

SHARING RESEARCH RESULTS WITH MULTIPLE PUBLICS

Introduction

Taking Research Results to the Public: Purposes, Audiences, Messengers, and Formats

Taking Research and Results to Policy Makers and Inciting Action

Dissemination Research: Adapting and Retesting or Comparing and Scaling Up Interventions

Summary

INTRODUCTION

In prior chapters of Book 7 of the *Toolkit* and in other books, we have discussed the many steps required in the development and conduct of research in and with communities and other partners. Our conversations have covered the formation of research alliances, approaches to theory development including development of intervention theory, intervention approaches, and ways of analyzing data. In this chapter, we concentrate on methods and approaches for sharing research results with others, and not just with the scientific community through books, conference presentations, and papers in peer-reviewed journals alone. We also are concerned with sharing research results with specifically targeted publics, evaluation recipients, repeat-research audiences, and the public in general.

It is important to distinguish between three main types of research results:

- Results that emerge from “basic research” that answer questions identifying the need for interventions (or more research). These research results should be shared with members of the communities or other institutions that participated in the research, with the public at large, and with actors, activists, newspaper reporters, and policy makers who can utilize the

results to improve their policy making.

- Results that emerge from different types of evaluations with multiple stakeholders, each of whom may need different kinds of information.
- Results that emerge from “applied” research that answers questions about how to create transformative changes with individuals, groups, organizations, communities, and policies, especially those changes that remediate injustices and contribute to improving social, economic, health, and legal conditions.

While it may seem that we have implied above that each type of result is designed for a specific audience, in actual fact, all of these results should be shared with members of the communities who participated in the intervention activities and with other publics. This is so that the intervention or other results might be adapted in other settings, or shared with other potential implementers via consultancies, manuals, social media and websites, and technical assistance.

The first section of this chapter focuses on ways of sharing the results of “basic” or formative research. **Formative research** is ethnographic (mixed methods) research that helps to map out dynamics and descriptors of a community or problem, generate information for an initial model, and provide the basis for constructing an intervention in different formats and with different audiences. The second section of the chapter reviews the challenges involved in sharing the results of evaluations with multiple stakeholders—funders, administrators, people who are the beneficiaries or participants in various types of innovations or social and environmental change programs, local residents, school children, policy makers, the media, and many other potential audiences. Here we will review main approaches, and common challenges.

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The third section focuses on dissemination and implementation science. These terms, which we define below, refer to sharing information about researched and evaluated interventions with others so that it can be applied together with people/partners in a new setting and reevaluated. In this way, the process through which these research-based intervention approaches are integrated into and implemented in other settings can be studied. **Dissemination** is the purposive distribution of information and intervention materials to specific audiences. The intent is to spread information about evidence-based interventions. **Research** on dissemination examines how information on any intervention is created, packaged, transmitted, and interpreted among a variety of stakeholder groups and audiences.

Implementation is the use of strategies to adopt, adapt, and integrate evidence-based interventions so as to transform or change practice patterns within specific settings. The “evidence” in “evidence based interventions may consist of any and all credible sources of information that can convince reviewers that the plans enacted have been effective or useful. **Implementation science** explores the process through which interventions carried out in one location can be adapted to another, and to what extent such interventions can be integrated into the ongoing life of the new setting.

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TAKING RESEARCH RESULTS TO THE PUBLIC: PURPOSES, AUDIENCES, MESSENGERS, AND FORMATS

Ethical considerations in contemporary research call for sharing results with participants (AAA February 2009; Fernandez, Kodish, and Weijer 2003; Fluehr-Lobban 2013). An ethical *requirement* of collaborative research is that research be shared with patients, students, community residents, students, and other partners (Banks et al. 2013; Fernandez 2003; Flicker and Worthington 2011). Community or stakeholder dissemination differs from sharing data through publications because its purpose is not simply to communicate to scholarly audiences. Rather, it is both to inform and to inspire viewers to think, inquire, critique, and even to mobilize them to effect changes in programs, policies, service delivery, or the environment. As Roger

Sanjek notes, social science researchers “should” communicate beyond their disciplinary colleagues and to “the public sphere” (Sanjek 2004, 452). The dissemination process should be informative, dialogic, and politically and socially motivated and motivating, and it often can be transformational.

Any effective efforts to share the results of research require consideration of the purposes of the dissemination effort, the audiences who will be the recipients of the information, the types of participants who will engage in discussion about results and their possible uses, which participants will convey the results, and what formats should be used to convey them. Purposes of dissemination include:

- improving knowledge;
- informing communities for whom the research is relevant about the results and engaging them in dialogue;
- convincing the public that research can be useful;
- persuading audiences to take action because of the urgency of the results;
- convincing politicians and policy makers that policies and regulations need to be changed;
- shedding light on historical or current but unknown or unrecognized disparities or injustices, often as a wake-up call to action;
- persuading the news media that the research story is worth promoting through newspaper and television reports and programs.

The first three bullets can be classified under the rubric of “engaged social science”—they rest on conveying important research results and information to a general audience without the requirement that action follow. Roger Sanjek (2004) tells us that there are many ways that research can be shared with public audiences including:

- writing books that can be read by non–social scientists in contemporary language;
- getting the attention of various publics and leaders by sending research results to newspaper editors, television and radio talk shows, book review editors of nonacademic publications, organizational leaders, government officials and their staffs, and popular magazines;
- appearing on radio and television talk shows;
- testifying at government hearings, commissions, and community-sponsored events;
- acting as a source to reporters;
- serving as an expert witness.

To Sanjek’s list, we add

- sending out press releases;
- creating blogs and posting on social media such as YouTube, Twitter, and Facebook;
- engaging with main social and scholarly network sites such as LinkedIn and ResearchGate;
- creating and circulating research briefs or summaries, project newsletters, and policy recommendations.

