COMMON HEALTH: THE ROLE OF NON-PROFIT ORGANIZATIONS IN SUPPORTING COMMUNITY ACTION FOR HEALTH EQUITY AND JUSTICE

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Abstract

This dissertation explores the ways in which reporting requirements, evaluations, management decisions and other metrics and processes contribute to a growing gap between community development goals of community health centres and their practice. My argument is that there is a gap between the community development mandate of non-profit organizations and their practices, which is increasingly shaped toward direct service-delivery and steered away from the advocacy and community development pillars of their mandates. As a result, the capacity of non-profit organizations to support equitable community participation is curbed. Such a gap is largely facilitated through funding relations that prioritise functional accountability and results-based performance measurement that are consistent with extractivist capitalism. Extractivist goals of neoliberal capitalism imposed on non-profits undermine the goals of equity and social justice in urban community development.

The purpose of this research is a careful examination and explication of power relations in everyday work of practitioners in the non-profit sector. I examine non-profit organizations as civil society actors, situated in the broader context of neoliberal capitalism where some actors are subordinate to others, and where subordination results from unequal access to and distribution of resources. I employ institutional ethnography and participatory action research as a methodology. I collected data from two community health centres and one inter-organizational network located in Toronto's priority neighbourhoods and interviewed community volunteers, frontline workers, management staff and funders. I also reviewed documents such as reporting requirements and templates, evaluation frameworks and reports. In order to capture the ways in which reporting and functional accountability systems normalize extractivist processes in the non-profit sector, I constructed maps and diagrams to make such processes explicit. My research analyses how the role of non-profit organizations in regard to community action is shaped within capitalist power relations. To counteract and resists extractivist processes, I propose directions for strengthening the role of non-profit organizations as partners in collaborative processes involving co-production with community members.

Dedication

To my parents for imparting the art and wisdom of unconditional love.

To my husband for the unwavering support and love that endure.

To my daughter for being the light of my life.

To my teachers and mentors for helping me to become a better version of myself.

To my friends for making me believe I can do it.

To feminist circles in Ireland and Canada for teaching me the language of solidarity and hope.

To the beautiful land of Turtle Island that I promise to cherish in solidarity with its Indigenous keepers.

To our Mother Earth for her wonderful gifts of life.

Acknowledgments

No dissertation is solely a product of its single author. In today's world where academic and other achievements are often presented as a result of exclusively individual efforts, I would like to emphasise the collective aspect of such an endeavour. As an intellectual journey, this dissertation has been nurtured by many people’s input, influence, and generosity of their time and spirit.

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To my daughter Aleyona Fursova… Finishing this dissertation and thinking about all possible improvements and potential gaps to fill, I have to conclude that nothing is perfect in this world… Nothing, except my daughter! Thank you for being the light of my life, my shining star, and for opening my soul to such depths of love I didn't know could exist.

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Glossary of Acronyms

AOHC	Association of Ontario Health Centers
CHC(s)	Community Health Centre(s)
CIHI	Canadian Institute for Health Information
LHIN	Local Health Integration Network
MIS	Management Information System
MSAA	Multi-Sector Service Accountability Agreement
OHFS	Ontario Healthcare Financial and Statistical System
OHRS	Ontario Healthcare Reporting Standards
OMHLTC	Ontario Ministry of Health and Long-Term Care
ONPN	Ontario Non-Profit Network
OTF	Ontario Trillium Foundation
SDH	Social Determinants of Health
WHO	World Health Organization

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Preface

> We can't save the world by playing by the rules. Because the rules have to be changed (Greta Thunberg in speech to the UN Secretary General, December 2018).
>
> We need economic models, rules, and policies that support caring for ourselves, others, and our Mother Earth (Riane Eisler, 2008).

I have been a practitioner in community development and health promotion for seventeen years, which includes seven years working outside Canada and ten years in Toronto (Tkaronto), one of the largest metropolitan centres in North America (Turtle Island). While living on this land I have been striving to tread carefully and minimize the harm I may inflict as a European settler. One of the very first steps, and certainly not the only step, to take in exercising such commitment is cultivating awareness of the past and present history and impacts of the European colonialism, as well as developing the understanding of how my individual presence on this land can challenge or support the ongoing processes of colonization. For this reason, I would like to start with acknowledging my presence as a white settler on Indigenous lands. I have been privileged to live and work on the territory known as Tkaronto. I am cognizant of broken covenants and treaties, and aware of the profound and urgent need for a peaceful coexistence with human and non-human inhabitants of the Earth. In my academic and non-academic existence, I am committed to honoring the histories, spirituality, and cultures of Indigenous people on Turtle Island. I am committed to honoring and protecting this land in solidarity with its Indigenous stewards. My research work is part of how I practice such commitment.[1]

I entered my doctoral studies in 2014 prompted by a strong conviction that there is an urgent existential need for the cultural and socio-ecological transformation defined by a shift from the behaviours and practices that are extractivist[2] and exploitative,

[1] This territorial acknowledgment is created with the help of the resources on the website of Toronto Conference of United Church of Canada, (2018).

[2] Exractivism is defined as non-reciprocal, dominance-based relationship with the goal to extract resources, knowledge, skills, or labour without providing a return of comparable value (Klein, 2015; Gago and Mezzadra, 2017).

towards those that are caring and nurturing. I strongly believe that the seeds for such transformation exist within civil society, and that civil society organizations, such as community-based non-profit organizations, have a social responsibility to nurture these seeds. The ascent of neoliberal capitalism, however, has produced state- and market-driven influences aimed at supressing or curbing advocacy and rights-based civil society activities (Schwab, 2013). For the non-profit sector, such influences have been expressed as its marketization, where through funding conditions and administrative policies, the sector has been pressured to adopt the approaches and values of the private market (Salamon and Anheier, 1997; Eikenberry and Kluver, 2004; Phillips, 2003; Fyfe, 2005; Evans, Richmond and Shields, 2005; McBride and Whiteside, 2011). Many researchers and practitioners have been concerned with the consequences of market-based management for civil society. With respect to non-profit organizations, it has been widely noted that marketization strongly affects the sector's ability to support vibrant civil society and citizen participation (Brown, 2003; Eikenberry and Kluver, 2004; Giroux, 2008; Littler, 2013; McBride and Whiteside, 2011).

In 2014, I optimistically anticipated that the governments of industrially advanced nations, and especially those nation states that proclaim themselves democratic, would start taking immediate action to cease the extraction of fossil fuels, transition to renewable energy, and implement strong measures to protect the health of the environment. I was naïve. I am completing my doctoral dissertation in 2019, shortly after the publication of Intergovernmental Panel on Climate Change report that unequivocally states that, at the global level, we are less than 12 years away from the point of no return. The report describes the dire consequences that are to unfold if humanity fails to limit global warming to 1.5 C degrees.

Although some shifts towards more sustainable forms of production and equitable resource distribution have been taking place, most of these initiatives unfold locally and on a small scale, inadequate to the scale of the unfolding crisis. Politicians who have risen to power on the wave of conservative populism, continue to ignore the evidence and further weaken environmental protections and social safety nets with the goal to advance extractivist and destructive economic models. In the words of Gus Speth (2013), one of the leading environmental lawyers and campaigners, "[t]he top

environmental problems are selfishness, greed and apathy… and to deal with those we need a spiritual and cultural transformation."

Speth's statement brings me to the main impetus for my dissertation, the conviction that discursive, pedagogical, political and economic alternatives to extractive capitalism are urgently needed. Such alternatives will be truly transformative only if they are grounded in the ethics of care and partnership as opposed to the ethics of extractivism and domination (Eisler and Eisler, 2008; Menzies, 2014; Kidd, 2016, Bauwens and Niaros, 2017). Prompted by this conviction, I set out to seek a better understanding of how community-based non-profit organizations can strengthen their role in contributing to a more caring, connected and active civil society.

Introduction

My doctoral research focuses on how non-profit organizations can support community participation in a collaborative action for health justice in ways that are empowering and generative, as opposed to those that are disempowering and extractivist. I argue that there is a gap between the community development mandate of non-profit organizations and their practices, which are increasingly shaped toward direct service-delivery. As a result, the capacity of non-profit organizations to support equitable community participation in collaborative action is curbed. My research aims to contribute to the development of reflexive practice in the non-profit and philanthropic sectors. As part of this work, I hoped to provide guidelines on how to fund, evaluate and support non-profit organizations in ways that advance collaborative action for health justice and the advancement of urban commons.

As a practitioner in the non-profit sector, I have observed how neoliberal policies impose for-profit logic and values on the aspects of the non-profit sector's work concerned with issues of equity and social justice. While the non-profit sector's very name denotes values and principles other than profit accumulation, for-profit rationale and logic increasingly facilitate and engender processes that are too often consistent with extractivism and profit accumulation. Unfolding within the non-profit sector, and in particular in the community development sector, such processes undermine the transformative counter-hegemonic potential of community development work.

I entered my doctoral studies puzzled by some of my experience with community work in the non-profit sector. My puzzlement condensed into one critical question: how can we, as practitioners in the non-profit sector, address oppressive structures of the wider socio-political-economic system? I wanted to understand how our work at the individual and organizational levels is at times structured in ways that undermine the very principles and values we claim to uphold, such as empowerment, community participation, equity and social justice. I wanted to make visible and untangle the entanglements of the external and internal power structures that shape what we call 'work', i.e., our everyday actions in a professional setting.

The purpose of my research is to identify ways in which non-profit community-based organizations can support community action around social determinants of health, as well as to identify structural and systemic barriers to the non-profit sector's ability to support effective and equitable community action. My dissertation specifically examines how the role of community-based non-profit organizations located in low-income neighbourhoods in Toronto (i.e. 'priority neighbourhoods' and most recently 'neighbourhood improvement areas') is institutionally structured in relation to supporting community action for health equity and justice. I discuss the potential of non-profit organizations in advancing the urban commons as a discourse and practice to resist extractivist practices imposed by neoliberal capitalism.

I focus on the work of non-profit organizations in the context of health promotion and community development that include efforts towards protection and expansion of the urban commons. This work includes but is not limited to initiatives advocating for the use of city space for community gardening, increased access to community centres, advocacy efforts for improved community services and programs, and other initiatives targeting social determinants of health. I look at non-profit organizations as civil society actors positioned within an institutional system where some actors are subordinate to others and where such subordination results from unequal access to and distribution of resources. I examine how the role of the non-profit agencies specific to supporting community participation is shaped within such power relations. Many community organizations came from the grassroots and developed in communities for communities. As a result, they often focused on activities such as mutual aid, access to space and resources, local organizing, advocacy and group activities. As community organizations are increasingly pushed by funders into direct service delivery, they engage less and less in their original activities, and the gap between their social justice and advocacy mandates (often still present on paper) and their daily activities grows.

