaking them out about research.

Table 3 gives a summary of suggested indicators, data collection methods and data sources.

DISCUSSION

Summary and interpretation

The interviewed health promotion practitioners felt that the evaluation of participation and empowerment would be useful in certain projects. The mentioned benefits did not refer only to the project itself (in terms of quality assurance), but also to the community members. An evaluation of empowerment and participation would emphasize the necessity for communities to participate in decision-making and delivery, and in turn, lead to increased power to act collectively and achieve positive outcomes. The evaluation design and data collection methods could play a role in increasing community power. The majority of the interview partners embraced qualitative methods for the evaluation of empowerment and participation for two reasons: they seem more appropriate for capturing the rich social data connected with empowerment, and the processes of collection and analysis can be empowering in themselves. It is interesting that the interviewed health promotion professionals proposed innovative and unusual assessment methods, e.g. theatre, Story Dialogue (Labonte et al., 1999), citizen jury or documentary photography (Wang and Burris, 1997), rather than conventional and acknowledged methods such as interviews or focus groups. One can only
speculate whether Australians may have a stronger relation to these methods, e.g. the Most Significant Change approach was put forward by Australians and has been used in some Australian projects (Davies and Dart, 2005). In addition, the proposed methods can be interpreted as an expression of radical realization of the concepts of participation and empowerment. This is in line with the understanding of some authors that evaluation can assist empowerment and capacity building when it allows the project’s intended beneficiaries to get involved in the evaluation process in ways that give them more resources and skills (Fawcett et al., 1996; Mayer, 1996).

Although the respondents were unanimous that it would be important to involve participants in the evaluation, they did not agree on who would represent the community: involved community groups, community leaders or random citizens. Current literature shows that community evaluation should involve people from throughout the community (Fawcett et al., 2001), but there is a lack of evidence as to who is best qualified to represent the community. Few studies conducted on this issue have chosen different data sources, e.g. by interviewing randomly selected community members (Israel et al., 1994), key informants (Eng and Parker, 1994), key participants (Fawcett et al., 1996; Roger et al., 2011) or community project coordinators (Naylor et al., 2002).

Although convinced of the benefits that an assessment of empowerment and participation may have, and having made encouraging experiences with innovative evaluation methods, the interview partners conceded that developing and performing evaluation studies can be difficult. It transpired that the evaluation of empowerment and participation frequently is not supported by the funders and decision-makers, because those concepts are usually not considered an important outcome, as opposed to changes in health (behaviour). The health authorities’ scepticism towards empowerment and participation outcomes may be enhanced by a lack of acceptance of the favoured qualitative measures. Therefore, the combination of several data sources (source triangulation) was embraced by the interview partners. These perceptions reflect Nutbeam’s (Nutbeam, 1998) observation that quantitative, experimental research is given a higher status in public health, and that qualitative methods are generally undervalued.

In contrast to the proposed data collection methods, the indicators given in the interviews were predominantly in line with the outcome variables for empowerment and participation that can be found in the literature. It became clear, though, that a number of interview partners did not consider the subjective perceptions of community members, e.g. on skills and power, sufficient to judge whether meaningful empowerment has actually been achieved. In addition, they suggested finding ways to track the actual power and impact that community members had on the programme, e.g. by following how suggestions of community members are dealt with and taken up in the course of a community programme.

**Applicability**

A main limitation of the study is that it presents the views of health promoters from an Australian state and cannot be expected to be representative. One may assume, however, that many findings can be transferred to other countries as well, e.g. statements and ideas on indicators and methods, because these refer to the concepts of participation and empowerment themselves and not to (political) conditions that are specifically Australian. It remains unclear, however, if all of the suggested evaluation methods can be culturally accepted by members of communities that have no or little experience in working with the empowerment approach. This may especially apply to the highly participatory methods as theatre or citizen juries. These procedures seem to require an extraordinary commitment of the community members (and special skills of the health promotion practitioners), which may be unusual in many countries. It seems important to determine the extent to which such data collection methods can be achieved in health promoters and citizens of the respective countries. Other interview results presumably apply to the health promotion practice in many other countries, e.g. the identified barriers to evaluation, such as lack of adequate funding or lack of adequate methodological training.

The suggested evaluation methods cannot simply be applied to every health promotion programme using an empowering and participating approach. They reflect the personal attitudes, preferences and even visions of health promotion practitioners and do not universally/
consistently correspond to scientific demands of programme evaluation. The practitioners embraced an evaluation approach using a combination of quantitative and qualitative research paradigms; this is, from a researcher’s point of view, a justified way to capture complex concepts such as empowerment and participation (Tremblay and Richard, 2011), as are the suggested indicators. It is questionable, however, whether all of the data collection methods mentioned actually provide reasonable and instructive scientific data. It is a central aim of an evaluation to produce useful and applicable results, e.g. on programme implementation or effectiveness (Rootman et al., 2001). If evaluation ‘is not going to have any effect on decisions, it is an exercise in futility’ (Weiss, 1972). Theatre or citizen juries may be an effective tool within the programme logic of an empowerment process, but it remains to be shown whether the data collected through these suggested innovative techniques help in assessing the process or outcome of a health promotion project. Therefore, the aim and the expected benefit of an evaluation should be considered carefully before choosing the data collection methods. Some of the methods seem promising, such as story dialogue or photodocumentation, as they have proved to be valuable techniques in other health contexts. Their relevance and potential in researching empowerment and participation in health promotion needs to be explored and tested in future studies. Additional research is needed for a more systematic approach for determining the most appropriate evaluation method in different contexts.

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