A brief publication by CARE, a community-based research center at Yale University, provides useful tools and checklists for considering dissemination goals, audience, medium (ways of reaching the audience), and execution. The guide includes tips that are useful when writing materials for dissemination, suggesting that text materials be responsive to the audience, concise, interesting or compelling, logical, directed (that is, with key points highlighted), useful, attractive, and with clear recommendations for action (CARE 2012, 2–3). For dissemination to multiple audiences, an adapted version of the CARE checklist is shown in Table 8.1.

Taking Research Back to the Community Where It Was Done

Beyond outreach to the general public, probably the first and most likely audience for community researchers is the community or institutional setting in which the research has been conducted. The approach that we have taken in this book as well as in others in the *Toolkit* calls for creating partnerships with organizations and with community leaders and change agents. Often these partnerships take the form of alliances, research advisory boards, or full participatory arrangements. The principles of good partnership require involving partners in all aspects of research, including analysis and assembly of results. Thus, partners are the first and ongoing recipients of research results, presented in formats that are readily understood by study “insiders.” However, though the partners may act as planned on the results, they do not always share them with the larger community. The public health and social science literature is filled with excellent examples of alliances and collaborations that have made policy recommendations or otherwise acted upon the research results to promote policy, improve health service delivery, and stimulate other structural changes without actually disseminating the results to the community at large. Researchers Chen and colleagues (2010) conducted a survey of authors who had published articles on community-based health research and dissemination in peer-reviewed journals and found that, though many of the respondents were positive about dissemination, including to local communities, they encountered many obstacles. These included lack of recognition by universities of such dissemination as a valuable research-related activity, the cost and time required to prepare materials for dissemination, language/literacy constraints of the study team in relation to the language requirements of the community, insufficient funding for proper dissemination efforts, and changes in personnel or receptivity by local community partners.

Cross Reference:

See chapter 3 of this book

<Insert Table 8.1 here>

Disseminating research results to the study community, regardless of what the research is about, is an ethical imperative as well as a practical matter. It is especially important because research partnerships and alliances are formed to address specific issues that affect people directly; it is those people who may be in the best position to act on the results or to forge relationships with others who can work with them to do so. As we noted earlier in this book, communities and other organizations are complex. Most important, reading reports does *not* usually constitute a major activity in the daily life of community residents, community organizations, and other institutions that partner in research. The relative ages of participants; the composition of the community audience; differences of language, educational level, and culture; and other factors will shape how the information should be presented, who presents it, who should receive it, and how.

There are many ways in which research results can be shared with study populations in an interactive way. These include creating:

- easy to understand presentations in PowerPoint or a similar computer presentation program or on newsprint;
- performances and street plays;
- dialogues/conversations;
- banners, posters, and panels;
- gallery exhibits and installations;
- films and photovoice.

Reaching the study population requires a different kind of effort from standard academic formats to make sure that the participants and others know about the dissemination events, recognize their importance, are encouraged to attend, and are offered information in a form that is relevant and appropriate and that ensures their understanding and engages them in conversation about the results.

Sharing information with participants and others in the study community can produce many good ideas, additional data, and suggestions for intervention. The following example illustrates how dissemination in a complex study community engaged three main audiences: the women who were the subjects of study, service providers and community educators working with them, and commercial establishments selling unhealthful products.

EXAMPLE 8.1

DISSEMINATING RESEARCH RESULTS TO THE STUDY COMMUNITY: SMOKELESS TOBACCO USE AMONG WOMEN

Results of this mixed methods study conducted in Mumbai between 2010 and 2013 showed that approximately 23 percent of women of reproductive age used smokeless tobacco (SLT) daily, and one-third of chewers, including those who rubbed powdered tobacco on their gums, were users of multiple types of tobacco on the same day. More than half of the women in the study started their tobacco use late (mean age twenty) and after marriage, and of those, one-third started during pregnancy. Women reported consuming smokeless tobacco at the same rate during pregnancy as otherwise, were not impeded in their use by negative norms, saw few risks in use, and were able to purchase their tobacco themselves or through their underage children in shops very close to their homes. Women had no notion that the use of smokeless tobacco products

might affect fetal health or create problems at birth such as low birth weight and premature birth. Shop owners reported that they felt no responsibility to limit the sale of tobacco; they felt that use was the responsibility of the user.

The study team led by Jean Schensul and Saritha Nair decided to disseminate these results to three groups in the community that were active in the study: community health workers and women leaders (key informants), tobacco sellers, and the women SLT users themselves. Two different strategies were prepared for these groups. The first involved using the study results to create a semi-scripted drama highlighting how a woman first learned to use tobacco (through her mother-in-law's advice to solve her gum problem during pregnancy), how she became addicted, and what happened to her during pregnancy (having a very low-birth-weight baby). The study team performed this play in multiple sites in the study community, with invited key informants and with community women who were informed about, and recruited to, the performance sites by the research team and key informant helpers through study networks. More than two hundred women attended the performance. After the presentation, several presented underweight babies to the study team as examples of what happens when women chew SLT. Subsequently, women discussed the need for help in quitting the use of SLT.

Approaching tobacco sellers required a different strategy because some of them earned their entire income from the sale of tobacco. Thus, the team decided to appeal to their sense of responsibility by showing study results in a professional-office setting with a PowerPoint presentation. The team discussed the legal implications of selling tobacco to minors, which could result in damage to mothers and children. After watching the presentation, these men moved from initial indifference to agreement that refusing to sell tobacco to children would not impair their business; they could, they said, replace the gap in revenue with the sale of other products.

The results of the dissemination are being transformed into a *multilevel intervention* approach for use in communities where women are frequent users of SLT.