I argue that there is a gap between social justice and advocacy mandates of community-based non-profits and their practices that are increasingly shaped toward direct service-delivery and the capacity of non-profits to support meaningful community participation is curbed. Such gap is largely facilitated through funding relations that prioritise fiscal (i.e. functional) accountability and results-based performance

measurement. Both are part of the neoliberal policies of austerity applied to the non-profit sector that have curbed the sector's capacity to carry out advocacy and community development work in the context of social justice. I discuss the advocacy and community development aspects of the non-profit sector's work as potential contributors to the protection and expansion of the urban commons necessary to protect public resources and advance health justice discourse. I define health justice as concerted efforts on behalf of equity seeking groups and allies to eliminate inequities in health through equitable distribution of material/economic resources, and access to social networks and information, as well as through the protection and care of natural environments. The urban commons are defined as shared or pooled goods and/or resources, including public resources, combined with an activity that involves co-production and maintenance of those goods/resources under the mode of governance designed to protect the goods or resources from commodification and allocate their usage.

Mapping of the Dissertation

My research is designed as an iterative process of action-reflection, which is not easily presented in a conventional linear way. The intention of my work is to elucidate and make visible connections that re/produce inequalities through ruling relations and accountability mechanisms embedded in a hierarchical system at its various levels. Breaking down the iterative and reflexive process into a series of linear and discrete steps contributes to severing connections between the parts, therefore, obscuring the whole picture and the dynamic relationship between the parts of the whole. In search of representations that are more holistic, cyclical and integrated, I turn to Indigenous cosmovision models, Socratic dialogue, dialectical thinking and praxis (Manzo, 1992; Absolon and Willet, 2005; Barndt, 2011). While writing this dissertation, I often found myself distanced from the 'real world' of everyday life by complex theories, concepts and the process of weaving them together into a coherent academic text. To prevent such fragmentation and distancing of the self from the practicalities of life that informed and inspired this research, I introduce 'intermissions' written in a colloquial language in an otherwise dry academic text. I also occasionally introduce less conventional ways of presenting information such as hand drawn illustrations and mixed-media collages that

were created to make visible the interconnectedness in ways that are not possible in a linear written format. Such illustrations were used in my conversations with community members as a community-friendly way to communicate the research process and its findings. The illustrations and 'intermissions' served as my creative and spiritual respite.

This dissertation consists of seven chapters and the presentation of the research process is aligned with the reflection-action learning spiral embedded in the research design. The first four chapters constitute the reflection part of the research. Chapters 1 and 2 are dedicated to matters of location. Chapter 1 introduces my social location and positionality as a researcher, as well as research loci and context, situating the research focus within a broader context of neoliberalism, non-profit sector and urban locale. Chapter 2 focusses on the issues of theoretical and epistemological locations and explains how such locations inform the research design and the choice of methodology. In this chapter, I pay particular attention to the interconnectedness, alignment and complementarity of various elements of the research design while making explicit how the choice of methods is informed by my theoretical and epistemological locations.

Chapter 3 focusses on the analysis of funding conditions, reporting requirements and accountability systems using the example of two community health centres. I analyse how reporting requirements and funding conditions may support or impede approaches to evaluation that are consistent with key principles of health promotion. Chapter 4 examines the epistemological and methodological challenges posed by reporting requirements and accountability systems and discusses evaluation as a process for promoting reflexive practice development and balanced accountability in community health promotion.

Chapters 5 and 6 present the 'action' part of the reflection-action spiral. These chapters describe the participatory evaluation design process that I facilitated to support participatory evaluation of a collaborative community action and to analyse how non-profit organizations can foster meaningful community participation in non-profit-community partnerships. Chapter 5 describes the experience of designing and implementing the participatory evaluation process. Chapter 6 discusses the roles non-profit organizations may perform when addressing community participation and

concludes with guidelines for non-profit sector practitioners on supporting co-production and co-governance in the context of non-profit-community partnerships.

Chapter 7 is the concluding chapter on the reflection-action spiral bringing together lessons learned and discussing the potential role and responsibility of community-based non-profits for organising civil society in the context of supporting the new forms of public-commons partnerships and *commonification* of public services to advance and protect urban commons (Bauwens and Niaros, 2017). In this concluding chapter I also propose a mapping process for a multi-level social system analysis in intersectional feminist research.

Chapter 1: Location Matters

Identifying Researcher's Location, Research Loci and Context

I must be the bridge to nowhere
But my true self
And then
I will be useful
(Rushin in Moraga and Anzaldúa, 1983: xxi)[3]

When setting out on a journey, it is important to understand what baggage one carries. For the purpose of this dissertation as an intellectual journey, I discuss different aspects of my identity as essential pieces of my 'baggage' that together produce my positionality and social location. I analyse such aspects through an intersectional feminist lens that brings together the parts of the whole, while paying attention to how the parts and the lines between them are socially and politically constructed, affording holistic analysis of the complexity of human experience (Crenshaw, 1991; Collins, 2001; 2016). Intersectional analysis of my autobiography provides evidence and a framework for the understanding of how white and middle-class privilege are socially constructed and re/produced to support oppressive institutional discourse.

Reflection provides a reason for one's action and beliefs; it is through reflection we bring ourselves into being (Metcalf, 2017). Reflection on *the self* as the point of departure in the pursuit of critical reflection on the larger socio-political-economic structures provides a rather more accessible and less daunting point of entry into reflection on the system as a whole. One offers her mind as a framework for the entry into the world and for this reason one's location is a critical starting point in Indigenous research and life teachings (Sinclair, 2003 in Absolon and Willet, 2005). While Western

[3] I used this poem, written by a woman of colour, as the epigraph to the reflection on my experience as a white woman. I am still debating with myself whether I have the right to interpret the words of someone who reflected on the experience of being racialized within my context. I have used the excerpt from the poem to illustrate that for me the journey to my true self started with acknowledging my privilege and analysing what role it may play in the oppression of others. Acknowledging my privilege also helped me understand how I may oppress the 'other' inside me, those aspects of identify that do not align with the privileged aspects, therefore constructing the separation from my true authentic self. Acknowledging the existence of 'the other' within myself ultimately paved the way towards personal liberation through making connections with the 'otherness' of others. That was the first step in the long journey in the pursuit of an existence that is honest, authentic, and anti-oppressive.

epistemological traditions often demand that researchers distance themselves from their individual location to minimise potential bias, critical social research argue that revealing the researcher's location is a necessary step to ensure transparency and epistemological honesty in the research process (Absolon and Willet, 2005). In anti-oppressive and decolonizing research practice, reflection on the self is important for identifying and understanding those aspects of identity that may be aligned with the oppressive forces of the system,[4] or in the words of Lorde (1984: 123) "the piece of the oppressor which is planted deep within each of us". Locating and understanding aspects of our positionalities that are aligned with oppressive discourse, of which material relations are a part, is of a paramount importance for understanding how we can strengthen anti-oppressive discourse and intersectionally approach the struggle for social justice.

Understanding my *self* as a whole consisting of different parts delineated along the characteristics of race, class, gender, sexuality, immigration history, age and mental health status was instrumental for a conceptual shift towards transcending those lines and arriving at an intersectional view of self, and subsequently at an intersectional conceptualization of oppression and privilege. Critical reflection on a personal journey made *self* an important location for developing and sharpening the intersectional lens required for recognising how local spatial-temporal contexts can structure situations of oppression and privilege that are not equally visible yet interlocking and necessary for systemic re/production of relationships of domination and subordination structured through social institutions (Collins, 2001).

Researcher with Baggage
An autobiographical account through an intersectional feminist lens

I start with the more visible aspects of who I am at this stage in my life - a white Eastern European immigrant/settler woman in a heterosexual family union. These characteristics simultaneously denote marginalized and privileged status. I came to

[4] I define 'the system' in Gramscian terms referring to the set of state institutions exercising their control and holding a monopoly over the repressive forces regulating the relations of production (English and Mayo, 2012).

Canada as a settler in 2007 and presently live and work on the land that belongs to Indigenous people; this immediately denotes my privileged status in relation to Indigenous peoples. As an immigrant, I had to re-establish myself professionally in a new environment. My appearance immediately boosted my chances as my physical features and the way I dress allowed me to blend easily among the white settlers of European descent, who institutionally are still the most powerful group in Canada. My Eastern European accent, however, denotes my 'newcomer' status consistent with certain negative stereotypes and assumptions among some settled Canadians affecting my ability to access rental accommodation, open a bank account, and secure credit, etc. Yet my whiteness has conferred significant advantage, which, coupled with my academic background and professional experience, has translated into employment opportunities where I am likely to receive remuneration significantly above the minimum wage, and where I have a higher degree of self-determination and freedom in relation to how my work is organized. In other words, the combination of whiteness and settler/newcomer status has produced my middle-class experience where I am more likely to have more opportunities to contest, challenge or secure my social positioning (Levine-Rasky, 2011).

Underneath what is visible lie less obvious but no less important parts of my identity and history. I identify as bisexual and experienced oppression and discrimination as a bisexual youth growing up and coming to terms with my sexuality in a culture that is openly hostile to LGBTQ+ people. Through that experience, I learned what it means to navigate the system staying 'in the closet' and sacrificing part of your identity as a human being in order to be accepted by dominant groups in the society and stay safe from discrimination and violence. Entering a heterosexual family union masked my marginalization and helped secure privilege. This relative privilege was constructed through gender and marital status. Later as an immigrant woman in the Republic of Ireland, prior to my immigration to Canada as a permanent resident, I experienced exclusion as my immigration status impeded my access to employment, education and social services. Through the institutional lens, my existence in the country was justified and structured only as a 'spouse of a migrant worker'. Such life experiences provided material for reflection on how one's social location is produced

through multiple aspects of positionality that are socially and politically constructed and depend on a geographical locale and socio-political context. In one case, my marginality was produced through a combination of my gender and sexuality, yet made less visible as it was disguised by my marital status in a heterosexual union that consolidated my privilege. In another case, my marginal location as a 'spouse of a migrant worker' was also produced through the combination of gender and marital status but in this case instead of merging into a privileged position they merged into a precarious 'immigration status' that pushed me to the margins of the system. The reflection on how the social re/construction of my positionality defined my social location in the system was instrumental in activating my activism, no pun intended.

