

**Evaluation Report: March 31, 2023**

***Prepared for The Wellbeing Partners by LaShaune P. Johnson, PhD of Estella Lucia Evaluation, LLC.***

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**Section 1: Introduction**

In March 2022, LaShaune P. Johnson, founder of Estella Lucia Evaluation, LLC (ELE, going forward), was asked to participate as an evaluation and learning partner for the pilot of a mental wellness/behavioral health intervention geared towards African American/Black populations, utilizing barbers/stylists who service clients in the Omaha, NE metro area.

ELE, based in Omaha, NE, specializes in arts-based, community-based research, and culturally responsive, race equity [evaluation](https://expandingthebench.org/about/terms/), coaching and training. Evaluation of health equity and maternal/child interventions are some of their specialties. Dr. Johnson, in her evaluations, deploys tools used by her work as a training for the Michigan Public Health [Institute,](https://mphi.org/our-teams/center-for-culturally-responsive-engagement/) and as an alumna of the Leaders in Equitable Evaluation and Diversity [(LEEAD)](https://expandingthebench.org/leead/) program.

Practitioners of [culturally responsive evaluation](https://www.mdrc.org/publication/guiding-questions-supporting-culturally-responsive-evaluation-practices-and-equity-based) center the voices and lived experiences of the communities [most impacted](https://mphi.org/wp-content/uploads/2022/05/Considerations-for-Conducting-Evaluation-Using-a-Culturally-Responsive-and-Racial-Equity-Lens.pdf) by the issue/policy being studied, and emphasizes making sense of the distinct intentions, impacts, and (sometimes disparate) outcomes an evaluation has on the priority (sometimes called “target”) community.

Below, this image offers a simple visual of the domains explored by a culturally responsive evaluator:



In addition to evaluating the development and process of an intervention, for interventions funded by non-profits/foundations, ELE also employs the Equitable Evaluation [Framework](https://www.equitableeval.org/framework), to help understand if the processes and deliverables of the evaluated program also support its goals that support progress towards equity in its teams, outcomes, and design.

The image below represents the three main questions the Equitable Evaluation asks philanthropic organizations to ask of themselves. Image is taken from their full white [paper](https://www.equitableeval.org/_files/ugd/21786c_7db318fe43c342c09003046139c48724.pdf):



These aforementioned frameworks—along with a few theoretical tools--will be key in helping to describe the program’s successes and areas of growth, and offer recommendations for changes going forward.

I was invited to be an evaluation and learning partner by members of The Wellbeing Partners (TWP) team members. I was already familiar with the work of the Center for Holistic Development (CHD), through my work as a public health faculty. Beginning in March 2022, I was invited to internal TWP and CHD planning and development meetings. In the early meetings, it was determined that I would conduct qualitative interviews of students and staff connected to the pilot, potentially conduct pre-test evaluations, and content analysis of materials for the pilot. *In the Evaluator’s reflection later in the document, I discuss the coordination difficulties that resulted in my not distributing a pre-training survey.*

***Project Goals***

**Recruitment of a cohort of Black Barbers/Stylists**: During the early meetings, I was informed that the goal was to recruit up to ten (10) African American barber shops/salons, and to offer culturally-relevant training about African American/Black behavioral health and to share Omaha-area resources for screening, treatment and additional education.

**Co-Creation of Culturally Competent Educational Materials**: The team from the Center for Holistic Development was identified as the community partner who would help with recruitment of potential barbers/stylists and to help with addressing the culturally competent needs and the training needs.

**Developing and Dissemination a Model to Address Black Mental Health Disparities**: Early evaluation notes indicate the hope that, by fall, the hope was that the first training group would be complete, that marketing of the project would be rolled out.

**Marketing, Monitoring, Evaluation, and Learning**: In notes from early meetings, I observed that The Wellbeing Partners team appeared to be set to offer logistical, marketing, educational, and evaluation support (through my work). Finally, the teams would participate in shared sensemaking of collected data (from evaluator and from barber/stylist/community feedback) for the next stage would begin.

To understand the development of the project, to assess the cultural responsiveness, and to assess the preliminary successes, I was able to conduct participant observation during planning meetings and training sessions, review materials and interview participants in the project. *These activities occurred between March 2022-January 2023.*

***The Charge for the Evaluator***

In conversation with the current TWP Executive Director, I was asked to highlight in this report the following elements of the early processes of the project (modified from March 10, 2023 email):

* *Were program activities accomplished?*
* *What is the quality of the program components? This would be information about knowledge and skill increase because of the training.*
* *How well were program activities implemented? To what extent was the program implemented to fidelity/how was it delivered?*
* *Was the target audience was reached?*
* *Were program activities culturally appropriate?*
* *How did external factors influence program delivery?*

***Recommendations and Reflections for the Onboarding Process***

This program was a pilot of an initiative aimed to address the mental health disparities in Omaha’s Black/African American community.