This dissemination effort was created on a very limited budget. The play was created and enacted by talented members of the study team who were intimately familiar with both the data and study community. The stage props were minimal. The study team members knew, and stayed in touch with, key informants, shopkeepers, and women through repeated visits in a small geographic area. Thus, it was easy for them to recruit study participants and their friends to the events. The community sites were donated and spread throughout the study community so no costs were incurred for transportation. The only cost to the study was for refreshments.

Two related art-based dissemination efforts on youth culture and substance abuse, one involving animated panel displays and gallery exhibits and the second involving a film based on the study in question, took place in Hartford, Connecticut, and in other locations around the United States and Canada. The following example describes both of these as linked efforts.

EXAMPLE 8.2

DISSEMINATING NARRATIVES OF YOUTH CULTURE AND SUBSTANCE USE TO THE STUDY POPULATION

Between 1999 and 2010, the Institute for Community Research carried out three studies on emerging adult lifestyle and substance use. These studies took place during a period when drug selling was decentralizing from larger gangs to smaller crews, substances of choice were changing to include ecstasy (MDMA) and other club drugs and diverted prescription drug use, and PCP use was widespread, but little was known about it. The first study followed the circumstances under which young urban adults age sixteen to twenty-four became involved in

drug use and drug selling and eventually were drawn into injection drug use. The second focused on club drug use and the “club” scene with the same population. The third considered the underground use of the drug ecstasy (MDMA) for sexual enhancement and its role in sexual risk. In all studies, many inequitable dimensions of urban life that young minority adults have to face every day came into play. The first study focused on the role of drugs in an underground economy within a formal economy that lacked employment opportunities for young people. The second study addressed the lack of available information about club drugs and their risks in formats that urban youth customarily utilized, as well as the ways in which the city manipulated young people’s desires for inclusion while building a vibrant downtown economy. The third study explored the use of MDMA to reduce symptoms of depression in youth who had no access to treatment and wanted to negotiate challenging and potentially risky intimate relationships. The study team, made up of researchers from the city’s neighborhoods, artist Colleen Coleman, study director and physician Raul Pino, and anthropologists Jean Schensul and Sarah Diamond decided to work with youth from the study population to tell the story of how use of the main substances, MDMA and PCP, interacted with the lives of young people in the city. These substances were chosen because they are opposite in effect and play very different roles in drug selling and social life. PCP is associated with violence; and MDMA is associated with fast friending, interpersonal intimacy, and sexuality.

The project was built upon a 2005 dissemination project featured in the ICR gallery, which illustrated the situations facing women infected with HIV in Africa. It featured stories and photographs of women infected with and affected by HIV on three-foot-by-ten-foot laminated panels. In 2005–2006, the ICR study team decided that a portable version of this format would allow the research team to “drop” panels on street corners and other public locations where youth

in the study population gathered, in order to foster dialogue along the lines of ACT UP, an AIDS activist organization based in New York City (Murphy 2013), and other users of guerrilla art as protest forms. Though we were not allowed to place the panels we created on street corners in public places, we did manage to work with a team of young people and a young animator from Hartford to produce thirteen laminated three-foot-by-nine-foot panels that told the story of youth, lifestyle, drug selling, and drug use in the broader context of economic decline/development in an industrializing urban center. The panels illustrated in Figure 8.1 included national and local history, narratives of six characters, data in the form of simple graphics and drawings, and quotations from actual interviews about drugs, risks, and the situation facing youth in the city.

These panels were featured first in an interactive exhibit in the ICR community gallery (see Example 8.3 for details about the gallery) along with other accouterments of the “club scene” and club drugs, including videos, club fliers, rave toys, animated novels, replicas of MDMA, and a guide to club drugs and their risks. The opening brought in many people from the community, including study participants. The panels were later shown at events in the local convention center where they were accompanied by an informational treasure hunt, a guide to panels, and an assessment. Youth from many other sites across the city, including galleries, youth centers, and city hall, came to see the panels and reflect on their messages of risk exposure, struggle and achievement, and the omnipresent appeal of drugs that have useful functions in clubbing and sexuality, as well as drugs and the underground economy. The exhibit traveled elsewhere in Connecticut and with staff to Los Angeles, Vancouver, and Minneapolis (Schensul et al. 2012; Schensul et al. 2005).

A student and a member of the research staff subsequently decided to use material from in-depth interviews to create a film about the risks of using MDMA. They created a script in

partnership with a group of young adults involved in street-violence prevention who knew the cultural setting from which the data had been collected. The team selected de-identified quotes from the study archives, took photographs of the city, integrated the quotes into the script, and recorded it. The film, entitled *Borders Beyond Bliss* was shown along with PowerPoint presentations to many groups of young people throughout the city, followed by discussion about the findings and implications for intervention.

<Insert Figure here>

Unlike the dissemination in Example 8.1, the panel exhibit was quite expensive and was funded with the dissemination budget included in NIH grants, as well as supplemental funds from NIH for minority summer youth research education experiences. The panels are still being used to inform young people about Hartford youth history and substance use and to help youth to recognize that there are forces beyond those of their peers that have an effect on their decisions about drug use. The film was created with no budget at all. In each case, access to the study population was enabled by taking the panels, the film and the PowerPoint presentation to places where young adults gathered or were likely to visit. In both cases, researchers and youth from the study population facilitated discussions around the materials that were intended to highlight the context of substance use, social influences on youth, and myths about the economy of drug selling and the broader political arena of illegal drug use and markets in the United States.

Taking Research and Results to the Broader Public

A third example highlights the ways in which information about the latest prevention research on HIV can be shared with a wide variety of community publics over time.