When living in Ireland, I observed how for immigrant women gendered experiences were marked by their specific social location produced via immigration status that defined the range of services migrant women were able, or not able to access, including health care, education, and social services. For women of colour and other 'visible' minorities (e.g., Muslim women), vulnerabilities related to gender and immigration status were intensified by their racialized experiences. My whiteness, however, even within the precarious social location, positioned me as more privileged as it was often conflated with 'middle-classness' because I did not exhibit, or was able to choose to not exhibit, additional 'visible' characteristics of 'otherness' (Levine-Rasky, 2011). That re/construction of identity into white-middle class, even within the precarious social location, shows that whiteness is an invented construct that blends history, culture, assumptions and attitudes (Kendall, 2013; Levine-Rasky, 2013). The fact that I was not exhibiting other 'visible' characteristics signifying my 'otherness', such as skin colour, hair style, the way I dress, religious symbols, or even mannerisms was instrumental in constructing my whiteness and subsequently my 'middle-classness'. With other differences obscured (e.g. sexuality and mixed ethnic heritage[5]), it was easier for me to secure 'white middle class' niche despite my precarious immigration status. From that location and standpoint, I attempted to use my advantage to disrupt

[5] I come from a family that ethnically and culturally identifies as Russian but is of a mixed ethnic heritage, including Romani ancestors. A detailed reflection on the family history, culture and genealogy and the role of cultural assimilation in the production of whiteness exceeds the bounds of this chapter and dissertation.

the privilege and forge alliances with other immigrant women and Irish women who were marginalized by the system. By connecting with and trying to support other women, I further learned how race, ethnicity, sexuality, dis/ability and marital status play a part in the production of privilege and oppression.[6]

My immigration experience through an intersectional lens highlighted spatial aspects of social location and positionality. From my present 'social location,' I would like to focus next on middle-classness and the temporal aspect of positionality/social location. While living in Canada, I experienced post-traumatic stress disorder that caused incidents of anxiety and panic attacks, which for some time limited my ability to perform certain daily tasks and activities, including those that were work related. Thanks to a timely therapeutic intervention, access to an extended health care, flexible employment arrangements, and the support from my family members, the post-traumatic stress disorder related symptoms did not have a detrimental effect on my life. I was able to 'bounce back.' For me this experience further illuminated intersectional nature of privilege and oppression. The advantage conferred by my current social location made the experience of mental health crisis more manageable. With the material resources, cultural capital and social networks that I was able to access from my middle-class position, I came out as a 'winner' from this personal crisis. Yet the popular narrative, consistent with neoliberal individualism, obscures systemic advantages and presents such positive outcome as an individual merit, something achieved as a result of individual strength, gumption and determination. Such narrative strengthens white middle-classness and re/produces it through the normalization of white middle-class experiences while 'othering' those that somehow deviate from the 'norm.' The intersection of middle-class and whiteness, as Levine-Rasky (2011: 250) argues, "confers legitimacy in its distance from the difficult, immunity from complicity in racism, confirmation of merit and entitlement, a pleasure in itself, and a positive

[6] Between 2002 and 2007 I was involved as a program participant, a volunteer, a board member, and briefly as a researcher with Clare Women's Network in Ennis, Ireland. I would like to acknowledge the Clare Women's Network as a place that developed and nourished my activism, solidarity, commitment to social justice and intersectional feminism. I am forever grateful to the brilliant collective of Clare Women's Network for their solidarity, wisdom, mentorship and the spirit of sisterhood that supported and nurtured me through my transformative years in Ireland.

personal identity. It produces forms of knowledge, defines normalcy, delineates inclusion, accords value." My white middle-class experience of dealing with post-traumatic stress disorder was consistent with what is normalized in dealing with mental health issue: accessing therapy, focussing on self-care, taking a break from work, etc. It rendered invisible the systemic advantage I had to be able to do all these things prescribed, yet it gave me as an individual, a legitimacy to say that I have been through some adverse circumstances and defied them. Accepting such discursively legitimatized position uncritically would further contribute to the discursive guidelines for addressing women's mental health that strengthen the white middle-class narrative while marginalizing women whose experiences are not consistent with those of white middle-class. However, this experience is also evidence of how our social location and positionality are temporal and constructed and therefore unstable in the system of ruling relations structured to support the dominant and the privileged. Even under slightly different circumstances entirely outside of my control (e.g. less flexible work schedule, absence of health care benefits covering therapy), the post-traumatic stress disorder symptoms could have triggered a chain of events leading to job loss, financial insecurity, worsening mental health, crumbling family relationships, etc. However, such negative outcomes would more likely be perceived as resulting from my individual 'failures' rather than particular vulnerabilities that are systemically produced.

What is the relevance of such personal details to this research? Based on the sum of my various privileges that translate into the experience of white middle-classness, I am less likely to be in the position of a service-user or being a 'client' of community-based non-profit s providing various social programs and services. Some 'visible' aspects of my positionality (e.g. race, education, class) enable me to experience the system from a comfortable location within such system that affords me a higher degree of self-determination and participation in the decision-making, including those decisions that affect people who are 'program participants', 'service users' or 'clients' of the community-based non-profits. The less 'visible' aspects of my identity connected to experiences of marginalization helped me develop a critical stance towards decisions and policies applied to marginalized communities. If I may say so, the experience of different locations within the system, on the margins of the system and on those fluid

points of somewhere ‘in between’ sharpened my intersectional feminist lens. Such experiential knowledge impacted and informed my academic approach to understanding how knowledge and power are socially constructed and re/produced. It has taught me about the dangers of making judgments based solely on the ‘objective’ knowledge produced from social locations aligned with privilege and power, and without the subjective/experiential insight into the context. Such lessons have a direct impact on how I approach my practice in the non-profit sector, including but not limited to research and evaluation, and especially when applied to the activities of non-profit organizations working with marginalized communities. Through applying intersectional lens to critically reflect on my *personal* experience I developed my *political* awareness. I learned to resist institutional structures or ‘the system’ every time it attempts to incorporate my privilege into its oppressive discourse and strengthen the system of oppression through my participation in it. I must also acknowledge that I am still learning.

Reflecting on my autobiography I was able to understand and to make visible how one’s identity is “emergent in relation to power” by focusing on the shifts in privilege and oppression that occurred in different spatial and temporal locations (Levine-Rasky, 2011: 242). Individual identity or who one ‘is’ is not static and fixed in time; it is constructed in relation to others, in relation to institutional discourse, and in relation to organizations through which one moves on a corporate ladder (Levine-Rasky, 2011). Individuals are structured by but also structure power relations through their participation in oppressive or anti-oppressive discourse. Power relations are institutionally structured, yet their effects are experienced most poignantly and painfully at a micro- or individual level. Although the primary focus of my research is on the meso- or organizational level, I look at how power relations at this level are produced institutionally, i.e., at a macro-level, and are challenged or reinforced at a micro- or individual level. Application of an intersectional feminist lens to power relations within and between the levels opens a vista for a deepened understanding of how hegemonic discourse is re/produced and identify strategic and tactical points for its disruption.

Research Loci and Context

The setting for my research is at the intersection of community development, health promotion, empowerment and participation located within the non-profit context. The non-profit sector itself does not exist independently from the other sectors of society and is subjected to the same political and economic forces that have touched the public sector and civil society. In the late 20th century, the social and public spheres of the major industrialized capitalist economies were subjected to the process of neoliberal restructuring. Brown (2003: 1) describes the workings of neoliberalism in a radically free market as "maximized competition and free trade achieved through economic deregulation, elimination of tariffs, and a range of monetary and social policies favourable to business and indifferent toward poverty, social deracination, cultural decimation, long term resource depletion and environmental destruction." While the primary focus of neoliberalism is enabling the market economy, neoliberalism is much more than exclusively an economic phenomenon. Neoliberalism is often conceptualized as *a set of distinct economic policies* that favour privatization and free movement of capital; as *ideological transformation* and a mode of social regulation that asserts the primacy of the market; and as *governmentality* where neoliberalism is analyzed as discourse in its poststructuralist understanding as a system of meaning that constitutes institutions, practices and identities (Brown, 2003; Larner, 2000).

Dikeç (2006) outlines three main features of neoliberalization in urban environments that reflect the general characteristics of neoliberal development, and that are important for understanding how neoliberal policies intensify extractivism in relation to natural resources, information and labour. The three main features relate to i) the intensification of inter-urban and inter-regional competition that promotes place-marketing, free enterprise zones, urban development corporations and public-private partnership in relation to developing urban infrastructure and service delivery; ii) deepened socio-economic inequalities, displacement and dispossession through the strategies of neighbourhood gentrification; and iii) increased surveillance and criminalization of poverty.

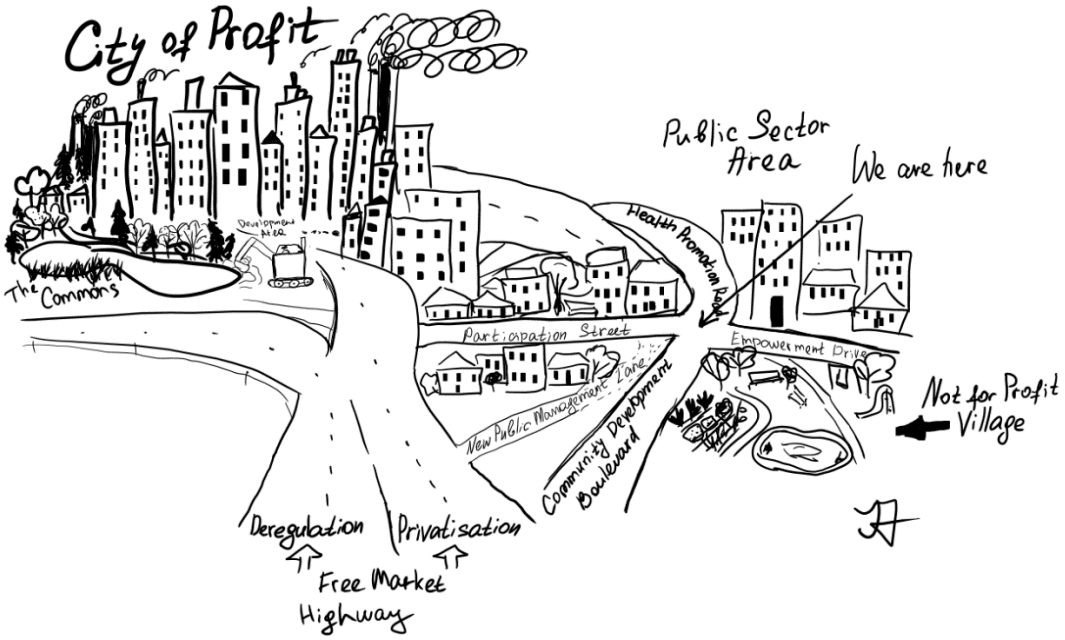
Such processes contribute to growing income inequality, crumbling municipal infrastructure accompanied by the withdrawal of the state from the social service

provision. At the same time, neoliberal roll-out affected the ability of the non-profit sector to respond to the roll-back of the welfare state (Pross and Webb, 2003). Shaw (2011: 32) notes that both roll-back and roll-out "have been endemic in public policy" while return to the community was used to justify the roll-back of the welfare state. The neoliberal system of governance has rolled in through various means and regimes, most notably coded under the names such as 'modernization', 'new public management' and 'accountability'. The relations between the non-profit sector and the state became structured as contract-based relationship (Wolch, 1990; Phillips, 2003). Ng (1988: 26) analyzing the history of the non-profit sector in Canada demonstrates how deteriorating economic conditions raising urban and rural inequality and increased fragmentation of the society inform the development of state funded policies and programs framed in the rhetoric of 'citizen participation' that in fact "represented different ways to administer government funding to community groups for managing their own affairs and working out their own solutions to specific problems of their respective communities and constituencies." Yet those specific problems were constructed outside the community realm; they were shaped by coercive laws of competition that enabled extractivist and plundering practices of capital (Harvey, 1989; 2005). The very same dynamics spilled over into the non-profit sector conditioning the sector to competition, market-based logic and aligning its activities with the interest of capital.

