Instructions for Using the Primary Prevention Capacity Assessment Project Staff Team Self-Assessment

Purpose of the self-assessment: To assist the agencies/programs and Ohio Department of Health Rape Prevention Education Team in developing Training and Technical Assistance opportunities that focus on the priority needs of the service providers for building primary prevention and evaluation capacity.

1. The assessment should be completed once a year to determine Training and Technical Assistance (TTA) priority needs and subsequent changes in primary prevention and evaluation capacity and training needs.

2. There are no right or wrong answers on the assessment. The assessment will not be used in a punitive manner or to make funding decisions. The self-assessment should be viewed as a tool to openly and honestly discuss with your team members and the RPE staff where your services are on the continuum of best practices in primary prevention and help you plan realistic priorities for building your primary prevention and evaluation capacity. Resource constraints often influence strength in some areas at a cost to others. For example, having multiple presenters representing diversity and modeling healthy relationships may make it more difficult to offer high dosage of sessions due to the time and cost of coordinating multiple presenters. So in some cases choices have to be made regarding which strength to prioritize. One use for this assessment tool is to help address these decisions by encouraging discussion within the agency about them.

3. Each of the site staff involved in delivering and supervising primary prevention services should take part in completing the assessment as a team. Team members may include supervisors of field staff, volunteers, and prevention educators.

4. Review each of the four sections and discuss the various characteristics with your team to determine which level of each factor best describes your current primary prevention strategies/activities.

5. In the Word or hard copy document, select the level for each factor and mark the corresponding score, 1 through 5, for each within the factor box. For example, in section 1 (Program Characteristics) Factor 1, Strategy/Activity Comprehensive: if your strategies/activities most closely match the Moderately Comprehensive description, you would mark a “3” in that factor description box. For Factor 2, Teaching and Learning Methods: if your strategies/activities most closely match the Varied Teaching and Learning Methods described by Strategies/activities emphasize skill development and incorporate peer modeling and/or club formats to extend learning and skill development, then mark a “5” for that factor. Follow this procedure for each of the factors in Section 1 then write in the Section Score after the “Section Score=” in the right corner of the Section Header. Then move on to Section 2, 3 and 4 to determine your capacity for each of the sections.

6. Enter the section score for each section and then the Overall Score at the top of the 1st page of the Word or hard copy document. The Overall Score is the sum of the four section scores.

7. Once you have completed the scored sections discuss the barriers/challenges and successes/lessons learned over the past years in implementing the strategies/activities and building primary prevention and evaluation capacity with your team. Enter the comments in the sections marked "Barriers/Challenges", "Successes/Lessons Learned". Through this discussion the primary prevention and evaluation training and technical assistance priorities should emerge. It might be helpful to take notes as you discuss and score each factor.

8. In the part of this section marked **Action Plan**, describe your three (3) top priorities for the upcoming year for building your primary prevention and evaluation capacity.

9. You will notice two (2) new items are included in the assessment for your consideration; ***community engagement*** and ***community mobilization***. Community Engagement and Community Mobilization scales are in Section 3 and these two new concepts are included in the final section of the PPCA. **Unique Community Context** is another new term for the PPCA. For more on Unique Community Context see Global Health Equity resource on cultural humility and community engagement.

10. Once you have completed the Word or hard copy form and feel that it accurately reflects your team's capacity, transfer the information to the online form and inform your ODH program consultant that you have completed the self-assessment.

11. The project staff should be prepared to provide verification of each of the primary prevention capacity items scored by the program staff so the TTA assessor can verify the score assigned by the program staff.

The Primary Prevention Capacity Assessment matrix is adapted and informed from the following:

City of Santa Rosa (N.A.) Spectrum of community engagement. Available at https://www.srcity.org/1537/Community-Empowerment

Nations, M., Crusto, C., Wandersman, A., Kumpfer, K, Seybolt, D, Morissey-Kane, E and Davino, K. (2003), What Works in Prevention, Principles of Effective Prevention Programs, American Psychologist, Volume 58, No. 6-7, 449-456. The principles can be found in http://www.mentoring.org/downloads/mentoring_4.pdf

Global Public Health Equity, Guiding Principles for Communication: Principle 1: Embrace cultural humility and community engagement. (cdc.gov) U.S. Centers for Disease Control and Prevention

Health Equity Guide.org. *How Can We Share Power with Communities?* https://healthequityguide.org/strategic-practices/share-power-with-communities/

Ortega, S. (2006). The impact of outcome measurement on nonprofit organizations, Doctoral Dissertation, The Ohio State University. If you are interested, you can ask Dr. Ortega and she will share the document with you.