EXAMPLE 8.3

ENGAGING PUBLICS, INCLUDING RESEARCH PARTICIPANTS AND OTHER STAKEHOLDERS, IN DISSEMINATION OF HIV STUDY RESULTS

In the early 1990s, the Institute for Community Research opened its gallery, a community art space. The purpose of the ICR gallery was to create a safe and open space for dialogue between researchers and community stakeholders on important issues affecting the local community. It also was intended to help integrate the dialogue with performances and displays of material culture. ICR researchers and board members believed that a variety of art forms not only appealed to different learning styles but also stimulated emotional responses to the topics addressed, and encouraged intimacy across cultural and other boundaries through personal stories, beautiful objects of art made by local artists, and music and dance. The gallery offered an excellent opportunity to highlight ICR's prevention research on HIV, a then-seemingly intransigent problem that was increasing ethnic/racial disparities in the area and affecting active drug users, women exposed to transactional sex, and men having sex with men.

The first opportunity arose in response to World AIDS Day, which roughly coincided with the Mexican Day of the Dead. In honor of both, ICR decided to host an exhibit with multiple components: artwork by local artists who were HIV-infected; artwork by professional artists whose work made a statement about the devastating impact of HIV on these communities; a living altar, which offered anyone the opportunity to show objects, poems, stories, and memorabilia about their loved ones taken by AIDS; and a local quilt made by family members of infected people. A well-known curator, Sal Scalora, worked with HIV-infected artists to curate the work; the altar drew hundreds of people from Hartford communities who left mementos and attended the exhibit/installation. Accompanying programs offered a mix of attractions. Two workshops presented data from area studies designed to appeal to a wide variety of audiences; at

two special events, volunteers presented testimony about their loved ones, describing their lives and helping the public to recognize that regardless of the source of infection, those infected were talented, intelligent, loving human beings with families who cared.

“Giving Women Power over AIDS” (2005) linked a traveling exhibit in the ICR gallery, based on photographs of a woman living with HIV in Zimbabwe, to the importance of women’s ability to protect themselves from HIV. The exhibit, entitled “In Her Mother’s Shoes,” was created by its two photographers to convey the challenges that women face, regardless of their country, in coping with their illness, working, and dealing with stigma and discrimination, while at the same time sustaining their families (GCM 2002). The exhibit was shown in conjunction with a panel highlighting the importance of female-controlled prevention technologies, an important area of emphasis in ICR’s work, including microbicides, female condoms, and more recently, PrEP or pre-infection prophylaxis. All of these technologies are controversial, regardless of efficacy, because of their capacity to enable vulnerable women to make decisions about their own protection independent of their male partners. The exhibit and a panel discussion focused on gender inequity, the root cause of women’s vulnerability, and women’s limited ability to ensure their own safety from infection. Panelists included researcher and anthropologist Margaret Weeks, two HIV-prevention counselors from different clinical services, and Bindiya Patel, then North American Sites Coordinator for the Global Campaign for Microbicides. It was moderated by Laurie Sylla from the Connecticut AIDS Education and Training Center. The event attracted a highly diverse public consisting of both women and men stakeholders in the fight to help women to maintain their sexual independence and their sexual safety and health.

Another event in 2008 involved a group of peer health advocates (PHAs) working to promote syringe safety and sexual protection against HIV infection among drug users in the community

as part of a study funded by the National Institute on Drug Abuse (NIDA). Risk Avoidance Partnership (RAP) PHAs decided that they wanted to expand their leadership capacity. With the support of community installation artist and ICR gallery curator Colleen Coleman, they created works of art that made their own statements to the public about themselves and their lives. A press release described the event as follows:

The exhibit includes collage, masks, posters, paintings and fabric art. An AIDS Awareness quilt created by the PHAS and ICR staff will be on display. Portraits of the artists with personal quotes that describe their participation in Project RAP and present hopeful messages about the power of change, memories of family, and the importance of faith also are included in the exhibit. Curator Colleen Coleman: “We all could see the interest and excitement growing within the group as the PHAs began to open up about their life experiences while developing ideas for their artwork. One PHA told me this project allowed him to sit with his mother for the first time in many years, because she was helping him to sew his quilt square.” One artist featured in the exhibit had been HIV positive for 21 years. She said “I am a survivor, not a victim . . . for me, this exhibit is my way of telling my families and the community that I’m doing something positive.”

These vignettes illustrate just how important the availability of public exhibit spaces that are embedded in community settings can be. With such spaces, it is possible to bring together researchers, study participants, other stakeholders, and social justice motivated artists and curators to develop mixed media events that integrate research methods and results with social gatherings. These events allow people to cross cultural, racial/ethnic/age/lifestyle and other boundaries in ways not possible in other more traditional or formal ways. There are many such spaces that can be found through creative searches—in unused downtown space; in the exhibit

spaces and entryways of large new urban libraries, book stores, and other cultural centers; in youth-serving organizations; in old warehouses, beauty salons, bowling alleys, coffee shops, and restaurants; and on school and college campuses. All it takes is social capital and a little bit of venture capital to secure such spaces and to find artists who can connect with social issues to create works of art with high emotional and intellectual appeal.

A final example illustrates an interesting process that used the results-dissemination event with community stakeholders as an opportunity to help participants consider possible actions to be taken to address the problems raised and examined by the study.