The role of the non-profit sector in this relationship is reduced to instrumental, and activities of non-profits are increasingly streamlined to make them more compatible with the neoliberal rationale that praises individual effort and responsibility while obfuscating systemic inequalities. Furthermore, the neoliberal discourse emphasises efficiency, professionalism and accountability to funders rather than the sector's constituents. Such priorities re/shape the practices of the non-profit sector as more elitist, professionals-led and technocratic and affected the practice of the non-profit sector (Eikenberry and Kluver, 2004; Evans, Richmond and Shields, 2005). In order to survive in the neoliberal environment many non-profit organizations have to re/orient their activities towards direct service provision aimed at individuals while reducing their advocacy outputs aimed at policy and systems change. In such context the potential to

support counter-hegemonic discourse in solidarity with the communities affected by the neoliberal policies is significantly curbed for community-based non-profit organizations created around the goals of advancing equity and justice. Figure 1 below situates my research location at the intersection of emancipatory non-profit activities such as health promotion and community development concerned with empowerment and participation. The primary research focus is located at such crossroads yet the research studies the processes unfolding there in connection with the broader context surrounding this intersection. This context is referred to in the illustration as the 'City of Profit' representing neoliberal development and extractivist processes.

Figure 1: The Non-Profit Village in the City of Profit



The following sections discuss health justice and the commons movement as theoretical frameworks for advancing the emancipatory discourses alternative to neoliberal capitalism. The sections also deal with the implications of the suggested

frameworks for the work of the non-profit organizations and outline potential risks for neoliberal co-optation.

Health Justice for Advancing the Commons

Health justice has been proposed as a framework for the achievement of health equity through the lens of social justice. Benfer (2015: 278) describes health justice as a concept that is “premised on fundamental principles of equity” and “requires that all persons have the same chance to be free from hazards that jeopardize health, fully participate in society, and access opportunity. Health justice addresses the social determinants of health that result in poor health for individuals and consequential negative outcomes for society at large.”

There is a strong relationship between people’s material living conditions and their capability to be healthy. Everyday living conditions such as housing, income level, working conditions, water and air quality, food security, access to health and social services, education, healthy environment and access to recreation shape the health and wellbeing of individuals or their capability to be healthy. The World Health Organization (WHO) (2016) defines these health influencing factors as social determinants of health (SDH) and describes them as the conditions in which people are born, grow, live, work and age, as well as the wider set of social systems shaping those conditions. Social systems determine the distribution of money, power and resources at different levels, including global, national and local that shape living conditions (Mikkonen and Raphael, 2010; Bryant, Raphael and Travers, 2007; WHO, 2016). Health inequities, i.e. the unfair and avoidable differences in health outcomes within and between different population groups, are the result of inequitable distribution of social determinants of health. Within a health justice framework, social determinants of health can be discussed as indicators of the material living conditions and circumstances that shape health and differ depending on individual social location, such as class, dis/ability status, gender and race (Brassolotto, Raphael and Baldeo, 2014). Social determinants of health as indicators of health justice are determined by decisions at the different levels of (municipal, provincial and federal) governments in a range of different public policy domains (Mikkonen and Raphael, 2010). From this perspective, health justice may be

proposed as an overarching policy framework encompassing environmental regulation, labour protection, social welfare and other aspects of the public sphere with a view to address social determinants of health as a means to enhancing health capability. Benfer (2015: 337) describes health justice as a policy framework that considers the health ramifications of decision making and therefore "requires the development of laws and policies that prevent health inequity and increase individual capability."

Describing the effects of austerity and neoliberal policies on health, Loyd (2014: 237) states that "health and urban justice remain an intertwined project" and argues in favour of analyzing the urban space and the urban crisis in terms of ongoing colonial processes that result in often racialized "pockets of poverty" where people are made poor (i.e. 'underdeveloped') through ongoing violence, occupation and exploitation. In times of neoliberal restructuring of the urban environment and social welfare, the most marginalized communities generally bear the biggest brunt in terms of poor health outcomes. Yet while eliminating the concept of public good and collective responsibility, neoliberalism assumes that the poorest people in the society must find the solutions to address their health issues, as well as the lack of access to resources that impacts their health (McGregor, 2001). While access to health care presents the most obvious concern and the cause for mobilization, a broader framework would allow mobilization for the cause of health while encompassing concerns beyond access to health services. A health justice framework enables mobilization around health as an embodied concern, as a marker of environmental wellbeing and sustainability, and as an indicator that reflects social determinants of health, i.e. health influencing parameters lying outside the walls of the clinic.

Such an overarching framework unites health and environmental rights and incorporates an anti-militaristic stance in response to the intensification of global structural violence, while emphasizing equitable and sustainable access to and distribution of resources that ensure individual, community and population wellbeing. Resisting the commodification of health care and of related resources impacting child and elder care, education, and housing present targets for influencing policy action within a health justice framework. Public funding and national provision of such resources have historically been the targets of neoliberal policies as capital perceives

the area of human services as an additional frontier to conquer in its thirst for growth and profit accumulation. Yet, the public system is better positioned to support social solidarity and a vibrant civil society as it is based on shared responsibility and public, not private, accountability which technically supports more equitable distribution of power (Bourgeault, 2006).

One of the most important steps in the struggle against the continuous assault of capital and corporate power on public resources and common good is the resistance to the encroachment of the profit-accumulation rationale. Such resistance involves efforts to preserve the gains of collective claims that advance the concept of public good, and most importantly expands those claims. Such efforts suggest a new form of organizing for civil society under *'commonification'* to protect and expand the commons in opposition to 'commodification' efforts of neoliberal capitalism. Within the health justice framework, preserving and expanding the commons constitutes a legitimate claim. The commons present a discursive, ideological and practical antidote to neoliberalism, and are often discussed as a possible 'third' space besides and equal to the state and the market, an alternative especially relevant within the context of an urgent imperative for the socio-ecological transformation (Weston and Bollier, 2013, Caffentzis and Federici, 2014; Bauwens and Niaros, 2017).

The commons are defined as shared or pooled goods and/or resources combined with an activity that involves co-production and maintenance of those goods/resources under the mode of governance designed to protect the goods or resources and allocate their usage (Subirats, 2015; Bauwens and Niaros, 2017). At its basic level, the commons include the earth and its ecosystems while in its most comprehensive notion, the commons include much of the wealth of both nature and society. Such an expanded definition of the commons encompasses various kinds of public resources and services (Swift, 2014). The key defining feature of the commons is they are not given but produced through social relations and constitutive social practices (Caffentzis and Federici, 2014). Even in relation to so-called natural commons (e.g., water and air), it is through social relations that such elements are constantly re/constructed as commons against the efforts of market to commodify and privatize them. The commons are also distinct from public resources as public resources are

governed and controlled by the state. However, there is an important overlap as the public sphere involves the wealth that was produced collectively signifying its 'commons' dimension. In the struggle against capitalist forms of production, the wealth produced is collectively re/appropriated by the commons, not the market, as it has been happening through various privatization and commodification schemes. Public resources may qualify as the commons only when the public takes a more active part in maintaining these resources, which is necessary for protecting public resources from private interests and re/constructing their reproduction as 'commons,' simultaneously weakening state control and increasing community control over their production (Caffentzis and Federici, 2014).

In times of increased privatization, de-regulation and other incentives to support profit seeking behaviour, the issue of the commons gains more prominence as the latest attack of neoliberal capitalism targets the commons as the new frontier for primitive accumulation. The commons – whether defined as natural resources, information and knowledge, and/or public spaces and services – emerge as the most significant battlefield between the forces of capital and those who oppose the pillage and ransacking of the environment for private profit. Advancing the commons discourse and advocating for the expanded commons, with claims reaching beyond access to health care or other public services, presents a new opportunity for grassroots community action. Gore and Kothari (2012) argue that there is a need for structural interventions that are redistributive in nature in order to broaden the distribution of power, resources and services across the communities. Discussed as seeds and embryonic forms of new types of anti-capitalist social organizations in the making, commoning initiatives can be classified as one of such redistributive interventions (Kidd, 2016; Caffentzis and Federici, 2014). Kidd (2016) argues that approaching commoning with an intersectional feminist theory lens allows the inclusion of all marginalized groups in the struggle against capitalist economic and social relations with the focus on power differences resulting from intersecting categories of class, race, gender, immigration status, sexuality, etc. in social and material re/production. Within the commons as a new organizing framework for civil society, intersectional feminist approach makes the commoning processes less prone to neoliberal co-optation via identity politics along

class, race, gender, etc. As a counter-hegemonic and anti-capitalist discourse, the commons place a great emphasis on the community as opposed to a hegemonic capitalist discourse centred on the individual. Indeed, the commons are not possible without a community that participate in its re/production.

Community Development and Health Promotion Practice

Considering the need for the new forms of civil organising to promote structural intervention that are redistributive in nature, such as the commons movement, what are the implications for community development and health promotion practice?

The International Association for Community Development (2017) defines community development as a practice and academic discipline concerned with mobilizing, empowering and educating people within their communities. As a process and practice, community development seeks to strengthen the capacity of people as active citizens, as well as the capacity of institutions and agencies, to work in collaboration with citizens when identifying and implementing the changes required to improve a community's quality of life and as such plays an important part in supporting democracy and active civil society (Scottish Community Development Centre, 2018). Outside the academic world, and in particular within the non-profit sector's day to day activities, community development is the term used to describe activities of community members and non-profit workers working together for collective change (English and Mayo, 2012). Most importantly, community development implies collective rather than individual action, and intentional focus on participation of various actors (or stakeholders) involved in a process. Community development projects are often supported by various local non-profit organizations in urban and rural communities that are described as 'marginalized', 'disadvantaged', or 'underserved', and experiencing higher than average underemployment or unemployment rates, higher than average proportion of immigrants, single parents, or seniors, combined with limited infrastructure and access to resources. Often community development projects initiated within such environments have direct connections to the goals of improved health and wellbeing for community members. As such they become part of the health promotion efforts at a community level that involve participation of community members in projects or

initiatives that address social determinants of health.[7] Community participation and empowerment are among the key guiding principles of health promotion (Rootman et al., 2001). Thus, many health promotion programmes addressing health inequalities are developed and implemented in partnership with communities intended to benefit from the initiatives.

Community development is rooted in critical pedagogy and popular education and distinguished itself as a field of practice that advances the values of democracy through greater participation (Mayo, 1999; Shaw, 2011). This field of practice is described as located "tactically inside and strategically outside the system" therefore living and working critically from such location requires "readiness to experience the tension involved in trying to move towards the 'transformative end' of the continuum while being pushed towards the other end by the material forces with which we contend daily" (Mayo, 1999: 6).