Prevent Connect (N.A.) Community development, mobilization, and engagement. Available at https://wiki.preventconnect.org/community-mobilization/

Virginia Sexual and Domestic Violence Action Alliance (2009), Guidelines for the primary prevention of sexual violence and intimate partner violence. Available at http://www.preventconnect.org/downloads/2009/VSDVAA-2009-Prevention-Guidelines.pdf RPE Local Evaluation Capacity Assessment, Centers for Disease Control and Prevention, 201

Primary Prevention Capacity Assessment Tool

Program Name: Assessment Team: _____ Assessment Date: Is this an Initial Assessment_____ OR Annual Assessment_____ Overall Score = (100 is max score)

Section 1. Program Characteristics				Section Score = /35
Low (Minimally includes the Characteristics of Primary Prevention)		Moderate or Mixed	High (Includes the Characteristics of Primary Prevention)	
1	2	3	4	5
Not Comprehensive:		Moderately Comprehensive:	Comprehensive:	
Strategies/activities are offered **only at the individual level** of the Spectrum of Prevention and are limited to presentation style education settings or information "fairs."	Strategies/activities are not linked **OR** do not support each other; The activities address only 2 levels of the Spectrum of Prevention effectively and/or the strategies/activities are **not** offered in multiple settings.	Strategies/activities work at 3 levels of the Spectrum of Prevention effectively or cover more than 2 levels, but in an incomplete manner, such as in limited settings and/or content addresses common set of risk/protective factors and prevention messages between participant groups are somewhat connected.	Strategies/activities work at 3 or more levels of the Spectrum of Prevention effectively, are offered in multiple settings, and each of the components is designed to complement each other to reinforce primary prevention messages.	Strategies/activities work at 3 or more levels of the Spectrum of Prevention effectively, are offered in multiple settings, and **include policy level efforts** that reinforce primary prevention messages.

1	2	3	4	5
Singular Teaching and Learning Methods:		**Moderate:**	**Varied Teaching and Learning Methods:**	
Strategies/activities use singular teaching and learning methods such as "assembly style" lectures or presentations focused on knowledge change and do not provide opportunities for participants to acquire or practice new skills.	Strategies/activities incorporate varied format, but only minimal opportunity for skill development. Most of the activity/strategy's focus is on knowledge or awareness change.	Strategies/activities use varied formats and include some opportunity for group participation and acquiring new skills including time for processing potential skills; but are heavily dependent on lecture format.	Uses teacher-learner models; emphasis on active/interactive approaches, practicing skills, modeling; group participation is highly valued and frequent, allows time for processing and role-playing.	Strategies/activities emphasize skill development and incorporate peer modeling and/or club formats to extend learning and skill development.
Does Not Promote Protective Factors:		**Partially Address Protective Factors:**	**Promotes Protective Factors:**	
Strategies/activities focus primarily on avoidance behaviors and are not informed by a social justice perspective.	Strategies/activities do not promote protective factors that support the development of healthy relationships but focus on the risk factors for perpetration without linking risk to social justice/oppression.	Strategies/activities partially address protective factors that support healthy relationships, sexuality, or positive social outcomes, but generally focus on risk factors for negative behaviors.	Strategies/activities promote and sustain development of healthy sexuality, healthy relationships among peers, role models and adults; but do not integrate information/skills for developing social justice.	Strategies/activities promote and sustain development of healthy sexuality, healthy relationships among peers, role models and adults; and integrate information/skill development to promote social justice.