* *Evaluation Reflection #1: Target Audience*. The creation and implementation started off well. The community partner, CHD, is well-known and well-placed to assist in reaching the priority population for both barber/stylist trainees and the priority African American population.
* *Evaluation Reflection #2: Equity and Cultural Competence*. The inclusion of staff from both TWP and CHD in early planning meetings was helpful in the goal to create quality and culturally componence to the programming. Establishing a culture of participatory leadership will be key for continuing the work.
* *Evaluation Reflection #3: Changes led to delays.* Because there was a shifting in staffing during the process (new hires, leaves and reassignments), there may have been some miscommunications between the team and the external evaluator. This may have also adversely impacted the implementation. These are external/internal pressures that are hard to avoid in a dynamic partnership, but may be addressed with the recommendations below.

More specific suggestions for the different parts of the timeline (pre-, during, and post-training) will be provided below, but I offer a few broad recommendations here.

* *Recommendation #1*:*Understanding context and internal/external factors:* In previous projects, I have conducted pre-project [developmental evaluation](https://www.betterevaluation.org/methods-approaches/approaches/developmental-evaluation) conversations with team members in projects, to understand their roles and their other (potentially competing) tasks, and to understand how the project fits into the organization’s larger values/principles/timelines. Sometimes, with the partners to an organization, I will also have conversations using a [Utilization Focused evaluation](https://wmich.edu/sites/default/files/attachments/u350/2014/UFE_checklist_2013.pdf) approach. In this project, I did not. In conversations with TWP staff after earlier drafts of this report, I recognize that these conversations would have assisted in helping to understand how to fit the evaluation process into TWP and CHD calendars and needs, and how to educate team members on what information would be helpful for a thorough evaluation.
	+ *Going forward, when working for a new evaluator, consider making time for brief pre*-*project evaluation conversations, to set schedules and to contribute to planning.*
	+ *Evaluation: The evaluator (me) should have implemented these conversations, and potentially missed some key opportunities early on*.
* *Recommendation #2 Creating a shareable workplan and timeline*: While the TWP/CHD teams seemed to be on the same page for the broad goals of the project (supporting a reduction of mental health disparities in North Omaha), team meetings may have been aided by the presence of a Logic Model and/or a Theory of Change, that could be used to onboard new team members and be used as a shared reference point when making adjustments to timeline. An evaluation and learning partner can facilitate this creation, and the Logic Model can help refine a project timeline. Sometimes the use of project management software can aid in this process as well.
	+ Logic models can create a conversation about outcomes and outputs. This example from St. Louis is an [useful example](https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/images/logicmodel.jpg).
	+ Logic models can also help team members and community partners uplift assumptions and external conditions that might be impacting the project, as highlighted by this [Canadian tool](https://www.publichealthontario.ca/-/media/documents/f/2016/focus-on-logic-model.pdf?la=en).
	+ While Logic Models give a simplified version of the project plan, a [Theory of Change](https://www.aecf.org/resources/theory-of-change?gclid=EAIaIQobChMImK7SloOD_gIVrcmUCR09JQu6EAAYASAAEgLPDfD_BwE) can offer the opportunity to discuss external conditions, cultural beliefs, and social relationships that could impact the project. An evaluator could facilitate a discussion about the pros and cons of implementing a ToC.
	+ *In the next iteration of the project, team should create a Logic Model and overlap its goals with the evaluation and training/marketing timelines. Offer trained barbers/stylists an opportunity to review/comment on finalized model, to identify any other external factors that might influence the project.*
* *Recommendation #3: Make space a diversity of experiences and skills*: Before starting the project, consider adopting some conversation [guidelines](https://couragerenewal.org/library/courage-renewal-touchstones/) like the Touchstones to help ensure that the conversation remains respectful to all, and that allows the teams to make space for all partners’ experiences.
	+ When working cross-culturally, make time for difficult conversations. When working with community experts (such as CHD), practice [radical empathy](https://www.terrigivens.com/radicalempathy/) and deep listening so that you can remain open to consider their insights.
	+ Consider the [BRIDGE](https://www.themuse.com/advice/inclusion-mindset-bridge-framework-ruchika-tulshyan) framework as you go on your inclusive journey.

**Section 2: Theoretical Backgrounds used to understand the development, implementation and reception of project**

One of the impetuses of the start of this project is the [national](https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health), and [local](https://dhhs.ne.gov/Reports/Health%20Disparities%20Report%202020.pdf), African American/Black disparities in information about mental health/behavioral health diagnoses/treatment, disparate access to diagnoses and treatment, and disparate outcomes for Black patients. The COVID-19 [pandemic](https://omahafoundation.org/news/how-the-pandemic-has-impacted-our-communitys-mental-health/) has exacerbated these disparate outcomes, and potentially posed other barriers to accessing care.