Intended to support grassroots participation and action among communities who have been marginalized and denied access to resources, community development may often find itself at odds with institutional power. Moreover, community development as practice intended to mobilise communities for action may find itself challenging the state and its policies (Fursova, 2016). There is always an inherent danger that instead of becoming a mobilising force, community development may be used as a pacifier to quiet discontent growing within communities. Placing responsibility on communities without opening access to sufficient resources and effective strategies renders communities responsible for the social, economic and environmental ills they did not create but which are the results of the larger socio-political-economic context (Murray, 2004; Gore and Kothari, 2012). Once community development moves away from 'collective,' it becomes aligned with neoliberal discourse described elsewhere as the 'politics of responsibilities' or the tendency to individualise the social (English and Mayo, 2012). Without critical reflection and questioning of community development research and practice, researchers and practitioners are in danger of contributing, albeit implicitly

[7] Social determinants of health are health influencing factors that originate at the systemic level and manifest as material conditions shaped by the distribution of money, power and resources at different levels, including global, national and local (Mikkonen and Raphael, 2010; WHO, 2016).

and in most cases inadvertently, to the reproduction of inequities and oppressive power dynamics we claim to oppose.

Neoliberal policies push human services delivery to the volunteer sector while using the language of volunteerism and community participation to disguise the shift of social reproduction costs to the community realm (Fursova, 2016). By focussing on protection and expansion of the urban commons, including public services and public spaces, community development can contribute to re/engaging the public in the process of co-production of public services thus reshaping them as commons and simultaneously creating a community involved in the reproduction of the commons.

However, the processes of commoning are not immune to co-optation by the neoliberal discourse. A pertinent issue in the non-profit sector is unpaid labour from community members, which is often solicited as a way to embed communal efforts in capitalist forms of production, cheapening the costs of reproduction and contributing to lay-offs of public employees (Caffentzis and Federici, 2014). To further complicate the issue of commoning in community development, the commons maintain the right to exclusion as they come with a set of obligations as well as entitlements to its members. There is a danger that the commons may be constructed based on homogeneity of its members to exclude 'others' and in doing so turn into 'gated commons' that deepen social divisions and further play into the neoliberal discourse and the 'alt-right' movement emerging as a reactionary alternative to neoliberalism (Kelly, 2017; Peters, 2018). To support the commons as a viable *progressive alternative* to neoliberal capitalism, the non-profit organizations involved in urban commoning processes could integrate an intersectional feminist lens and participatory practices to promote co-production or co-creation of the urban commons. Yet, non-profit organizations, including those that are organized around principles of equity and social justice, function within capitalist social relations that reinforce and are reinforced by funding relations transpiring as reporting requirements and accountability systems that impede processes consistent with principles of equity and social justice.

My research asks the following questions:

- How, and to what extent, can non-profit community-based agencies apply a health justice framework when addressing social determinants of health?

- How are community-based non-profits able to support and advance health justice claims of community groups?
- How can community-based non-profit organizations contribute to advancing and expanding the commons, e.g. how and under what circumstances are such organizations able to support community action aimed at expanding access to public resources and increased community participation in decision-making concerning the use of programs and services?

Analytical Frameworks

My research examines the ways in which non-profit community-based agencies can support community action for health justice in the urban environment. I focus on the roles non-profit organizations may perform when addressing community participation in collaborative action. I consider non-profit community-based organizations as embedded in 'ruling relations' [8] produced by hegemonic neoliberal discourse. I, therefore, analyse how the role of non-profit organizations in relation to supporting community participation has been restructured under the influence of neoliberal capitalism that intensified extractivist processes in the urban sphere. I approach the analysis of neoliberalism and its effects on the non-profit sector from a neo-Marxist point of view complemented by governmentality theory. Both theories are valuable as analytical frameworks for the understanding of how the role of non-profit organizations is institutionally structured in relation to addressing community participation and identifying the potential for strengthening non-profits' capacity to advance community participation in collaborative action for the expansion and protection of the urban commons. The strength of neo-Marxist analysis of neoliberalism is in its ability to demonstrate i) how the new political formations involve multiple actors or class-alliance formation within urban regions as a powerful shaping force (Harvey, 1989; Larner, 2000); ii) how new welfare state arrangements emerge out of political struggle; and iii) how the tensions between

[8] Ruling relations is a concept proposed by feminist sociologist Dorothy Smith and describes those trans-local social relations through which organizations and organizational control come into being. Ruling relations encompass forms known as bureaucracy, administration, management, professional organization and the media (DeVault and McCoy, 2006).

hegemonic and counter-hegemonic claims can form new political subjectivities and social identities that become participants in the discourse of restructuring (Larner, 2000). The latter point is of special importance in my analysis of the position and positionality of the non-profit actors in the processes of neoliberalization and within sites of resistance.

The neo-Marxist understanding of neoliberalism is complemented by governmentality theory and in particular its discussions of power and discourse. The strength of governmentality rests in its contribution to the understanding of how neoliberal ruling relations permeate the social sphere encouraging people to see themselves as atomised individuals solely responsible for enhancing and promoting their own wellbeing (Larner, 2006). Such an aspect of the analysis is valuable for understanding the nuances in the work of community-based non-profit organizations immersed in the neoliberal institutional environment. For example, it enables the discussion of how civic participation and 'active society' are linked to a very particular politics of self in which individuals are encouraged to improve themselves in a wide range of domains, while systemic inequalities that shape individual ability and the need for 'improvement' are obfuscated. It also sees the technologies of functional accountability applied to non-profit actors that impose for-profit rationale and values on the sector through the language of cost-effectiveness, competition and consumer demand.

Both theoretical approaches, combined with an intersectional feminist lens (more details below), encourage researchers to transcend singular categories of analysis and consider complex relationships and interactions between positionalities, social locations, and neoliberal politics and policies that in combination produce vulnerabilities (Crenshaw, 1991; Collins, 2001; Levine-Rasky, 2011; Morrison, 2014; Hankivsky et al., 2014). By focusing on organizational practices (meso-level) as immersed in the larger institutional context (macro-level) that both produces and is produced by the hegemonic neoliberal capitalist discourse, the role that non-profit community-based organizations perform when addressing community participation in a collaborative action for health justice is better revealed.

Chapter 2: Research Design and Methodology

My research is designed as two-part research grounded in reflection-action spiral as consistent with hermeneutic tradition. Part I examines the reporting requirements and evaluation in community health promotion practice with an aim to understand what factors support or impede participatory and equitable approaches to evaluation within the current system of funding relations and accountability. Part I included interviews with health promotion practitioners in different roles and locations in relation to the evaluation process, including community volunteers, frontline workers, health promotion coordinators, managers, as well as a funding officer and an administrative officer. In addition to interviews there were two facilitated group discussions and regular meetings with the research advisory team. The findings of Part I inform Part II, which is focussed on analysing the role of non-profit organizations in supporting community action.

Part II included a series of participatory workshops for community volunteers with the goal to design evaluation frameworks for their respective projects/initiatives. I also supported a community-based network of non-profit organizations and community volunteers to implement a participatory evaluation process to evaluate the capacity of the non-profit organizations to support community participation in a collaborative action addressing social determinants of health. Figure 2 below illustrates the key milestones of the research project in relation to Part I and Part II.

The research design is adapted for participatory action research where the reflection-action spiral is incorporated in the research process as it unfolds on the ground. Such an approach to research design is aligned with the traditions of popular education, critical social research and the principles of interconnectedness and reciprocity inherent in Indigenous research traditions (Freire, 1970; Absolon and Willett, 2005; Kindon, Pain and Kesby, 2007; Barndt, 2011; English and Mayo, 2012). I chose the cyclical and spiral-like approach to research design in order to challenge dichotomous and linear thinking inherent in the Western tradition of positivist inquiry.

Figure 2: Research Project Roadmap

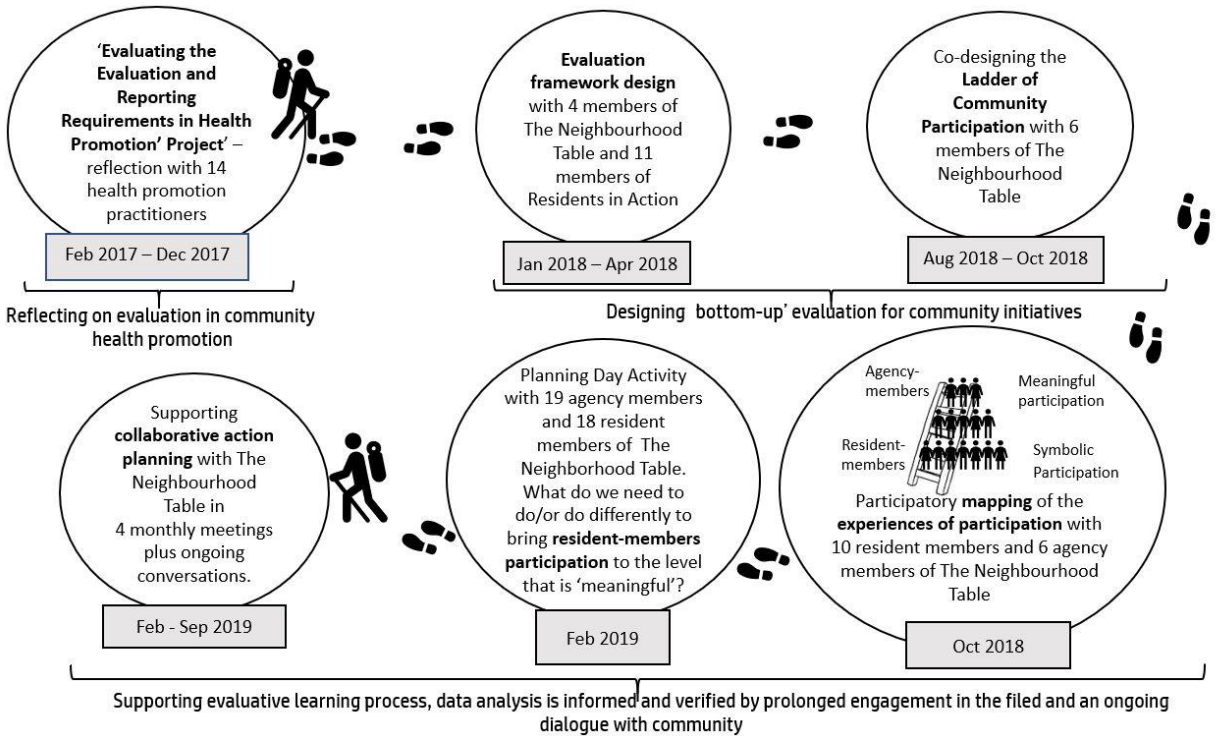
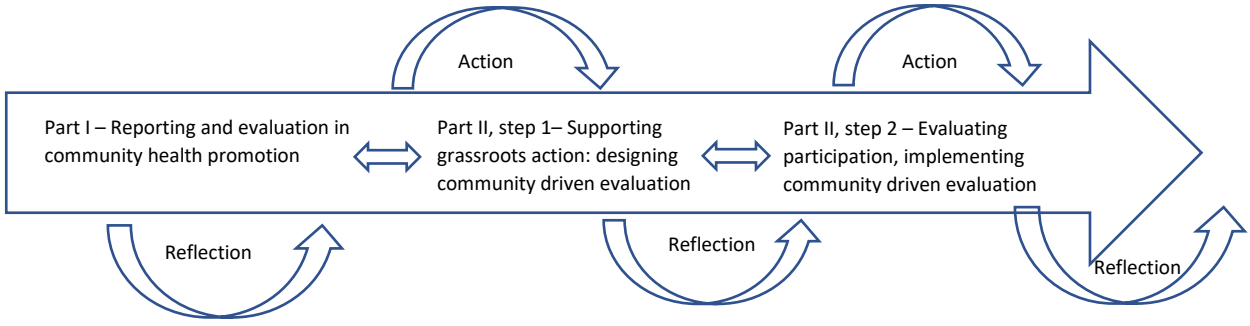


Figure 3 below illustrates how the two parts of the research are integrated. The action-reflection spiral is shown as extending beyond the boundaries of this research to indicate the nature of knowledge as ever evolving and emerging in its infinity.