1	2	2	4	5
Does Not Provide Sufficient Dosage:		**Mixed Dosage Provided:**	**Provides Sufficient Dosage:**	
Single opportunity for exposing the same participants to prevention messages; examples include assembly presentations, onetime short duration workshops; community proclamation events without participant follow-up.	Two to three offerings for the same participants; but does not follow the evidence base and does not include follow-up with participants to determine skill acquisition/use.	Strategies/activities provide several opportunities for message/skill exposure with same participant groups, but the frequency/duration has been shortened; minimal follow up is provided to reinforce messages/skills learned at initial activities.	Strategies/activities provide several opportunities for message/skill exposure with same participant groups within a concentrated time frame as the evidence-based practices but do not include follow-up activities to reinforce messages and new skill development/use.	Strategies/activities provide several opportunities for message/skill exposure with same participant groups within a concentrated time frame as the evidence-based practices and provide opportunity for participant follow-up activities that are specifically for reinforcing messages and new skills.
Not Theory Driven:		**Mixed Theory Base:**	**Theory Driven:**	
No theory or purposeful, logical rationale underlies the strategies/activities.	Strategies/activities are based on a causal foundation that is not well-established and are not informed by a strategic plan with clear achievable goals, activities and outcomes.	Some program components/activities appear to be based on a sound causal foundation and/or the program is informed by a strategic plan, but it is difficult to determine how the components/activities are connected to the overarching theory of change.	Strategies/activities are based on purposeful, logical rationale of risk/protective factors, change theory or process theory of prevention of initial perpetration and the evidence base for primary prevention of violence. Program components are clearly linked through the theory of change to which the program prescribes.	Strategies/activities are based on purposeful, logical rationale of risk/protective factors, change theory or process theory of prevention of initial perpetration. **All** components are based on a sound common causal foundation **and** are informed by a well-articulated theory of change.

1	2	3	4	5
Not Integrated into Agency Mission:		**Moderate Integration:**	**Integrated into Agency Mission:**	
SV/IPV primary prevention is outside the scope of the agency and does not seem to be a good fit for the agency based on organizational history, mission, and service provision.	Primary prevention is a fit with the agency/ organization mission but is not included in the agency mission because the agency is mostly focused on other types of service provision.	Some primary prevention concepts are reflected in the agency's mission, strategic plan, and practices, but primary prevention is not funded in proportion to other services provided **and** is not considered during strategic planning.	The agency demonstrates a commitment to primary prevention of SV/IPV, **but** primary prevention is not part of the organizations' strategic plan and resources are not allocated proportionately to prevention and other services.	The agency demonstrates a commitment to SV /IPV primary prevention, prevention is part of the agency's strategic plan, and resources are allocated to prevention in proportion to other services.
Do Not Model Positive Relationships:		**Moderate Modeling:**	**Positive Relationship Modeling:**	
Strategies/activities focus only on avoidance behaviors in informational presentations such as risk reduction or safety awareness building to prevent violence.	Strategies/activities focus primarily on avoidance behavior in relationships and do not offer opportunities for positive relationships to be modeled or practiced.	Strategies/activities provide information and skill building in positive relationships but may be facilitated by only one presenter without opportunity to model positive relationship building. ***Note: A co-presenter may include partners other than staff such as participants, school staff and/or other community educators.**	Strategies/activities provide exposure to adults and peers that support building healthy relationships through role play and problem solving with peers, at least one session is taught by co-presenters* who model positive healthy relationships.	Strategies/activities provide exposure to adults and peers in a way that promotes strong relationships and supports positive outcomes. Multiple sessions co-taught by diverse presenters who model healthy relationships.

Section 2. Matching Program with Participants				Section Score = /10
Low-Minimal Timing for Primary Prevention:		Moderate or Mixed Characteristics of Timing for Primary Prevention:	Highly Appropriately Timed:	
1	2	3	4	5
The strategy/activity materials use a one size fits all approach, they are intervention oriented, and are not developmentally relevant for the participants.	The strategy/activity materials are intervention focused and are not appropriately timed for participant age or socio-emotional development stage.	Strategies/activities work with more than one age group, including focusing on risk and protective factors relevant to early adolescents or younger; program content and format has been somewhat modified to fit the selected group that participates in the program, but is not totally adapted for the participants.	**Most** of the strategies/activities focus on risk and protective factors and begin in middle school or younger and are developmentally relevant for the majority of participants.	**All** strategies/ activities are developmentally relevant; begin prior to the emergence of unhealthy behaviors, and curriculum materials match the participant cognitive and social development.
Low Socio-cultural Relevancy:		Moderate Socio-cultural Relevancy:	High Socio-cultural Relevancy:	
Strategy/activity does not consider socio-cultural relevance to participants and was developed without input from community stakeholders or your intended audiences. Content/format is narrow and operates from one set of beliefs, practices or norms.	Strategy/activity was selected/developed without involvement of diverse community stakeholders or intended audience, but literature was consulted to assist in the development of the activities/strategies. Content and format are aligned with literature base.	Program selection/development involved diverse stakeholders, but their input was not thoroughly integrated, and the content/ format only somewhat reflect the contributions and interests of various cultural/social groups.	**Most** activities/strategies reflect the diversity of the participants and are developed using community and other prevention specialists'/educators' input.	**All** strategies/ activities are developed in collaboration with diverse community members and prevention specialists'/educators' input, are inclusive of diverse cultural beliefs, practices and reflect community norms.