The reasons for these disparities are complex and multifactorial: cultural, ethnic and religious beliefs may suggest that Black people do not experience mental illness and/or if Black people experience mental illness and/or the demonstration of symptoms of mental illness are not real, the result of non-Black/supernatural influences (like the Devil) and/or can be treated by non-clinical interventions (praying, exorcism, etc.). These beliefs may result in *some* Black community members to downplay the experience of symptoms, mock people experiencing symptoms and seeking help for them, and rejection of diagnoses, interventions or treatment.

To make sense of the efforts made by the Harambee team, I availed myself of two of the many public health tools, along with the culturally responsive evaluation framework mentioned earlier.

***Health Belief Model***

The first model helpful for understanding how the [Health Belief Model](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6163739/). The HBM, according to Rollins, et al, (2018): “correlates factors such as attitudes, beliefs, and perceptions about a particular health condition or health behavior with the actual practice of that behavior. The fundamental principle of the model is that an individual’s perceived risk of being affected by a particular health condition and the perceived severity of these effects impacts decision-making behaviors”. It has six elements, as listed below:

1. Perceived susceptibility—belief in your current “risk” to develop a condition
2. Perceived severity—belief in the negative (social or physical) consequences of contracting the condition
3. Perceived benefits—belief that the suggested behavior change will be helpful for preventing or reducing susceptibility or severity of a condition
4. Perceived barriers—perceived psychological, social, financial costs of initiating and/or continuing behavior change
5. Cue to action—the internal and external moment(s) when the person becomes aware of their feelings about the condition
6. Self-efficacy—the person’s belief that they can perform the recommended changes and performed the next steps.

In reviewing the materials offered during the training, I tried to assess the materials offered in the training to see if they addressed the generally understood belief of Black Omahans.

***Social Marketing***

A final theoretical framework that influenced the evaluation of the Harambee project was the Social Marketing approach to Public Health. As described in the [Community Toolbox](https://ctb.ku.edu/en/sustain/social-marketing/overview/main). The Social Marketing model has a long history of research, and is an evidence-based approach to reach priority communities, to customize messages that fit these communities in a culturally and linguistically appropriate way, and to support longer-lasting beliefs and behavior changes in these communities. The elements of Social Marketing can be explained through the 4 Ps:

1. *Product*—What is the behavior you are trying to change
2. *Price*—How much will it cost a person to stop or start a certain behavior?
3. *Place*—What is the context in which a behavior change must take place—what are the barriers and facilitators?
4. *Promotion*—What advertising are going you going to do?

***Recommendations and Reflections***

Although this is not necessary to dig deep into the “weeds” of theory, I believe that adding guiding theories for the project and/or theories for how to evaluate successes and failures would be helpful to establish early on. This is an area of improvement for the program, if it is to continue.

***Evaluation Reflections***

* *Reflection #1: Disrupted delivery and design*. In the conversations I participated in, there was not shared a shared theory for how knowledge, skills, and abilities would change and how members of the larger organization (marketing and design) might be able to support the program. I believe this may have disempowered the newly appointed TWP staff member. Being able to enter into conversations with a framework for how this work would take place would have allowed her to more strongly steer conversations about what she needed from all team members and the marketing team.
* *Reflection #2: Missed Social Capital Opportunities*. Because many of the members of the target trainee population (barbers and stylists) and the community partner (CHD) use various forms of social media to discuss important issues, not having an agreed upon marketing plan meant that potential opportunities to generate excitement about the program (even in its early stages) were lost. Comments/likes under posts previewing this program would have been additional data to analyze and might have helped with refining training/delivery.

***Recommendations***

* *Recommendation #1: Consider external events.* Although the project was not about the COVID-19 epidemic, as mentioned above, the epidemic was still a very fresh memory in the minds of community members. The experiences with—and responses to—the [public health efforts](https://ajph.aphapublications.org/doi/epdf/10.2105/AJPH.2021.306411) (i.e., social isolation and vaccination to prevent the spread of the disease) might have triggered collective Black community memories of the Tuskegee Syphilis Experiment. Project design conversations should take into account that fears about external influences/community “experimentation” might make Black community members less likely to participate in a “pilot” project. Careful wordsmithing must be undertaken to put already-nervous community already at ease.
	+ *The wordsmithing can be aided by conversations about external events and can create an opportunity to engage in “*[*structural competence*](https://www.sciencedirect.com/science/article/pii/S0277953613003778?via%3Dihub)*”, which offers a window into the historical, cultural, and structural barriers the community might be facing. They can also help to address and anticipate possible barriers, stigmas, stereotypes and* [*research fatigue*](https://chicagobeyond.org/researchequity/) *you might encounter.*
* *Recommendation #2*: *Make space for constructive feedback through the design, in order to maintain team “buy in”:* To assess progress towards goals, appropriateness of the frameworks, and the timeline, implement “evaluative” conversations at the end of meetings.
	+ *For small ways to integrate thought partners into the evaluation process from the start of a project, consider the Nexus Community Partners’ approach outlined in “*[*Everyone is an Evaluator*](https://www.nexuscp.org/wp-content/uploads/2017/05/Evaluation-and-Community-Engagement-Everyone-is-an-Evaluator.pdf)*”. There, they list small ways to make evaluative conversations as part of meetings, and describe how to work with an external evaluator.*