EXAMPLE 8.4

COMMUNITY-BASED DISSEMINATION OF RESEARCH RESULTS IN LUSAKA, ZAMBIA

Dr. Lwendo Moonzwe carried out her dissertation work in the largest migrant community in Lusaka, Zambia. In looking for factors that contributed to women's empowerment and their ability to avoid sexual risk in this very resource-limited community, she sought partners among the international and local service agencies and political leaders working in the community. These included CARE, zone leaders, the Ward Development Committee, and local informal leaders. Born in Zambia though raised in the United States, Moonzwe returned frequently to Lusaka, where she had many friends and relatives. Her study took place over a year and involved interviewing men and women key informants, participant observation in the community, and an ethnographic survey based on the interviews. Her results show that positive male-partner relationships and joint decision making by women and partners reduced violence, men's sexual risk behaviors, and women's risk of HIV. However, food insecurity, abuse, and greater support-

seeking actions from friends and family were associated with greater sexual risk, which limited women's abilities to use their networks for support.

To disseminate study results, Dr. Moonzwe returned to Lusaka and set up two dissemination events and a follow-up event. The first dissemination event presented feedback to representatives from the study community; the second was directed to NGOs, community-based organizations (CBOs), and government ministries; and the third was directed to community representatives who discussed community problems and identified resources to help to solve them. For the first, an interactive PowerPoint presentation with time for dialogue was combined with composite case studies read to the gathering by residents. The event ended with a discussion about the findings, in which four groups discussed what strategies could be put into place to equalize gender norms, support women's empowerment, improve male-female relationships and prevent HIV. Some of the community residents met the next day with the NGOs and government organizations. A summary of the previous day's activities was presented along with the PowerPoint presentation, and the conversation that followed focused on women's empowerment and how men should be brought into efforts to empower women. The community representatives also described how government institutions whose obligations were to provide services and infrastructure, including education and economic development, failed to do so, shortcomings which had not been recognized earlier. All parties agreed that more community involvement in women's empowerment issues would be an improvement over current practice. The agenda for the last meeting was to engage representatives of both groups, including all the stakeholders, in drafting a proposal to present to the authorities.

The meeting introduced to stakeholders the systems analysis approach described in chapter 9 of Book 2 and again in chapters 4 and 6 of this book. This type of analysis begins with

identification of issues that need to be addressed in the community, plus a topic to address. Participants in this case chose the increasing rate of HIV infection among youth as a topic. The exercise called for the participants to identify issues leading to HIV infection among youth at the “organizational” level (gaps in government institutions, poor education, inadequate service delivery from international NGOs) and at the community level (women’s groups need support, CBOs lack resources, local political action groups do not include women). Next, the group was asked to identify resources at the organizational and community level available to address these gaps. These included women’s groups, cultural traditions such as rites of passage for women, churches, the local ward officials, and trained professionals. Finally, the group was asked to consider how these resources could make a difference in reducing the factors identified as contributing to HIV among youth. This produced an action plan that the joint group was able to present to the multiple sectors represented among stakeholders. This model of dissemination, ending with an analytic strategy in which all stakeholders are able to participate regardless of educational level or other factors, can be used in any setting where the goal is to share information and, at the same time, support local capacity for resource assessment and problem solving.

Cross Reference:

See Book 2, chapter 9, and chapter 4 of this book

TAKING RESEARCH AND RESULTS TO POLICY MAKERS AND INCITING ACTION

In their 2010 exploration or scoping review of publications on approaches to dissemination, Wilson and colleagues found that most dissemination efforts directed to public audiences were

based on communications theories (Wilson et al. 2010). Cognitive behavioral theories based on beliefs, values, knowledge, motivation, and intention underpin most efforts to persuade audiences to engage, and to transform themselves and their behaviors. The most highly referenced family of communicative theories are cognitive behavioral theories. These theories seek to modify or transform thinking and behavior through appeals to norms (customary practices), beliefs, perceptions of self efficacy (ability to actually make the change), and motivation to change. They also include stages of readiness to change (Prochaska, Prochaska, and Levesque 2001). Other theories involve risk and benefit assessment (Hawkins, Catalano, and Arthur 2002).

Diffusion theories are the second most frequently cited. Diffusion theories are based on the idea that information and persuasive influence flows through social networks (Rogers 2003). Some diffusionists believe that opinion leaders convey persuasive messages best, as they are role models already identified as those to whom others look for advice and guidance. Others think that the opinion-leader concept is both too narrow and too unstable and that everyone in a change community has the potential to convey information and persuade others, especially if they are clustered in small subnetworks (Pfeffer and Carley 2013).

Both creative problem solving and persuasive communication are required to take dissemination to the next step: influencing policy makers and motivating people to action. Persuasive communication, the most frequently cited, and one of the oldest theoretical frameworks, includes using emotive and empathetic qualities to attract, engage, and ultimately encourage audiences to change or act. These qualities often can be conveyed by using the artistic media we have described earlier; they engage audiences and are usually culturally based, holistic, and appealing to heart, mind, and values. It is partly for this reason that well-known

media personalities and performers are chosen to model behaviors desired by public health authorities, such as vaccinating one's children or using condoms. They also are used by corporations to promote undesirable behaviors such as drinking a particular brand of alcohol or consumption of sugary highly caffeinated energy drinks by teenagers. While these approaches are often considered appropriate for the dissemination of qualitative research results, they can be used with all forms of research results, depending on the audience.

Cross Reference:

See chapter 5 of this book

Persuasive communication, as first described by McGuire (1961; 1969), and since noted by virtually all persuasive communications theorists, rests on five attributes or strategic considerations: the source of communication, the message to be communicated, the channels of communication, the characteristics of the audience (receiver), and the setting (destination). Each of the considerations mentioned above requires thinking about who the audience should be and how that audience can best be reached. For example, sharing information for general knowledge might simply involve presentations at local colleges, in NGOs, local libraries, in university centers devoted to the topic, or public fora organized by others. However, persuading policy makers to take on an issue emerging from a research project calls for other strategies, including press releases and press conferences, face-to-face engagement with policy makers, using persuasive arguments, lobbying, presenting testimony, publicizing findings on social media, and other community organizing strategies.