Section 3: Community Engagement and Community Mobilization				Section Score= /10
1	2	3	4	5
Low Community Engagement:		Moderate Community Engagement:	High Community Engagement:	
Strategies/activities seek to ***inform the public*** with balanced and objective information. Strategies/activities ***do not allow for community participation.***	Strategies/activities are ***presented to the community for feedback***. ***Changes may be made*** to a strategy or activity ***based on community feedback***. The ***community is kept abreast of changes*** or updates motivated by their input.	Activities/strategies ***involve the community throughout the process*** of conceptualization, planning and delivery. ***Community concerns/aspirations*** are understood and ***actively incorporated*** into all activities/ strategies.	***Each decision is solved by partnering with the community to find the solutions.*** This includes the development of alternatives and the ***identification of the community's preferred solutions.***	The ***community is considered the primary stake holder***. All final decisions pertaining to ***strategies/activities*** seeking to impact a community are put ***into the hands of that community***.
Low Community Mobilization:		Moderate Community Mobilization:	High Community Mobilization:	
Strategies/activities are informed by clear theoretical rational offered to the community by prevention staff and focus on addressing risk and protective factors for sexual violence.	Members of the community ***are actively recruited to be a part of the strategy/activity development and implementation team.*** Strategies/activities are informed by clear theoretical rational and focus on addressing risk and protective factors for sexual violence ***grounded in funder guidance.***	Members of the community are actively recruited based on the unique community context. ***Strategies/activities are informed by clear theoretical and community beliefs about root causes of the issue.*** ***Leadership is shared between the prevention staff and the community members.*** ****Unique context*** *refers to the cultural norms, expectation, and beliefs within the community you are seeking to mobilize.*	Members of the community are recruited who represent the unique community context. ***Leadership is held by the community members*** who represent the unique community context. Strategies/activities foster the ***strengths the community brings forth to address the root causes and drive the strategy implementation***.	Community members who represent unique context ***occupy leadership positions for all strategies/activities affecting that community.*** Strategies/activities are informed by ***community strengths, priorities and community voices*** and foster strengths of the community. ***Prevention staff support*** the success of the strategies/activities based on community leader requests.

Section 4. Implementation and Evaluation					Section Score = /45
Low (Minimally includes the Characteristics of Primary Prevention Evaluation Capacity)		Low (Minimally includes the Characteristics of Primary Prevention Evaluation Capacity)	High (Includes the Characteristics of Primary Prevention Evaluation Capacity)		
1	2	3	4	5	
Low Organizational Support for Evaluation		Moderate Organizational Support for Evaluation	High Organizational Support for Evaluation		
Evaluation is not a priority for our agency's work, there is not support for staff using time to increase evaluation capacity. We also do not have any funding allocated to support evaluation of prevention strategies.	Our organizations do have some support for evaluation, there is minimum agency support for staff using time to increase evaluation capacity. We have limited resources for evaluation of prevention strategies.	Our organization supports evaluating our prevention efforts. Staff are encouraged to build evaluation capacity by monitoring and tracking prevention efforts, but it is unclear if the results are used to inform organizational practice. We have some funding for building evaluation capacity and leadership does permit us to attend free training opportunities to build evaluation capacity.	Our organization and leaders view evaluation as an agency priority and have mechanisms in place to integrate evaluation into the various aspects of our work. The leadership has some resources available to increase staff evaluation capacity and supports us in attending evaluation training and technical assistance.	Our organizational leaders believe evaluation benefits the organization, support using staff time to increase evaluation capacity, ensure there are resources for evaluation of prevention strategies including contracting with external evaluators. Leadership considers evaluation a priority for improving our ongoing work.	