***Section 3: Methodology to understand process, design and effectiveness***

To answer key questions from stakeholders, I participated in team meetings and trainings; was given access to program materials; and was given an opportunity to interview TWP and CHD team members and to interview the trainees. This triangulation of methods allowed me unique access to the design and reception of the project. This triangulation borrowed partially from the Damian et al’s (2020) [approach](file:///Users/lashaunejohnson/Library/CloudStorage/Dropbox/EstellaLucia/WellbeingPartners/o%09https%3A/pilotfeasibilitystudies.biomedcentral.com/articles/10.1186/s40814-020-00678-y) to understanding a Community Health Worker (CHW) training. In their work they used surveys and focus groups to evaluate a training. Below is the rough timeline of my work.

***Timeline of Observed Project Activities***

* *March 2022-December 2022*—attended team planning meetings
* *September 2022*-- recruitment meeting (I did not attend, but included questions about it in the qualitative interviews)
* *October 2022*—binders were distributed with materials
* *November 2022*—attended virtual training conducted by nationally-renown psychologist
	+ Videorecording of training was distributed
* *December 2022*—attended in-person training facilitated by CHD team
	+ Additional materials were distributed at meeting
* *December 2022-January 2023*—TWP and CHD staff participated in qualitative interviews, and 5 training cohort members participated in qualitative interviews
* *March 2023*—Distribution of marketing and other supportive materials (did not see the materials, but was able to have an email exchange with a TWP team member that it had occurred)

***Thematic Analysis***

A helpful tool for making sense of the qualitative participant observation notes was [thematic analysis](https://journals.sagepub.com/doi/pdf/10.1177/0095798420962257). This allowed me to bring out recurring themes that emerged in the various sources of data and to discuss them as a whole in the evaluation report.

As the timeline indicated, I asked to participate in and observe team meetings (without the trainees present) and trainings. I also chose to delve deeper in the process with one-on-one interviews with trainees and staff. Accessing the materials that the trainees received helped me understand if/how the project was reaching goals, and also helped me understand what the trainees were reflecting upon a using in their work in the community.

***Design of Evaluation Interviews***

Understanding that the various stakeholders may have different experiences of the project, and that these diverse voices would enrich the evaluation findings, I requested to be able to interview all of the barbers/stylists, three of the CHD staff and one TWP staff. To be able to meet people where they are, I designed three different interview schedules, one for each of the groups (barbers/stylists, CHD staff and TWP staff).

After the second training was completed, I was invited to conduct these interviews. I did phone call or Zoom interviews (depending on personal preference) in the months of December 2022 and January 2023. The project stakeholders were offered the opportunity to select their interview day/time on Calendly or to text/call me to set up a time that was convenient. Stakeholders were told that the interview would take approximately 45 minutes to complete; some stakeholders received the interview schedule before their interview. ***Interviewees were assured that no names and identifying information would be shared from these recorded interviews, but due to the small N of the project, it is possible that someone might be able to attribute a quote to a specific person.***

When the transcript was not automatically created, the Otter.AI tool was used to create a rough transcription of the conversation. I was also taking notes throughout all conversations.

***Document/Video Review***

After attending the first training, I was given a recording of the training. After the second training, I was given files of the handouts given during this training. Using the same thematic analysis approach, I was able to review these materials for their content, health literacy level and cultural responsiveness.

**Recommendations and Reflections**

***Evaluation Reflections***

* *Reflection #1: Epistemic Justice*: Allowing all of the trainees and many staff have their views shared about the experience in a non-judgmental space was great for promoting [epistemic justice](https://epistemicjusticeiarslce2018.wordpress.com/a-brief-guide-to-epistemic-injustice-justice/#:~:text=Epistemic%20justice%2C%20then%2C%20also%20takes,understanding%20of%20the%20knowledge%20receiver.) and leans into [collaborative evaluation principles](https://aea365.org/blog/strongmodel-for-collaborative-evaluations-strong-by-strongliliana-rodriguez-campos-strong/). The teams are to be commended for willing to be vulnerable in this way.
* *Reflection #2: Mixed Methods*: Because the stakeholders have different levels of engagement with data collection methods, planning to allow for both surveys and qualitative methods was a good choice to allow space for speaking in the way they feel most comfortable.
* *Reflection #3: Content Analysis for cultural responsiveness*: Because of the noise of and (sometimes closed, always personal) culture of the salon/barbershop, there may not always be space to speak about intimate issues such as mental health at length. The team’s willingness to invite some content analysis of the training materials is a plus. It would have been helpful to see the “swag” distributed in March 2023.

***Recommendations***

* *Recommendation #1: Offer a pre- and post-test*. In earlier project meetings, the idea of a pre- and post- quantitative test was discussed, but was eventually not implemented. Instead, questions about previous experience and knowledge were inserted into the qualitative interviews. In future iterations of the project, a simple pre- and post-test might offer some insight into the effectiveness of the trainings.
	+ *There are a number of models of pre- and post-tests, but* [*this heart disease one*](https://www.nhlbi.nih.gov/sites/default/files/media/docs/Session12-CommHWPrePostTest-508.pdf) *is particularly useful in its use of plain language, terms taken directly from the training, and Likert scales to allows for measuring feelings.*
* *Recommendation #2: Investigate internal barriers*. Connect the interview questions and survey tools more tightly to the previously created Logic Model and Theory of Change. During the group conversations, translated my notes and observations to create a series of questions for the stakeholders. While the interview tool produced many candid conversations, not explicitly applying an agreed-upon design meant that there might have been insights not revealed.
	+ *Evaluator (external or internal) should offer a specific time in early meetings to discuss evaluation tools and methods. Learning from a different project I am currently evaluating, I would recommend creating a shared virtual draft of the evaluation tools, setting a “review period” for the team to add comments to the draft, and setting a brief meeting for stakeholders to make any final revisions and discuss the distribution of surveys/recruitment for interviews.*

***Section 4: Pre-training Context: Design and Recruitment***

In the months of March 2022 to September 2022, I was able to participate in team meetings that discussed the planning and recruitment of barbers/stylists to undergo the training. Also discussed at these meetings were the referral and tracking processes to evaluate the project.

*Observed Recruitment and Design Goals*

Field notes from meetings reveal that:

* The team was targeting ten (10) shops. From those shops, the trainees would emerge.
* There was a hope to create a TWP website to advertise these efforts.
* The CHD hoped to grow their internal team to manage the duties of this project, possibly even adding a male team member.
* There was an effort to find a replicable/modifiable curricular model that was appropriate for the Omaha context.
* There was two be a second group to be trained after debriefing the first training.
* There was also a plan to offer “in the moment” tracking for barbers/stylists to keep track the number and tone of conversations with clients.
* There was a hope to develop a system (perhaps using fliers with QR codes) that would allow streamlined community referrals.
* Training and evaluation should be completed by the end of the calendar year.
	+ *Due to unforeseen circumstances, this timeline was adjusted.*

*Design and Recruitment Activities and Findings*

* After co-creating a list of engaged barbers/stylists in personal and professional networks. In Fall 2022, the team put on an educational/recruitment event to kick off the project. This project was attended by the team, but not the evaluator.
	+ *Qualitative interviews reveal that this kickoff event was framed as a fun and open session to allow community members to discuss the issue more broadly and to activate them to want to become involved.*
* After a considerable search, a nationally-known expert on Black hair and Black views of mental health was identified and she was tasked with making a modified training that was approximately half of the time of some of her other trainings.
	+ This training was to be offered virtually.
	+ The training was to be interactive.
	+ *Qualitative interviews revealed that CHD/TWP staff had heard good things about her work, and also a few of the trainees were also aware of her work before the start of the project. This national reputation was both impressive and reassuring (because of its reputation for cultural responsiveness) for community members.*
* The CHD team was tasked with creating a shorter, in-person second training.
	+ This training was to be interactive and to allow trainees to meet in person.
	+ *Qualitative interviews showed that trainees were thrilled to meet each other and excited to (re)connect with a well-known group of providers (CHD).*
	+ *Qualitative interviews revealed that the CHD staff was looking forward to share their community-level and content expertise, in order to ensure a strong, culturally competent program.*
* TWP team began to work with internal and external partners for the design of the logo, and other marketing materials.
* After the kickoff event, the final trainees for the first event were identified.
	+ Members of the CHD team contacted the trainees to help facilitate the scheduling of the first and second trainings.

***Recommendations and Evaluative Reflections:***

***Evaluation Reflections:***

* *Reflection #1: Lack of tracking of who has been reached:* At the time of the interviews, the trainees were not able to identify one single process for counting with whom and about what they had spoken. Because of this, there was no readily available tracking process for the barbers/stylists to implement after training, there will not be uniform data to track if this program has reached the intended audience.
* *Reflection #2: Lack of tracking for referrals:* At the time of the qualitative interviews, none of the trainees nor the CHD staff were able to identify a strategy for how to document the effectiveness of the referrals to CHD (or other affiliated providers). Because of this, any idea of success or failure is purely anecdotal.
* *Reflection #3: Lack of tracking of outreach*: Because the “pre” and “post” knowledge conversations were only qualitative, the trainees’ assessment of their learning/growth is a bit more objective. In all of the interviews, they indicated understanding more and learning a lot, but we did not have a supportive quantitative measure.