Sometimes change cannot be incited simply by persuading policy makers alone to act. Some policy makers rely on authoritative sources and wait for the endorsement of science and

scientists before they can be persuaded to act. Influencing the scientific community and scientists through publications and presentations in respected journals or widely read books is often required in addition to other direct actions to convince policy makers of the legitimacy of an argument. However, such approaches are not at all effective with so-called science deniers; such people reject the findings of science and foment “cultural wars” that are based on beliefs, opinions, ideological commitments, deep-seated values, and religious fervor rather than science findings and facts. These wars are increasingly fought on global Internet sites, through social media, and in blog discussions.

Cross Reference:

See Example 6.14 of this book, on changing educational policy in Chicago

DISSEMINATION RESEARCH: ADAPTING AND RETESTING OR COMPARING AND SCALING UP INTERVENTIONS

In the previous pages of this book, we have described many different successful projects, research programs, and approaches, most of which have been carried out as a result of short- or longer-term “immersion” experiences in local settings and in collaboration with partners in those settings. Regardless of duration or scope, it is always desirable to share what happened in these experiences so that their successful processes and outcomes can be reproduced in other similar or even different settings. However, because our focus is on “communities,” and not clinical or laboratory settings, we must caution readers that duplication is not always possible; we cannot control for the multitude of events and forces that could or do impact on our efforts, even in the best of situations. Further, once we attempt to try out our accomplishments with partners in other settings, no matter how similar, we invariably must go through a process of exploration and

discovery, using ethnographic methods, in which differences between the original and subsequent sites and problems will emerge. These will necessitate adaptation of approaches and methods to record what has happened, what should be done, and how outcomes can be assessed.

Extending and Adapting Approaches Used in One Setting to Another Setting

To initiate this discussion, we begin with the idea that approaches that evolve in communities and community development in one place can lead to similar efforts in other settings. Here, we are referring to the kinds of situations that we described in chapter 2 of this book—long-term experiences in community development. Taking as an example the action research projects in Chicago described in Example 2.1, we now examine efforts to adapt these projects to fit conditions in Miami, Florida, and Hartford, Connecticut.

All adaptation/replication efforts require the identification of “key components of the intervention.” Identifying these key components is required in order to confirm just how similar or dissimilar a site is to the original, and to assert convincingly that a repetition has been attempted. The Chicago Mexican American community development experiment migrated first to Miami and later to Hartford. Below we list key components of this long-term intervention that needed to be present for replication or adaptation elsewhere.

- Identification of key community actors and activists in ethnic/racial communities
- Identification of core community organizations concerned with community development on multiple fronts
- Interest within the community in using research as a means of identifying issues and new directions to resolve them
- Interest in collaboration across disparate sectors
- Availability of outside funding to support innovative programs

- Sufficient politicization within the communities that people would be willing to demand rights in relation to dominant political and economic forces
- A felt need for community development in areas of education, health, mental health, and culture
- Minimum negative opposition to community development

These core elements were applied first in the city of Miami. In this extraordinarily multiethnic and Latin American-oriented city, six or more different ethnic/racial groups are vying for recognition, resources, and cultural presence. The Chicago approach applied to Miami in the 1970s identified some key actors in each of these communities; however, these key actors were arrayed in a hierarchy dominated by Cubans and their African American partners, who in turn were allied with the entrenched white power structure. Nascent community organizations existed, but they were too poorly developed to represent assertively the cultural and other interests of communities such as West Indians, Haitians, Puerto Ricans, Cubans, and other African Americans. While research was viewed as an asset, some key gatekeepers believed that providing mental health services was more important than doing research, given that the program implementing community development was funded through community mental health dollars. So it was difficult to mount the kind of research efforts needed to assess programmatic needs. Other than existing alliances created for political purposes, the Miami community had created no efforts to collaborate across ethnic/racial lines. In addition, during the mid-1970s, federal funding policy shifted from supporting community development to service delivery—an approach designed to treat the symptoms of an ailment rather than cure the underlying problem—followed by a dramatic decline in public sector support for services to people who needed them. Community development was no longer perceived to be a major issue. In this

conservative state, political mobilization was limited by a political environment in which “deals” were arranged behind closed doors and little overt public political activism existed. Community development was needed, but unlikely to take place except through channels that supported neither research nor advocacy. The transfer of the “Chicago Model” to Miami was unsuccessful because the requisite core components were missing.

In Hartford, Connecticut, however, the story was somewhat different. Community advocates in both the Puerto Rican and African American communities existed and were visible. Their organizations already were attempting to promote community development, and they had a strong commitment to research. An umbrella organization had already brought Black and Puerto Rican advocates together to fight for community development; it had developed strong plans for acquiring outside funding. Communities had learned how to fight for their rights in the late 1960s and were highly politicized. In several cases, the developmental priorities had already been identified (e.g., in the Puerto Rican community, priorities included economic development, housing, education, and health). The environment was ready for further development, especially in the areas of health and culture. The effort proceeded in a manner comparable to the Chicago approach: identification of key partner advocates and their organizational bases, development of participatory research efforts to highlight needs and issues, creation of new advocacy teams and organizations serving the community, and promotion of community-based participatory research for community development. This comparison reminds us that it is critically important to use ethnographic skills to determine whether the core components of a long-term community development effort are viable and whether using them is practical. There is little in the way of useful literature that compares and contrasts the longer-term community development interventions we outlined in chapter 2; this makes it difficult to suggest either what the core

components of such interventions might be or which qualities might make them most effective over time. Perhaps the best summary is that of van Willigen. His seminal chapter on community assets and the community-building process uses a six-point rating mechanism to rate assets from the perspective of building on community capacity in his work with Arizona's Native American Tohono O'Odham community. It included these points:

- The internal (to community) location of the implementing institution identified as a resource. Internal was rated as higher because of the community's ability to maintain control over it.
- The focus of the resource on community rather than individual goals; a focus on community was rated higher.
- The generality of the goal orientation—the more general the goal orientation, the greater the opportunity for the community to plan and include its own priorities, and the higher the rating.
- The longer duration of the funded program effort—financial resources without deadlines would allow greater community participation, and garner a higher rating.
- The capacity to link a resource with the community's organizations. Stronger and more numerous linkages received higher ratings.
- The formation of new roles within the community; the more new roles created, the higher the rating (van Willigen 2005).