1	2	3	4	5
Low Logic Model Development/Use:		**Moderate or Mixed Logic Model Development/Use:**	**Highly Developed and Used Logic Model:**	
No logic model was developed or used to guide program activities and focus staff on program goals, objectives, and outcomes.	Although a logic model was developed, it does not link to realistic goals, outcomes, and measures to support theory of change.	Logic model contains theory of change, but outputs and outcomes are not consistent with goals OR the outcomes are unrealistic in that they do not match program resources and timeframe of the program.	The program logic model clearly includes goals, resources and outputs that are linked to realistic outcomes based on the programmatic theory of change, but it is not used to monitor the program implementation or achievement of program outputs and outcomes.	The program logic model clearly includes goals, resources and outputs that are linked to realistic outcomes based on the programmatic theory of change and adheres to the SMART or ABCDE Framework. The logic model is used to monitor implementation and achievement of program outputs and outcomes.
Low Alignment with Needs and Resources Assessment:		**Moderate Alignment with Needs and Resources Assessment:**	**High Alignment with Needs and Resources Assessment:**	
No formal needs and resources assessment was conducted.	No formal needs and resources assessment was conducted, although input from community members on SV/IPV needs was gathered.	An informal needs assessment was conducted but is based on limited data on community needs and does not include community resources regarding comprehensive IPV/SV primary prevention.	Needs and resources assessment data specific to community IPV/SV primary prevention were used in combination with other community resources and needs data such as data from United Way to determine program service priorities.	A formal needs and resources assessment was conducted, and the strategies/activities are based on observed gaps in primary prevention of SV/IPV and aligned with other community organization efforts to reduce duplication and increase reinforcement.

1	2	3	4	5
Low Process Monitoring and Use:		Moderate or Mixed Monitoring:	Highly Developed and Used Process Evaluation:	
There is no implementation monitoring in place to determine participant satisfaction or ensure program fidelity.	Process evaluation is based on participant satisfaction measures only and no formal implementation monitoring is in place to ensure program fidelity	Process evaluation is conducted which includes monitoring program fidelity, but the implementation data are only consulted occasionally to improve activity/strategy content and format.	Implementation is monitored regularly for fidelity including dosage, timing and implementation quality measures are in place, but CQI practices have not been fully integrated into practice by program staff.	Implementation is monitored regularly for fidelity including dosage; timing and implementation quality measures are in place **and** are used by staff to inform program improvements.
Weak Outcome Evaluation Plan:		Moderate Outcome Evaluation Plan:	Strong Outcome Evaluation Plan:	
No outcome evaluation plan is in place to monitor outcome achievement as stated in the logic model OR no measurable outcomes were included in the logic model.	Outcomes are not measured in a systematic manner that aligns them with project implementation and they are not used for program improvement.	Program has an evaluation plan, but the specific measures and infrastructure to support the data collection and analysis are limited by staff resources and skills.	Mechanisms are in place to generate outcome data, but outcome evaluation is not used to monitor program achievement OR used to fine-tune activities due to staff resources/skills.	Mechanisms are in place to generate outcome data including pre/posttests, data analysis and an infrastructure to support continuous quality improvement using outcome data results.