Figure 3: Research as Reflection-Action Spiral



I adopted an intersectional feminist framework as an overarching ontological and epistemological framework to enable the research focus on the experiences of those actors in community development and health promotion who are most likely to be pushed to the margins of the system.[9] The processes of neoliberal urban development most negatively affected people of colour, women, seniors, differently abled people and those with jeopardised immigration status, as well as people who are 'othered' in various ways. Numerous reports produced by public and non-profit agencies in Toronto note that women, people of colour and immigrants are the poorest Torontonians and reveal startling differences in health status based on socio-economic status (Khosla, 2003; Levy, Asara and Stover, 2013; Van Ingen, Khandor and Fkeiszer, 2015). Khosla's (2003) report notes the labour of women in low-income neighbourhoods fills the cracks in the crumbling social infrastructure while years of dismantling public services and programs contributed to the barriers to women's participation in public life, especially for low-income, immigrant and women of colour. In addition to being residents of low-income neighbourhoods, women are also over-represented in low-income urban neighbourhoods as frontline community workers involved in human services delivery work, health promotion and community development as full-time, contract or casual employees of community-based non-profit organizations. Ontario Non-Profit Network (2018) states that 80% of the non-profit labour force consists of women workers yet women are underrepresented in senior leadership positions. Research by the Ontario Non-Profit Network (2018) into intersections between labour, the non-profit sector and gender identified a gendered racialized hierarchy in the non-profit sector where white men and women occupy leadership positions and Francophone, immigrant and racialized women are often concentrated in non-management positions or specific subsectors such as human and social services.

The non-profit sector is not immune to inequality and oppression. Power dynamics within and between non-profit organizations often mirror those in the private and public sector where particular vulnerabilities are constructed through the

[9] I use the term 'actors' instead of 'stakeholders' that lately permeated the non-profit sector vocabulary. The term 'stakeholders' is a market-based term that implies individuals holding a stake, or financial share in an enterprise, rather than a group of people working towards a common goal resulting in collective benefits equitably distributed.

interlocking system of oppression along various lines of 'othering' that are structured and reinforced by institutional power and discourse. To assess the experiences of actors with the least power, as well as to make social relations that structure unequal access to power explicit, I focus on the experiences of people in and with the community-based non-profit organizations based on their *roles* – grounding my research in everyday realities of community volunteers and frontline workers in two low-income racialized neighborhoods in Toronto.

Intersectional Feminist Framework as an Epistemological Lens

The intersectional feminist framework has a complex history; its origins come from Black feminist thought and its pre-feminist genealogy is traced to Black abolitionists activists Sojourner Truth and Harriet Tubman (Coker, 2017; Witt, 2017; Sharan Sinha, 2018). Audre Lorde (1984) and Kimberle Crenshaw (1989) introduced the concept of 'intersectionality' and the idea has been further developed by Patricia Hill Collins (2001; 2012, 2016) and bell hooks (1999) among others (see also Dudley, 2006; Morrison, 2014). Many feminist academics and activists, including Indigenous feminists, Global South scholars, queer and post-colonial theorists contributed to the development of the intersectionality paradigm (Hankivsky et al., 2014).

In *Intersectionality: An Intellectual History,* Hancock (2016) describes intersectionality as an intellectual project that is two-fold: an analytical framework for between-category relationships and a project to render visible and remediable the previously unaddressed and invisible material effects of the sociopolitical location of Black women or women of colour. While I choose to extend the latter category to include the unaddressed and invisible material effects of the socio-political locations of 'the other' to include additional categories such as immigration status, indigeneity, dis/ability, sexuality, and other social determinants of health, I would like to emphasise clearly and unequivocally that in the current socio-political-economic system of extractivist domination, race still remains the category/denominator with the most devastating consequences. In other words, when race/racism enters the entanglement of intersecting categories for 'othering'/oppression, it deepens the extent of disadvantages.

Collins (2001) writes how one category can have salience over another depending on a given time and location, pointing out that the issue of salience of one particular type of oppression does not minimise or make irrelevant the imperative for intersectional approach toward analysing categories of oppression as interlocking, and with attention to power dynamics that produce the interlocking and compounded effect. In a similar way, Hancock (2016) warns against limited engagement with intersectionality when the intersectional feminist framework is reduced to focus on multiple categories at the expense of a focus on power dynamics that produce them and/or when the privileging of the visibility of identity aspects occurs at the expense of reshaping ontological and epistemological knowledge creation. In the following research methodology sections, I return to this point to explain how I interrogate my practice to prevent or minimise the risks of narrower interpretations of intersectionality, including the ever-present risk of essentializing my own experience as a white middle-class researcher conducting the research in largely non-white and non-middle-class communities. [10]

Segregation and dichotomy aid the technologies of domination as in the hierarchy of oppression there is usually a man to rule over a woman, a white person to rule over non-white, an able body to subdue the less able, and so on. Resting on the pillars of dichotomy that stipulate the necessity to quantify and rank all relationships in the hierarchy of oppression, such an approach reinforces hierarchy as it perpetuates the debate of who is more oppressed weakening the potential for alliances across the differences (Collins, 2001).

Within the neoliberal discourse, competition is portrayed as a ‘naturally’ occurring impersonal force and is normalized as part of the social order. We are made to compete for a higher place in the hierarchy, yet we are also led to believe or rather discursively disciplined into thinking that this competition is somehow unfolding on a level playing field independently from the pyramid we are enticed to climb on. Yet such ‘natural’

[10] I consider myself as mostly ‘passing’, as most of the time, especially in spaces and places that are non-white and non-middleclass, I am likely to be interpreted as white, middle-class. However, in homogenous ‘solid’ white middle-class spaces I am quickly reminded that I am not ‘quite white’, neither I am fully middle-class. Whenever I can use my ‘passing’ to advance anti-oppressive discourse I will do that from the position of my relative privilege.

competition occurs in the hierarchical environment where some players certainly have more advantage when competing from the very start. Such advantages are disguised as ‘merits’ and are emphasised through the neoliberal discourse as results of ‘hard work’ while in fact they often are a direct consequence of privilege and access to material resources, networks and information that results from the specific social location at the intersections of privilege and oppression. These categories are socially constructed and are not static; they occur along the lines of race, gender, ability, immigration status, sexuality to name a few. The primary purpose of delineating along the other lines of privilege and oppression is to produce ‘class’ as a socio-economic category and as the key denominator signifying privilege and social location on the socio-political-economic pyramid.

Identity politics associated with social justice struggles have a history of conceptualizing race, gender and other identity denominators as parallel phenomena, which led to competition within the oppressed groups for support from the dominant political group and an opportunity to get to a higher place in a class hierarchy (Wilson, 2013). In other words, looking at a singular category of oppression, oppressed groups focused on competition with each other rather than on bringing down the institution of hierarchy and the very need to compete. In the non-profit work, even among the organizations that are explicitly social justice and equity oriented, fragmentation and hierarchy transpire as a constant classification of the ‘target groups’ and compartmentalisation of work. The result is constant tensions and debates over which groups deserve more resources or what issues are more ‘fundable’ in the current political climate or deserve to be ‘strategically’ prioritized to increase the chances of securing funding (e.g. women vs. seniors, differently able people vs. LGTBQ+ youth, Black youth vs. newcomer youth and so on). Ng (1988) notes that the focus of community organizations on individuals and individual advocacy contributes to the reproduction of class relations and inequality and such focus precludes fundamental social change. Theorising social justice activism in his work on social movements, Melucci (1995) contends that while being integral for advancing civil rights and social justice discourse, the politics of culture and identity become no longer useful, and therefore social justice activists must find a common issue of concern that can help to

simultaneously accept and transcend the boundaries of identities. The intersectional feminist framework presents such a unifying lens and is especially useful for organizations that aim to build networks and coalitions to tackle social justice issues. Drawing on the examples from the practice of radical social justice work among progressive community organizations, Collins (2016: 43) asserts that these organizations use intersectionality in three distinct but connected ways: i) as an analytical framework to address interlocking structures of oppression; ii) as a reflexive practice approach for linking social movements theory and practice; and iii) as a set of guiding principles for promoting new identities and new forms of democratic engagement among its constituents.

My research applies intersectionality as an epistemological lens to enable the synergy described above. It is focussed primarily on the experiences of participation in community action among different actors representing diverse social locations with a particular focus on community residents and frontline workers in community-based non-profit organizations located in low-income racialized neighbourhoods. An intersectional feminist lens affords a focus on power relations among different actors and makes explicit how particular marginalities and vulnerabilities are systemically produced through constructed and interrelated positioning and identities (Choo and Ferree, 2010; Christensen and Jensen, 2012). Such an approach is aligned with a Foucauldian theorization of power, where power is a relational concept shaped by both relationships of communication and objective capacities (Foucault, 1982).

Guiding principles adapted from Hankivsky et al.'s (2014) inform the choice of my methodology: multilevel analysis; reflexivity; attention to power dynamics, to time and space (historical contexts and geographies) and to intersecting categories of identities; respect to diverse knowledge and perspectives; and commitment to equity and social justice. Such principles inform the combination of the institutional ethnography and participatory action research as a choice of methodology and approach. Institutional ethnography affords multilevel analysis with the focus on power dynamics within intersectional categories of identities while participatory action research facilitates reflexivity, attention to historical and spatial contexts and respect to diverse knowledge

and perspectives. Both institutional ethnography and participatory action research are deeply grounded in the commitment to equity and social justice.

Participatory Action Research and Institutional Ethnography

My research objectives are inscribed in a threefold process of research, education and action (Barndt, 2011). My research applies institutional ethnography as a method of theoretical inquiry and methodological framework while using participatory action research as an approach to involve research participants in the co-production and sharing knowledge produced throughout the research to directly benefit community members involved. Participatory action research is also used as a tool for reflexive practice development by involving co-researchers in critical reflection on the larger political context of their practice.