Van Willigen suggests that strategies for implementing both long- and shorter-term interventions be considered in light of these criteria. He also notes the importance of community institutions, local knowledge, physical infrastructure, and history, suggesting that these are critical in addressing community development goals.

Key point

Other dissemination efforts reflect the shorter-term, more project-oriented programs that are more typical of participatory and collaborative interventions in community, school, and clinic settings. The key point is that *whenever interventions are successful, they need to be disseminated and shared with others, and then adapted to be usable in different settings and with different populations*. As we explained earlier in this chapter, *implementation science* is the term given to the area of research that examines the process by which adapting and transferring specific interventions from one location, often an ideal one, to another which may be less ideal or different in many other ways, occurs. The term *implementation science* is often used to refer to so-called **evidence-based interventions**, which means that they have been evaluated empirically using standardized and, almost always, quantitative measures to be effective in line with their expected outcomes. Most of these interventions are generated by psychologists or by interdisciplinary public health teams, though some are developed by anthropologists, sociologists, other social scientists, and educators. There are now compendia, archives, Internet storage sites, and other locations where researchers and policy makers can find interventions that they would like to adapt, adopt, and evaluate in their own settings.

The process of adapting, adopting, and evaluating these existing interventions and programs utilizes a specialized language summarized in Table 8.2 (Pemberton 2012).

Definition:

Evidence-based interventions are those that have been evaluated and determined to be effective, based on their ability to achieve their desired goals

<Insert Table 8.2 here>

It also utilizes common sense. Proctor and colleagues help us to consider the elements in implementation (Proctor, Power, and McMillen 2013). They propose the following guidelines to consider.

- 1. Name it.** Name the intervention strategy. Proctor et al. suggest using language consistent with existing literature; but naming also should be consistent with local language and meaning.
- 2. Define it.** Define the implementation strategy and any discrete components operationally—that is, in ways that they can be actualized in behavior.
- 3. Specify it.** Identify the *actor*—the person who enacts the strategy (e.g. teachers, counselors, advocates, residents, peer educators); identify the *action*—specify the specific actions, steps or processes that need to be enacted; identify the action target (who it is to be directed to); identify the *units* important in measuring outcomes. Specify exactly *when* the strategy is used (e.g., time of day, sequence in the overall intervention); specify *how much* it is to be used (e.g., frequency of delivery, amount of delivery, number of times delivered over a designated period of time); *justify* the choice of strategies both locally and through the literature.

Good intervention researchers know how important it is to study the context, the “delivery setting” (clinic, school, community organization, group), and the people involved when adapting an intervention for dissemination. Various researchers who do participatory dissemination work make it clear that all three—context, setting, and participants—need to be considered in detail and engaged as much as possible to ensure that an intervention shown to be effective elsewhere is feasible, acceptable, cost effective, likely to have good outcomes, minimally buffeted by external forces that could undermine it or negatively affect desired outcomes, and owned and embraced by those to whom it matters most.

Top-down approaches to dissemination of interventions generally are driven by social

scientists who may work with people in local communities to make adjustments to the intervention delivery process, content, setting, language, and other aspects of the program. Often in such cases, communities or schools or clinics are not given the option to choose from a variety of interventions. Instead, they are offered one approach that the social scientist is interested in. If the community is interested, the intervention is implemented and evaluated. However, whether that intervention actually was the best possible choice seldom is sufficiently evaluated ahead of time, especially if financial incentives of funding are attached to adoption of the intervention! This top-down and non-collaborative process really is not consistent with the egalitarian partnership approach that we have emphasized in this book and elsewhere in the *Toolkit*.

A more effective approach, although one that is rarely tried, is to involve communities, public health departments, parents, and other stakeholders in the selection of several possible intervention options, and to provide them with or help them to build criteria that help them to choose what works best for them. Layde describes an approach called the “community health improvement process” (CHIP) that involves stakeholder participation in defining the context and problem, choosing evidence-based options and alternatives, and evaluating them. The “EdCHIP” approach identifies critical health issues and stakeholders, evaluates community assets and health, participants’ educational levels, and other available secondary data, and then identifies relevant interventions from an inventory based on these priorities and desired outcomes. The data utilized by the stakeholder group is collected from secondary sources, and the assets are determined depending on the knowledge and resources possessed by the stakeholder group (Layde et al. 2012). While this approach reaches a broader swath of the community, it still does not guarantee that the voices of those experiencing educational or health inequities or other forms of disparity will be heard.

A fully participatory approach which does ensure the full engagement of marginalized communities is one in which community members generate an explanatory model for a health or other disparity of their choice, conduct their own research, and (based on their own data as well as other secondary sources and the literature) determine what kind of interventions they think would be beneficial, and how to identify or to create them. For this purpose, they can use any of the tools and techniques outlined in this book for generating local theory, linking it to “etic” or disciplinary theory, identifying intervention components, and even identifying interventions.

The following example shows how this approach can work for local residents.

EXAMPLE 8.5

LATINO PARENTS OF PRESCHOOL CHILDREN DO RESEARCH AS THE BASIS FOR CHOOSING THEIR PREFERRED INTERVENTION MODELS

In the late 1990s, the Center for Substance Abuse Prevention offered a unique two-year opportunity to communities to study with the creators/developers of six social science–based cognitive behavioral interventions for strengthening families. The goal was preventing substance abuse in the future. In a national convening, representatives from communities awarded grants by the Center for Substance Abuse Prevention were to come together to choose one of the six interventions. The Institute for Community Research in Hartford, Connecticut, together with a local Latino mental health and substance abuse facility, received an award. Most of the parents of young children involved in the center did not speak English and had not heard of prevention before. Under the leadership of Marlene Berg, a participatory researcher at ICR, and the center director, parents concerned about their children’s future substance use came together to determine what they wanted. The six parents who attended the convening could not decide on a

single program. Instead of choosing one of the preexisting interventions, the parents created their own conceptual model of what constituted a healthy family and a healthy home. Choosing elements from three of the six programs, they integrated them into a new intervention, “Encontrando el Poder Dentro de Ti” (Finding the Power Within You), that worked for them. They tested the model through in-depth interviews and a survey of other parents of young children. After triangulating the data, they defined what they considered to be a healthy family and a healthy home and drew up a statement that could be used at the convening as they looked for appropriate programs.

The approach of the Hartford parents was quite contrary to the principles of “dissemination science,” especially its emphasis on fidelity (consistency of implementation with the original model), but it fit well with the notion of enabling communities and groups to develop their own approaches to intervention rather than being dictated to by the scientific establishment.

“Scaling Up”: Expanding the Scope of a Program or Movement to the State or National Level or Globally

So far, we have been discussing different ways of expanding the settings in which interventions can be redefined, adapted, repeated, and assessed. We’ve also mentioned that by using the tools of research, communities and educators can become empowered to choose from a wide variety of interventions. With proper preparation and facilitative expertise, they even can choose elements from multiple interventions to craft their own. The final stage in dissemination is “scaling up,” a term that refers to broad implementation of an intervention across multiple settings and units. For example, the intervention known as GEMS (Gender Equity Movement in Schools), a successful program that promotes gender equity in educational settings, is being

implemented in many schools in the Indian state of Maharashtra, with minor process and outcome assessments. The All Stars program, a successful tested and evaluated substance-abuse-prevention program for middle school students (age eleven to fourteen) is designed to prevent and delay the onset of high-risk behaviors such as drug use, violence, and premature sexual activity. The program focuses on (1) developing positive ideals that do not fit with high-risk behavior; (2) creating a belief in conventional norms; (3) building strong personal commitments to avoid high-risk behaviors; (4) bonding with school, pro-social institutions, and family; and (5) increasing positive parental attentiveness, such as positive communication and parental monitoring.

The All-Stars curriculum includes highly interactive group activities, games and art projects, small group discussions, one-on-one sessions, a parent component, optional online activities and worksheets, and a celebration ceremony. Its thirteen forty-five-minute class sessions can be delivered by teachers, prevention specialists, or social workers. Multiple packages of student materials are available to support implementation, either by regular teachers or prevention specialists. The materials are meant to be administered without external facilitation.

Programs that are “scaled up” usually have a set of unique features. They are packaged so that they can be self-administered without much, if any, facilitation; they make sense to a broad spectrum of implementers in the settings for which they are intended; they are cost effective, especially in resource limited settings; they can be implemented by many different actors because they don’t depend on a narrow range of professionals; they can readily be culturally adapted to specific groups in specific settings; and they are often translated into multiple languages. Scaling up programs takes a considerable amount of financial support for the first few years, for packaging, testing, training, and evaluation. Thus, those who wish to scale up their

programs will find that good results are not good enough—they must be able to find donors, or government or business sponsors, who will help them to package their work. For example, the developer of a successful participatory intervention to reduce obesity among African American women, created with an alliance of Black churches in Connecticut, was able to find support for scaling up the program through Empire Blue Cross/Blue Shield, the company that provides insurance for New York’s state employees.

SUMMARY

In this chapter, we’ve discussed the variety of ways that researchers and their partners can and should share the results of their research and their successful interventions with others. In the first part of the chapter we argued that researchers have the responsibility to share the results of their work with the broader community in which it was carried out, and most especially with the community of participants. We’ve suggested that this is an ethical requirement for researchers, regardless of the degree to which they are partnering with local settings. This is because partnerships cannot and do not include everyone in a community, school, or clinic. Thus, it is not enough to share the results with partners and legislators. We have suggested a variety of ways in which research results can be shared, from various forms of media and face-to-face communication to more formalized planning to develop interventions and advocacy approaches based on the results.

In the second part of the chapter we discussed the growing field of “dissemination/implementation science.” This field began to emerge more than four decades ago, as information about successful approaches to education, and later to health and other service areas, were piling up in articles, on bookshelves, and in funders’ archives but were not being shared with the public. Public funding was not producing public benefit. The net result of

dissemination/implementation science is a rapidly expanding set of approaches to adapting interventions for use in multiple settings and a new language of dissemination to and with “end users”—the people for whom the interventions are intended so as to ameliorate their social, environmental, health, educational, and mental health suffering. These approaches also include ways of creating community infrastructure for choosing interventions, for supporting communities and other users to use research methods as well as secondary data sources and opinion, and to assess their own settings and population to determine what approaches suit them best.

In the next chapter, we discuss Participatory Action Research with adults and youth—a fully participatory approach that “teaches” action-oriented citizen groups concerned with social justice issues to use research as a means of assessing their environment in order to change it. In the PAR model, participant activists are the drivers of the research and intervention process, using all of the tools and methods we have described throughout the *Toolkit* to do active research on their environments, determine their assets and resources, decide what they need, and make intelligent and informed decisions with respect to social-change strategies.