1	2	3	4	5
Low Evaluation Use:		Moderate/Mixed Evaluation Use:	High Evaluation Use:	
Evaluation data/results are only used to report to funders upon funder request. No internal mechanisms for sharing evaluation results are integrated into organizational policies and practices.	Evaluation data/results are systematically reported to funders on a quarterly or semi-annual basis but are not used for other organizational purposes.	Evaluation results are used for reporting to funders and program management **but are not** reviewed in a systematic manner to inform program improvement, share with stakeholders or plan for future programs.	Evaluation results are reviewed at least annually and shared with stakeholders such as staff, Board, funders, and community members to inform program strategic planning, increase community buy-in and obtain additional resources.	Evaluation is integrated into program structure/process; use is systematic for informing decisions on program change, strategic planning, sustainability, resource allocation, sharing with stakeholders and grant writing.
Weak Sustainability Potential:		Moderate/Mixed Sustainability:	Strong Sustainability Potential:	
Resources beyond the current funding cycle have not been allocated or secured for the program. Program strategies are an add-on to an intervention staff/unit's responsibilities/tasks.	Primary prevention activities, strategies or program components and funding **are not** integrated into organizational strategic plan and are dependent on only one funding source.	Program components are integrated into organizational mission, policies, and practices, but funding post-current funding cycle has not been considered or obtained. ***Note: Integration for sustainability can include partnering with other organizations within the community prevention network to integrate sexual and intimate partner violence prevention/healthy relationship protective factors into their work**	Primary prevention activities/strategies are integrated into agency policy and practice and organization strategic plan includes seeking continuation funding for on-going support.	Systems for sustainability are in place for garnering further funding after current funding cycle, primary prevention activities/strategies are supported by multiple funders and program components are integrated into organizational mission and community social service delivery systems*.

1	2	3	4	5
Low/Weak Trained Staff:		Moderately Trained Staff:	Well Trained Staff:	
Staff training is intermittent, and staff is not well versed in primary prevention methods or the Spectrum of Prevention but has an understanding of social justice. There is no built in mechanism to engage in on-going training and technical assistance to increase staff skills set.	Staff has the minimal support for training on evaluation methods and has a basic understanding of how to monitor and track data to measure program implementation and outcomes. Opportunities for increasing evaluation skills are very limited.	Staff has a basic understanding of evaluation and access to free evaluation training and technical assistance in an on-going fashion. There are some opportunities for on-going training and technical assistance to increase evaluation knowledge and skills, but in general these opportunities are limited to local or regional offerings where the primary focus is not evaluation.	Staff has a firm foundation in both process and outcome evaluation. Staff has worked with external evaluators and/or calls on ODH's Empowerment Evaluator on an as needed basis to build evaluation capacity. Staff feels confident in data collection, analysis and reporting for informing practice. Our agency includes evaluation training in our new staff competencies.	Staff has a firm foundation in evaluation methods **and** knows how to use evaluation findings to inform practice. Our agency policy includes evaluation as part of the mandatory ongoing training Our staff knows how to draw on external evaluation experts appropriately.
Low/Weak Trained Staff in Evaluation:		Moderately Trained Staff:	High Alignment with Needs and Resources Assessment:	
Staff training in evaluation is not a priority. Staff is not well versed in basic evaluation methods. There is no mechanism to provide in-house evaluation training to new staff OR on-going evaluation training to current staff.	Staff has the minimal support for training on evaluation methods and has a basic understanding of how to monitor and track data to measure program implementation and outcomes. Opportunities for increasing evaluation skills are very limited.	Staff has a basic understanding of evaluation and access to free evaluation training & technical assistance in an ongoing fashion. There are some opportunities for on-going training and technical assistance to increase evaluation knowledge & skills, but in general these opportunities are limited to local or regional offerings where the primary focus is not evaluation.	Staff has a firm foundation in both process and outcome evaluation. Staff has worked with external evaluators and/or calls on ODH's Empowerment Evaluator on an as needed basis to build evaluation capacity. Staff feels confident in data collection, analysis and reporting for informing practice. Our agency includes evaluation training in our new staff competencies.	Staff has a firm foundation in evaluation methods & knows how to use evaluation findings to inform practice. Our agency policy includes evaluation as part of the mandatory ongoing training Our staff knows how to draw on external evaluation experts appropriately.

Section 5. Barriers/Lessons Learned/Action Plan for Primary Prevention and Evaluation Capacity Building
Barriers/Challenges to **Primary Prevention and Evaluation Capacity Building**:
Successes/Lessons Learned about **Primary Prevention and Evaluation Capacity Building**:
Action Plan for **Building Primary Prevention and Evaluation Capacity**: Include your **top 3 priorities** for building your primary prevention and evaluation capacity for the upcoming year.
List 1-2 ways community engagement can be strengthened/embedded into your prevention work:
List 1-2 ways community mobilization can be strengthened/embedded into your prevention work: