Child sexual abuse evaluation framework??
In my earlier email conversation with Jim, I laid the foundations of what I wanted to do in formulating the CSA evaluation framework. To refresh your memory, I said I would analyze the key theoretical frameworks, including the ecological model, using what scholars refer to as the ‘epistemological criteria’. Epistemological criteria refer to a set of established principles, used by theorists, to make judgments about the adequacy of theories/frameworks. These principles include: (1) empirical adequacy (2) internal coherence (3) explanatory depth (4) heuristic value and (5) unifying power. My plan was to come up with a comprehensive theory of CSA, combining the best elements of previous theories/frameworks.

And Jim, you challenged me to reflect how an theoretical framework for evaluation of child sexual abuse prevention be operationalized in your/or any other NGO/intervention context. While still committed to carry out my initial task, I have identified the RE-AIM model which I think can be appropriated to evaluate CSA interventions programs. I hope the RE-AIM framework form the basis of our discussion next week.

The RE-AIM Framework
Glasgow et al., (1999), building on the conceptual work of Green & Kreuter (1999), formulated the RE-AIM model as heuristic device for evaluating public health interventions. Five dimensions characterize the public health impact of an intervention: reach, efficacy, adoption, implementation and maintenance, hence the acronyms RE-AIM. The framework assesses the impact of an intervention at the individual level (Reach, Effectiveness and Maintenance) as well as at the organizational or setting level (Adoption, Implementation, and Maintenance). And the ultimate impact of an intervention is due to its combined effects on 5 evaluative dimensions (Glasgow et al. 1999).

The framework, initially used as a tool for consistent reporting of the results of research studies, has been appropriated to organize reviews of the existing literature on health promotion and disease prevention in different settings (Glasgow et al. 2004). In addition, the framework has been used to plan and evaluate evidence-based interventions which address different levels of the socioecological model. More recently, it has been used to plan,
implement, and evaluate the effects of environmental change approaches to enhancing population health (King et al. 2010).

Reach

“Reach” assesses the penetration of a program into its intended target audience. It is composed of the participation rate among eligible persons and the representativeness of these participants. “When the denominator of eligible persons is known, sociodemographic and health characteristics of participants can be compared with those who decline participation. When this denominator is not known, participants can be compared with characteristics of persons in that region or nation” (Glasgow et al. 2006: 689).

Efficacy

It has been noted that current public health and medical evidence rely heavily on efficacy information to make decisions regarding intervention impact (Glasgow et al. 2006: 688). The widely held view is that “experimental methods (randomised controlled trials) are the ‘gold standard’ for evaluation and that observational methods (cohort and case control studies) have little or no value” (Black 1996: 1215). Yet, a major feature of RE-AIM is that it “shifts the focus from short-term efficacy among restricted samples of participants in randomized efficacy trials to longer-term effectiveness in real-world settings” (Glasgow et al. 2001: 120).

For the efficacy dimension, the authors underscore the importance of assessing both positive and negative consequences of programs and the need to include behavioral, quality of life, and participant satisfaction outcomes as well as physiologic endpoints. The RE-AIM model is silent on the choice of efficacy measure, but Glasgow et al., (1999) suggest that any outcome that is quantifiable, reliable, valid, and important to scientific, citizen and practitioner communities is admissible.

Adoption

Adoption” is similar to Reach, but is assessed at the level of the settings (such as community-based organizations, clinics, worksites or communities). It consists of the participation rate among potential settings and the representativeness of these settings…. The key to both Reach and Adoption is the identification of a “denominator” of eligible persons or settings for use in calculating participation rate (Belza 2007: 3). Factors associated with adoption include
cost, level of resources and expertise required, size of the adopting organization or governing body. Adoption is usually assessed by direct observation or structured interviews or surveys.

**Implementation**

Implementation refers to the extent to which a program is delivered as intended. It includes the extent to which different components of an intervention are delivered as intended by the developers, “intervention integrity, or the quality and consistency of delivery when the intervention is replicated in real-world settings” (Glasgow et al. 2001: 120).

**Maintenance**

Maintenance operates at both the individual and the system level. At the individual level, maintenance refers to how well behavior change efforts hold up in the long term. At the organization level, it refers to the extent to which a treatment or practice becomes institutionalized as a routine part of usual care within an organization (Glasgow et al. 2001: 120). Glasgow et al., (1999) suggest a minimum of 6 months to 1 year for implementation and 2 years or longer for maintenance.

**Evaluative purposes**

The five dimensions of RE-AIM are interdependent and should not be evaluated in isolation. “Taken together, these elements represent the overall public health impact of a program or policy. It is not enough for an intervention to do well on one or two elements. To maximize overall impact, programs need to do well on all five elements. Significant program weakness in any of the elements may adversely affect impact” (Belza 2007: 2).

The data collected via the RE-AIM model can serve several evaluative purposes:

1. assessing an intervention's overall public health impact
2. comparing the public health impact of an intervention across organizational units or over time
3. comparing two or more interventions across REAIM dimensions (see Figure 1 below)
4. making decisions about redistributing resources toward more effective programs.
What make this model distinctive is its appropriateness for public health and population-based interventions because of its emphasis on external validity (Reach and Adoption) as well as internal validity (Efficacy and Implementation); and its consideration of both individual level and system level outcomes (Glasgow et al. 2001).

**Ratings on RE-AIM Dimensions**

This figure visually contrasts the strengths and weaknesses of hospital-based group sessions with health policies. A similar graphical approach can be used to help decide upon creative ways in which different modalities can be combined to produce effective, multi-component intervention packages (Glasgow et al. 2001).

**Limitations of RE-AIM Model**

The precise nature of the relationships among the 5 RE-AIM dimensions, and how they combine to determine overall public health impact, is unknown. The authors represented these factors as interacting multiplicatively because they believed it was closer to reality than an additive model.

Furthermore, as Glasgow et al. (1999: 1325) acknowledged, “we have implicitly assumed, in the absence of data to the contrary, that all 5 RE-AIM dimensions are equally important and therefore equally weighted. This may not always be the case. In situations in which 1 or more
of the RE-AIM dimensions are considered most important, differential weights could be assigned. Similarly, it may not be necessary to assess all RE-AIM components in every study.”

The RE-AIM model does not explicitly include economic factors. However, the authors suggest three ways to address cost issues. “First, we think that cost is often a major factor determining whether a program will be adopted, implemented consistently, or maintained. This hypothesis should be tested and substantiated or refuted. Second, cost-effectiveness and cost-benefit are certainly appropriate outcomes. They determine how well resources are being used and whether or not more good could be accomplished through alternative uses (opportunity costs). Finally, a population-based cost-effectiveness index could be calculated by dividing the resulting public health impact by the total societal costs of a program. Dividing each RE-AIM component score by the costs relevant to that dimension could help identify areas of efficiency and waste” (Glasgow et al. 1999: 1325).

References
Black, N. (1996). 'Why We Need Observational Studies to Evaluate the Effectiveness of Health Care'. British Medical Journal 312 (7040), 1215-1218.