Participatory action research is a type of research with explicitly emancipatory focus and a new epistemology rooted in popular education work and social movements involving oppressed people in the Global South; it was developed to counter conventional forms of research that were often used to advance colonization and oppression (Kindon, Pain and Kesby, 2007; Minkler and Wallerstein, 2008). Participatory action research is described as a systematic inquiry produced in collaboration with those affected by the issue being researched with the explicit purpose of education and taking action in response to research findings. Such approach is considered methodologically appropriate in health promotion (Wallerstein and Duran, 2008; Wagemakers et al., 2010). To minimize the risk of essentializing privileged experiences and to keep in focus the interests of community members who are most likely to be marginalized, a set of guiding principles for research project implementation was adopted to ensure that participating community members benefit from the research by being involved in data analysis, and that the knowledge produced is relevant and applicable in the context of community development and frontline health promotion work.

Participatory action research is integral to my praxis development. It aids in critically approaching my own position as a researcher to avoid the repetition of extractivist scenarios that may easily take place in community setting when researchers

come to communities to extract the data and to process them independently from their research 'subjects' by publishing findings not validated through the lens of the researched community in order to feed academic careers and professional egos. Such research practice is certainly not enriching for communities participating in the research, and more often than not, it is quite harmful for many racialized and impoverished communities.

Institutional ethnography is a method of sociological inquiry from a feminist standpoint developed by Dorothy Smith (2006: 2) as "alternative sociology that does not begin in theory but in people's experience." According to Smith (2006: 18), the point of institutional ethnography is not the study of organizations per se, but their social relations produced and reproduced by "people who are at work in… professional setting and organizations" and whose "capacities to act derive from the organizations and social relations that they both produce and are produced by." Using institutional ethnography as a methodology allows me to move beyond analyzing individual actions or actions of organizations as separate entities to study them in the context of the entire sector and its work being shaped by the wider socio-political-economic structures and from the standpoint of community members and frontline workers implicated in these structures. Institutional ethnography does not study individual practitioners in a particular agency but instead studies the sector as a whole and its work as shaped by the state through the experiences of individuals in an agency as a subset of the sector. An intersectional lens is of special importance as it allows to study the experiences of individuals in connection with their social locations and to analyze how the differences in experience emerge from different social locations. Social locations are inevitably tied to class as a set of practices, which organize relations among people and produce social and ruling relations (Ng, 1988; Smith, 2006).

Drawing upon Roxana Ng's (1988) study of community immigrant services, I pay particular attention to the historical context of the development of the geographical and organizational settings within which the research is carried, as well as linkages between the settings. Institutional ethnography allows me to look at social relations as practical activities through which dominant hierarchy and relations of power reproduce themselves, and how existing ruling relations are accomplished and maintained by

people, especially in situations when maintaining such relations contradicts the interests of those who are involved in reproducing them (Ng, 1988). In contrast to conventional ethnographic research that generally deals with organizations as separate stand-alone units of analysis, institutional ethnography provides a critical lens for understanding the dynamics of the non-profit sector within broader and more complex institutional relations that shape the local dynamics (Ng, 1988). I specifically examine 'ruling relations' within the non-profit and community sector in an attempt to analyze how (meso-level) organizational practices of non-profits that are shaped and activated at the (macro-level) political and policy-making level shape the (micro-level) embodied experiences of frontline workers and activists, and how they enable or hinder community action for health justice.

Understanding of texts as the primary methods of facilitating ruling relations in the matrix of power is one of the key principles in institutional ethnography. In the institutional ethnography study of community-based settlement services, Ng (1988: 91) notes:

> [t]exts and documents have become the general mode of ruling in advanced capitalist societies. Thus, it is impossible to understand the relations between state (ruling) processes and community struggles without understanding how documents work in mediating, enforcing, and transforming everyday life. This is an essential part of how community struggles become an extension of ruling in our society. Understanding how textual processes work can thus inform communities activities in and against the state.

I use the evaluation process and reporting requirements in community health promotion as an entry point for exploring how both the activities of individuals in their professional setting and health promotion practice at an organizational level are shaped by evaluation and reporting processes tied to funding. I studied organizational texts and evaluation and reporting processes as 'ideological instructions' governing social relations and shaping everyday practices of organizations and individual experiences of workers, clients and activists. I specifically studied organizational texts related to evaluation and reporting, including but not limited to reports, policies, frameworks, guidelines and standards in order to discern how requirements for evaluation and

reporting may enhance or undermine building efforts of health justice and equity depending on the contexts of their application. To understand how texts are reenacted from different locations in relation to evaluation and reporting processes, I conducted individual interviews with practitioners. Locations selected for individual interviews and how they were determined is described in more detail below.

By studying and understanding such texts and understanding how they are re/enacted from different positions of an individual in relation to reporting and evaluation processes, I examine what role non-profit agencies play as organizations in re/producing hegemonic ruling relations. By focusing on the evaluation process as an expression and the extension of "ruling relations" (Smith, 2006: 2), I study the reproduction of the evaluation discourse in health promotion that governs the parameters of what is framed as evaluation (McHoul and Grace, 1995). I examine how evaluation is expressed as (micro-level) individual practices of health promotion practitioners, which are mediated through (meso-level) organizational texts and practices that are in turn are structured at the (macro) institutional level. To understand how an evaluation process is facilitated from several locations in relation to the whole process, I explore how health promotion practitioners navigate and understand evaluation depending on their location in a professional hierarchy for "it takes a number of differently located people to enact the event" (Campbell and Gregor, 2008: 48). Such different locations in relation to the same event are known in institutional ethnography as *disjuncture,* which are described as different versions of reality between knowing something from ruling versus experiential perspectives. In institutional ethnography such difference becomes explicit and becomes a basis for how the research inquiry is conducted (Smith, 2006; Campbell and Gregor, 2008). Although institutional ethnography examines an issue, phenomena or event from the many locations that take part in producing it, institutional ethnography always methodologically aligns itself with those who experience the issue, phenomena or event firsthand rather than from a 'ruling' perspective. For this reason, when identifying the disjuncture, I drew upon my experience as a frontline non-profit organization worker and my previous experience of marginalization, as well as the experiences of other health promotion practitioners, including community activists and paid frontline staff.

Committed to avoiding the extractivist practice that has been indicative of industrial and post-industrial neoliberal capitalism permeating all spheres of society, including academia, I strive to create a research process that would enable me to stay aligned with the principles of empowerment and participation, and to decolonize my research practice from its ontological (what we consider as true reality' or what is worth knowing) and epistemological (how we can learn about what is true or generate knowledge) foundations (Strega, 2005). To facilitate such transformational shift, a change of perspective that approaches knowledge creation as a collective and emancipatory process is required (Wallerstein and Duran, 2008; English and Mayo, 2012). The combination of an intersectional feminist lens, institutional ethnography and participatory action research facilitates such transformational change in knowledge creation by shifting from individualist extractivist processes of knowledge production toward collective knowledge co-production processes. Table 1 below summarizes the integration of the theoretical and analytical frameworks, lens, approach, methodology and methods in the overall research design.

Table 1: Theoretical Frameworks, Epistemological Lens and Methodology

Theoretical Frameworks	Health Justice and The Commons		
Analytical Frameworks	Neo-Marxism and Governmentality		
Epistemological Lens	Intersectional Feminism		
Methodological Approach	Institutional Ethnography and Participatory Action Research		
Methods	Text Analysis	Semi-structured and Individual Interviews	Participatory Workshops and Group Discussions

Intermission 1: Memo for Participatory Action Researchers

Before you start your PAR project, and during your journey, remember:

- Enter the process from the point of 'not knowing enough' because this is what really informs your inquiry - your lack of knowledge, not the purported expertise.
- Participatory Action Research is a relational practice and as such requires an ongoing commitment to relationship building with the research participants. Such process involves much more than discussions about data collection and other research related matters. If permitted, stay around for the meetings and events that may not be directly related to your research, get to know community history through people's stories and experiences.
- Always be clear about your role, motivation and purpose as a researcher.
- Immerse yourself in the community. Make a commitment to be there physically, as well as intellectually. Try not to substitute face to face meeting with a 'remote meeting technology', unless it is requested by the people you are meeting with.
- Your role is to listen and ask questions, but don't try to provide all the answers yourself, encourage a collective quest for those answers.
- The key part of your role as a researcher is to facilitate a process that will help the group to collectively arrive to a set of shared decisions.
- Explain and clarify to community groups that it is their role to make decisions concerning the extent of their participation and information sharing, and make sure it is included in the Memorandum of Understanding you sign with the group.
- Part of your goal as a PAR researcher is to create a good process, a process that is equitable and enriching for community members. Much of the process-related work is the work of care and relationship buildings. As such, it is often 'invisible' because it does not necessarily produce immediate results. "Work in the invisible world at least twice as hard as you do in the visible" (Rumi, in C. Barks, 2001: 20).
- In PAR remember the balancing act analogy – balancing requires constant focus and awareness to what is happening inside and outside of you, the moment you lose that awareness, you lose balance. Balancing is never static, it requires constant movements back, forward, sideways, sometimes very subtle, and there are moments of complete stillness, but inevitably adjustment of movements will be required again. Similarly, in PAR, the researcher must stay aware of the changes happening, be alert and adjust the process accordingly.
- Your involvement with the community will continue well beyond 'data collection and analysis' phase. Plan thrice as much time as you think you may need. Continue sharing your knowledge, analysis and co-produce a platform for further knowledge exchange and mobilisation with community members.

Integrating Institutional Ethnography and Participatory Action Research

Navigating community development evaluation and participation processes through institutional ethnography and participatory action research presents an enhanced opportunity to understand how power is distributed in partnerships between non-profit organizations and community groups, and how participation of organizations and community members as partners is institutionally structured. Participatory action research has been criticized for its lack of power analysis regarding *participation* itself (Kindon, Pain and Kesby, 2007; Wallerstein and Duran, 2008; Springett and Wallerstein, 2008). On such grounds, postcolonial and critical feminist theorists critique participatory action research for its potential perpetuation of colonial relations of power, especially when it is implemented in the communities by outside 'experts', thus reproducing the same hierarchies of knowledge and ruling relations it claims to address (Barndt, 2011). Given this general critique, I feel it is beneficial to inject critical interrogation of power into the process by combining participatory action research with institutional ethnography, Neo-Marxist analysis and governmentality theory from an intersectional feminist perspective. Such a complex combination fosters an analytical synergy in the research process that make visible previously unquestioned assumptions embedded in participatory processes related to the exchange of knowledge and resources occurring within seemingly 'power neutral' spaces. Failure to examine participation as an aspect of power creates assumptions about uninterrupted exchange of knowledge, skills and resources within and between actors of participatory processes, while in fact systemic bureaucracy can limit redistribution of resources necessary for equitable participation. Participation is structured within institutional hierarchy that almost always tends to favour certain methods and methodologies as well as ways of participation (Kesby, Kindon and Pain, 2007). Institutional ethnography is particularly helpful for understanding how participation as both a process and a goal in community development is structured and shaped through institutional and organizational hierarchies and relations of power.

Participatory action research and institutional ethnography are both described as orientations to inquiry rather than a rigid set of methods. Both orientations demand

flexibility and agility on behalf of the researcher. The research process is guided not by a set of predetermined activities but rather emerges during the research journey where each step is informed by the learning and insights gained in the preceding steps, consistent with the notion of praxis and action-reflection cycle (Freire, 1970; Barndt, 2011).