**Recommendations:**

* *Recommendation #1: Consider adapting existing tools*. To potentially save time (considering the modification of an existing training took the national expert some time and might have impacted timelines), consider starting with peer-reviewed models that have been previously replicated. These models might offer “plug and play” pre- and post- tests or other supportive materials. They might also offer examples of how community partners are onboarded and trained.
	+ [Curry et, al](https://al-kindipublisher.com/index.php/jhsss/article/view/2767) , [Nadison et al](https://www.ingentaconnect.com/content/wk/phh/2022/00000028/00000002/art00026), and [Thomas](https://sph.umd.edu/hair) offer some great examples from barbershop initiatives.
* *Recommendation #2: Consider adult learning.* Because many of the learners may be far away from their time as students, they may need some assistance in developing new learning and retention patterns/activating old learning patterns. With the introduction of technology, learning may also look entirely different from their school years. Future projects should take into account adult learning styles. I noted that during the planning meetings, explorations of learning styles for adult populations were not explicitly done.
	+ While not explicitly about barbershop initiatives, these federal [resources](https://cancercontrol.cancer.gov/is/tools/practice-tools) offer tips about community health education models and are linked on the state of Nebraska’s Community Health Worker website.
	+ There are also stories about [successes](https://www.thecommunityguide.org/pages/the-community-guide-in-action.html) nationally that highlight possible barriers to educating adults from historically underrepresented groups.
* *Recommendation #3. Consider cultural competence*. While not all that is popular is peer-reviewed/scientifically accurate, you can often learn about fonts/images/language that draws the attention of your priority population.
	+ Consider creativity with imagery by letting the priority populations see [themselves](https://beam.community/wellness-tools/) in materials and data visualizations.
	+ See how national [experts](https://therapyforblackgirls.com/) and multidisciplinary [regional teams](https://www.sistaafya.com/) talk about cultural competence.
	+ Explore how complementary [practitioners](https://www.alexelle.com/about) discuss the myths in the Black community and what key words they use to draw community members to their sites.
* *Recommendation #4: Consider external factors*: During the interviews about the execution of the project, there was made mention about a similar project being produced which featured a [series of videos](https://youtube.com/watch?v=80MVVMeYar0&si=EnSIkaIECMiOmarE) produced about Black men in barbershops discussing issues. Some community members wondered if this project was connected in some way. Even if the team is not able to partner with this other project or access these materials, a neutral discussion about the existence of this complementary project might have cleared up any confusion.
* *Recommendation #5: Reach beyond the team in order to stay on track:* Integrate the marketing team in a discussion about the Logic Model/Theory of Change, so that they understand the sequencing and timing of events and can suggest some existing tools for achieving goals around tracking/evaluation.

**Section 5: Training, Evaluation of Cultural Competence, Content, and Delivery**

Once the conversations about design and implementation were completed, the training process began in the fall of 2022, after the initial kickoff meeting.

There was a virtual training facilitated by nationally renowned [speaker](https://link.springer.com/chapter/10.1007/978-3-030-83726-6_13), in November. This a full-day meeting, with slides and interactive activities. This training was a modified version of her full two-day training. TWP and CHD staff were in attendance.

In December, at the offices of CHD, there was an in-person training with the CHD team. This meeting was shorter, only two hours. There were multiple handouts distributed, and TWP and CHD staff in attendance. As with the first training, there were interactive activities for the barbers/stylists to participate in. The table below highlights some of the themes from the thematic analysis of the training process and materials.

Selection of Qualitative Findings from Interviews/Observations of trainings

|  |  |  |  |
| --- | --- | --- | --- |
| **Quote/Theme** | **Domain** | **Learnings** | **Recommendations** |
| Trainer was complimented for being “Afrocentric” and for having tangible lived experiencesUse of Harambee name | Cultural Competency | This project appealed to trainees need to see themselves | Keep Afro-centric elements, as it dispels myths about Blacks not needing to address mental health. |
| “Chair as a sacred place”/”Chair as a safe place”/Chair as “judgment-free zone”/”People want to talk” | Cultural Competency/Utilization-focused evaluation  | All stylists/barbers had indicated tools they had personally used to create space for vulnerability/sharing/learning. | When designing “swag”, considering engaging trainees in conversation on how they anticipate using the materials and what would be most useful for their processes. |
| “I’m not an email person” | Delivery | Community members needed to be surveyed about their email/text usage, as some were not as used to receiving information via email. | Provide timeline for events of project, perhaps estimating when they should be looking for communications. Consider asking preferred method of reminders, particularly during “peak” work seasons. |
| “Firestarter”/”Keep that fire going” | Delivery and implementation | Trainees recognized competing demands and need for more training. Trainees also recognized assets that existed among peers. | Consider refresher course and/or opportunity for ongoing community of practice that will help identify external factors that could change the relevancy of the program. |
| “People want to talk”/excitement about second training being in person | Delivery | Trainees enjoyed opportunity to meet each other to share a sense of camaraderie | Keep at least one training in person for community-building. |
| “Cheat sheets” and Flip charts | Delivery | Because the trainees had diverse learning styles, and because they were so eager to “get it right”, many wanted quick reference tools to take to the salon, as the notebooks were too bulky to easily have on hand. | Offer laminated materials for their stations that serve as tools to help assist in the recall of new information needed to help dispel common myths and to facilitate conversations that can lead to referrals.  |

*Observations and Interview Conversations about the First training*

I was able to speak to trainees and staff about the first session. Here is a summary of themes that emerged.

* During the observations and interviews trainees expressed their (often hard) emotions and excited by the portions of the trainings that allowed them to act out possible scenarios.
* The trainees loved the speaker’s ability to speak from the stylist’s frame of mind, and not just as a therapist.
* The speaker used Afrocentric and contemporary images to attack any myths about the Black community head-on. This was also appealing for [visual learners](https://www.splashlearn.com/blog/empower-visual-learners-with-actionable-strategies-in-school-home/).
* The speaker, while explaining dense content used [plain language](https://www.plainlanguage.gov/guidelines/).
* The use of stories and scenarios appealed to [auditory and tactile learners](http://www.educationplanner.org/students/self-assessments/learning-styles-styles.shtml).
* The pacing was a bit intense for some learners, as she was condensing a two-day training into one day. This made it difficult for some to take notes and ask questions.
* Because the training was one day, there was no opportunity to “process” and come back for questions.
* The slide deck was not given to the participants.

*Observations and Interview Conversations about the Second training*

The second training was in person, at CHD. As with the first training, I was able to speak to the trainees about their experiences and summarize some of the common themes here.

* The CHD team took an equitable approach to presenting and allowed for all three members of the team to lead some of the day.
* The team offered a slide deck that also had colorful images and practical activities.
	+ These slides reinforced a number of technical terms that were listed in documents and in the PowerPoint.
	+ These slides also offered verified statistics about the state of Black mental health in the US, and in Nebraska.
* In addition, the team offered links to other relevant handouts.
	+ These handouts touched on common themes that appeared in conversations in the first training—the sense of isolation that Black Americans have due to mental illness, the importance of “self care” for caregivers (like the trainees) and continuing this work, the disruption of the stereotype that African Americans do not experience mental illness.
* During the observation of this training, trainees were most energetic during the applied portions, where they were given an opportunity to practice their skills.
* Many of the links/fliers shared seemed to be chosen to be able to print and share in salons/barbershops, i.e., used plain language, culturally competent images, and non-stigmatizing language.
* All of the trainees identified a desire for this training to be longer, to allow for:
	+ Networking (with current cohort and future cohorts)
	+ Instructions about what happens after the training (in terms of continuing education and additional materials)
	+ Get reassurances that they are, in fact, ready to do this.

***Evaluation Reflections and Recommendations***

*Evaluator Reflections*

* *Reflection #1: Training needs slight improvement to be assured of learning goals.* Without the pre- and post-surveys it is hard to be 100% certain, but from the conversations with the trainees, all expressed a desire to continue their training and seemed to lack confidence about doing the work. I believe this doubt comes from two places:
	+ The pacing/style of the training. They recognized that they had learned a lot, and may not have realized just how much they retained. So they were perhaps nervous they would forget what they had learned in the moment.
	+ They had forgotten the goal of their roles, and might have started to think they needed to offer counseling/advising, when in fact they need only to make referrals and/or dispel myths.
* *Reflection #2: All materials presented need to be provided*. All of the trainees mentioned making notes and trying to track their questions and making notes for how they might handle the proposed situations in their salons. Providing presentation materials ahead of time would assist in notetaking.
* *Reflection #3: Training needs to address confrontations.* All of the trainees mentioned that stories about mental health occurred in church, salons/barbershops, community settings. Many of these conversations were confrontational and reinforce myths. A few of the trainees indicated they were concerned about resistance they may face. Since this programming is predicated—in part—on the fact that there is misinformation that might be contributing to the disparities. The training seemed to be lacking enough time to prepare for that.

 ***Recommendations:***

* *Recommendation #1: Community of Practice*: Consider convening a [community of practice](https://implementationsciencecomms.biomedcentral.com/articles/10.1186/s43058-022-00279-1) where recent graduates and current trainees can share ideas and continue learning. The alums of the first cohort may also enjoy being informal mentors to the new cohort. This supportive community, if run well, will also serve as a recruitment and retention tool.
* *Recommendation #2: Ask for all speaker materials:* Also consider making a folder “in the cloud” in case the trainees give out all of their hard copies and can print or share on their own.
* *Recommendation #3: Super learners with a “Cheat Sheet”:* One of the trainees mentioned offering a laminated “cheat sheet” or flip chart that they can refer to for starting conversations or with common myths/terms. This might also address the feelings of insecurity/time crunch that some felt after the training was complete.
* *Recommendation #4: Consider learning styles:* Plan the training to allow to adapt to a diversity of learning styles, particularly considering some trainees may be farther removed from their formal education and “out of practice” with processing and using very technical information.
* *Recommendation #5: Consider ongoing relationships:* Make a plan for sharing project progress and results. Not only will this let the partners know that their efforts were useful, but it will educate them about the design and implementation process, therefore offering opportunities to create more educated future partners.
	1. [Journey maps](https://aea365.org/blog/dvr-tig-week-weaving-together-narrative-through-journey-mapping-by-marsha-williamson-manon-matchett-and-mindelyn-anderson/), [data parties](https://aea365.org/blog/youre-invited-to-a-data-party-by-kylie-hutchinson/) and other [creative ways](https://aea365.org/blog/cp-tig-week-about-evaluating-health-promotion-efforts-by-lashaune-p-johnson/) to share information in community settings (always to go to them, do not make them come to you!) are great ways to get feedback and engagement with your work.
* *Recommendation #6: Keep track of patterns of those who might reply to survey about the trainees’ skills*. If you are getting poor responses from surveys from clients and others, consider non-traditional ways to do evaluations, such as [Talking Circles](https://journals.sagepub.com/doi/abs/10.1177/1098214019899164?journalCode=ajec).

**Section 6: Conclusions**

I was grateful to be able to participate in this project for this important project.

I am particularly grateful to the Executive Director for being a “[warm demander](https://www.edutopia.org/blog/warm-demander-equity-approach-matt-alexander)” and offering constructive criticism in my previous draft and giving me opportunities to reflect on and critique my work.

Overall, there were a number of good things that came through in my interviews and observations. There are a few areas of growth that I will highlight in my return to the original evaluator mandates.

* *Were program activities accomplished?*
	+ Yes. Yes, a culturally competent training was designed and delivered to a small group of trainees.
	+ No. As highlighted above, there were expressed tweaks needed to support different learning styles, and less training around engaging with confrontational/misleading members of the community who might interrupt the conversation. This is an issue of external factors—some stylists/barbers may be working in less than hospitable environments, and need tools to educate and push through feedback from non-clients.
* *What is the quality of the program components? This would be information about knowledge and skill increase because of the training.*
	+ Yes. The program had a number of highly regarded (by the trainees and by the standards of other community health worker programs)—some interactive components, some components that were aimed at drilling home basic vocabulary, increasing awareness of organizations/programs that address these issues, and increasing awareness of the severity of the issue.
	+ No. Condensing the program may have made the pace too fast for some learnings, therefore diminishing its value.
	+ Not sure. Because there were not pre- and post-test distributed, and the evaluator relied on the self report about knowledge, there may be additional strengths or weaknesses identified if they were tested now.
* *How well were program activities implemented? To what extent was the program implemented to fidelity/how was it delivered?*
	+ Well. Once the plan was made, generally the program was administered well.
	+ Unclear. Dr. Afiyah’s training was modified from a larger training, so we can perhaps assume she was faithful to her normal structure, but it is hard to know.
	+ Needs improvement. Interviews indicated some glitches around receiving/responding to scheduling emails for trainings, therefore there were late arrivals/early exits during trainings. This meant some material was missed by trainees.
* *Was the target audience was reached?*
	+ Yes, enthusiastic barbers and stylists who work with North Omaha/Black Omaha clients were recruited as trainees.
	+ Not sure. Because there was not a tracking tool for stylists or clients to count how many people were reached, we do not have solid numbers on this, only possibly anecdotes.
	+ Not sure yet. Additional marketing materials (aka swag) was not delivered at the time of the January interviews, but has since been distributed, not clear if interactions with this material/distribution of these materials are being tracked in any way.
* *Were program activities culturally appropriate?*
	+ Yes. In interviews and in sessions, trainees commented on the visuals, language and presentation style of all of the trainers, that it felt family and positive about the Black community. The use of the name Harambee was also greatly appreciated.
* *How did external factors influence program delivery?*
	+ Maybe. Conversations about COVID-19 and external (to the Black community) diagnosing and “testing” on Black people may influence community members to participating in a conversation about clinical interventions.
	+ Perhaps. Internal staffing changes and cold hand offs might have impacted timelines to get things done like creating a Logic Model, Theory of Change and Timeline.
	+ Maybe. The external evaluator not being available for the planned kickoff meeting meant a pre-survey was not distributed—this did not explicitly impact delivery but did impact ability to evaluate training.