My research intentionally combines institutional ethnography and participatory action research as I journey through participatory process as an institutional ethnographer with an intersectionality lens paying attention to how power is negotiated, navigated and shared by the different institutional actors, including myself. I also use participatory action research to challenge institutional structures that shape evaluation practice and community participation in ways that conforms to institutional hierarchies (e.g. community participation, aka 'engagement'), and is evaluated in a top-down manner according to the metrics developed by those who commission participation. I involved community groups in designing evaluation frameworks to assess the extent to which non-profit organizations can support meaningful participation of community groups, according to indicators for 'meaningful participation' as defined by members of those community groups.

While I am consciously striving to alter current relations of power and domination, I myself am caught within the system, which works in ways that prompt me to align my research practice with conventional approach. The rigidity of the academic system, especially at the research proposal stage for research ethics approval, puts pressure to shape my research as more conventional and aligned with exactly those traditions of linearity, dichotomy, hierarchy, detachment and distancing of the researcher from the 'research subjects' that I seek to challenge, as well as the centralization of power over the 'research subjects'. While I intend to make my social and institutional location in the process visible, along with the contradictions such a location produces, the dictates of conventional scientific objectivity stipulate concealment of the social and institutional location of the research and the researcher, as well as the contradictions created by the dominant ideology (Absolon and Willett, 2005; Kimpson, 2005; English and Mayo, 2012). As the research project was unfolding, I encountered these particular challenges and limitations:

- The existing academic structures, especially at the stage of the Research Ethics Board approval, did not support the flexibility required to maintain holistic reflection-action-reflection cycle integral for the quality of institutional ethnography and participatory action research;
- Institutional hierarchy was and is present in the research process through the institutional texts such as ethics protocols and informed consent forms, and my role is structured as the 'principal investigator' rather than a co-actor in the process of collaborative knowledge development that I facilitate with community members;
- Community research partners were not involved in the decision-making concerning research questions and data collection methods at the early stage of research proposal development. As a 'principal investigator,' I determined the foundational aspects of research design in order to secure ethics approval prior to the start of the research project;
- The resources to support community participation in data collection and analysis beyond the consultation level were limited. For example, I received no budget to hire community 'research assistants' and to involve them in data collection and analysis more actively while fully and fairly compensating them for their time.

My attempts to resist the incorporation of this research into conventional hierarchies of power included generating a small subsidy to cover the unpaid time of a community member during the evaluation and reporting part (Part I) of the research, which is hardly a reflection of my 'generosity' but rather a reflection of my privileged position that afforded me the use of personal funds. I also tried to disrupt the extractivist practices of conventional academic research, which do not necessarily provide timely and relevant exchange of information with communities. I did so by conducting preliminary data analysis and preparing 'data placemats' (Kranias, 2017) for discussion of my interpretation of data with members of a Research Advisory Team and Research Action Team on Evaluation assembled specifically to guide my research. The design of community driven evaluation (Part II) was largely informed by learnings about community activists' capacity building in evaluation (Part 1). Rather than holding a series of focus groups for reflective discussion, I conducted a series of workshops, group discussions and community meetings with the goal of capacity building in evaluation. Such a process resulted in a tangible outcome for community members, a knowledge product that was collaboratively developed and that can be used by

community members to advance their collaborative action for health equity and justice. In addition to the Research Ethics Board's approved written informed consent forms that were used for individual interviews and structured workshops, at each community meeting I provided a verbal explanation of my role as a researcher, the stage where I am at with the research project, how I am using the data, and I also solicited community members' input into the decisions regarding future findings sharing and publications. I see generating informed consent through a dialogue as essential for fostering values of respect and reciprocity throughout the research process. I describe such process as 'dialogical consent', which requires being intentional and deliberate in building a dialogue around consent and approaching informed consent as a relational and iterative process rather than 'one-off' event that happens when participating members sign a consent form.

Data Collection and Analysis

My research uses a qualitative methodology and methods including textual analysis, individual interviews, participatory workshops, group discussions and field observation. There are two types of participants in this research: organizations and individuals connected to the organizations in their professional or volunteer capacity.

The research being on the role of community-based non-profit organizations may perform when convening or supporting community action for health justice, I focus on organizations with health promotion and/or community development activities as part of their mandate. Health promotion is a multidisciplinary field concerned with enabling individuals and communities to act on matters that affect their health. In sum, health promotion addresses social determinants of health at the community levels through advocacy, capacity building and intersectoral collaboration to achieve better conditions for health (WHO, 2018). Health promotion goals and activities aim at enhancing health capabilities and are consistent with the goals of health justice. I therefore approach organizations that are directly involved in health promotion activities, including but not limited to community health centres.

The participation of community health centres was integral to the research because community health centres (CHCs) are specifically mandated to address social

determinants of health among the plethora of non-profit organizations mandated to support community development and civic engagement. Two community health centres and one collaborative inter-agency project supported by the participating CHC joined the research as community partners.

The first part of the research, supported through a Graduate Internship Grant provided by the Faculty of Graduate Studies at York University, included two organizational partners – Health Nexus and the Alliance for Healthier Communities (formerly the Association of Ontario Health Centers). Both organizations generously supported the research by providing financial, mentorship and in-kind support to enable collaboration with community partners. The Alliance for Healthier Communities continued supporting the research throughout its second phase by providing access to meeting space, participating in research findings review, and facilitating opportunities for knowledge exchange with the wider community of practice.

All phases of the research involved purposeful sampling of participants to ensure the selection of information-rich cases (Patton, 2002; Merriam, 2009). A letter of invitation describing the research project and outlining the research purpose and risks and benefits for participating organizations and groups was sent to two community health centres identified by the Research Advisory Team. Both community health centres accepted the invitation and additional information about the research project was then distributed among CHC staff. Individual participants were invited to participate in a one-hour interview and/or two-hour group discussion in Part 1 of the research, and to a one-hour individual interview and a three-hour interactive workshop in Part II. Screening questions were developed for individual participants to identify their role in evaluation process and the extent of their involvement in health promotion efforts.

The selection criteria for each part of the research, as well as the details of data collection and analysis are described in more detail below.

Part I: Evaluating the Evaluation and Reporting Requirements in Health Promotion

The community health centres (CHCs) model has been inspired by the original version of Medicare with a focus on prevention and a holistic approach to health rather than just treating illness (AOHC, 2016). CHCs acknowledge that ill health is caused by social and environmental issues and work with community members to address such issues (AOHC, 2016). CHCs emerge out of community driven advocacy for improved access to primary care and tend to concentrate in lower-income neighbourhoods that serve populations described as 'marginalized' (Torres et al., 2014). In Toronto, such neighbourhoods, once referred to as 'priority neighbourhoods' and renamed as 'neighbourhood improvement areas' in 2014, are generally characterized by having a higher percentage of low-income residents, new immigrants, a higher concentration of high-rise rental buildings and poorer access to services (City of Toronto, 2015).

For the first part of my research on evaluation and reporting processes, the recruitment process started with identifying participating organizations, followed by the recruitment of individuals connected to participating organizations. I approached two community health centres located in 'neighbourhood improvement areas' and identified through an initial consultation with members of the Research Advisory Team represented by Health Nexus and AOHC staff. For the purpose of preserving the organizations and individual participants' confidentiality I refer to them as CHC A and CHC B. Upon receiving an expression of interest on behalf of each organization, I shared an organizational informed consent form to recruit additional representatives for a Research Advisory Team. The team was formed to support participatory aspect of the research project and to ensure consistent input from health promotion practitioners in the research design, data collection and analysis, and knowledge dissemination. The Research Advisory Team sought participation from each of the partner agencies supporting my research, i.e. Health Nexus and the Alliance for Healthier Communities, as well as from each community health centre and inter-agency projects/groups.

The organizational informed consent form outlines the research goal and objectives, the benefits for the participating organizations, the value of the research, and the extent of participants' involvement. After receiving the organizational consent from each participating community health centre, I connected with community groups and an

inter-organizational network supported by one of the CHCs to recruit members for the Research Advisory Team. The final membership of the Research Advisory Team included seven members, including a researcher from the Alliance for Healthier Communities, one health promoter respectively from Health Nexus, CHC A and CHC B, and two community members from CHC B connected to an interagency network. The Research Advisory Team's terms of reference were drawn up to ensure the group's work was grounded in a collective understanding and common values in relation to the research process and goals.

Data collection on reporting and evaluation (Part I) of health promotion activities included a review of texts (grey literature), individual interviews, and participatory group discussions. Texts were selected based on their relevance to evaluation in health promotion and organized in two main groups: texts produced at the institutional level (i.e., texts produced by funders to guide the reporting and evaluation process within a sector) and texts produced at the organizational level (i.e., evaluation frameworks and reports). The Research Advisory Team members gave recommendations on the selection of the texts. The specifics and the relevance of such texts are presented in greater details in Chapters 1 and 2.

The Research Advisory Team members also gave recommendations on the selection of key informants for individual interviews. I relied upon purposeful theoretical sampling where the total sample of research participants was not selected ahead of time but was guided by the process of data collection (Merriam, 2009). I sought to include a wide range of informants to ensure input from various entry points on behalf of those who play a part in constructing *evaluation* from their specific location in that process and to represent people's experiences and social locations, with an attention to their identities, such as race and gender. However, socio-demographic information was not collected as part of the interview unless participants volunteered that particular data. I coded the research participants based on their location in the evaluation process as community volunteer, frontline staff, manager of non-profit organization, funder or administrator.

Group discussions were also facilitated with health promotion practitioners. Two discussions were conducted as part of the research data collection activities and three

additional discussions took place as part of the Research Advisory Team meetings. Discussions involved collaborative data analysis with the focus on preliminary themes that emerged from interviews and text analysis. Notes from discussions became part of research data.

A total number of 14 individuals participated in Part 1 of evaluation and reporting research. The location of the participants and their positions within the organizational structure in relation to the evaluation process is presented below.

Table 2: Participants in Organizational Structure

Position in organizational structure	Number of Participants
Community activists, i.e. volunteers	4
Frontline workers	3
Project Coordinators	3
Managers	2
Funders/Administrators	2
Total	**14**

I designed group discussions in a way that allow me to capture most of the information without relying on audio recording. I decided not to use audio recording as I had concerns that this might affect the levels of participation of community members and participants might start self-censoring. Activities for data collection were designed with the use of 'post-it' notes where participants recorded their answers during the group discussion. Key discussion points were captured on a flipchart, and I solicited clarification when points made were not clear. Moreover, information was also captured through mapping activities with colour-coded sticky dots for individual and small group input.

I organised evaluation data for Part I into general themes. The themes were further analysed from the specific positions in institutional hierarchy. I approached evaluation and reporting process as one of the functions of the non-profit sector that has implications for other functions including supporting community participation in action for health equity and justice. I examined health promotion processes by different people in

their various professional roles at different levels of organizational hierarchy. I began with the actualities of evaluation and reporting processes in order to understand them through the lens of experience of community frontline workers and volunteers, and to assess how they are brought into being as a coordinated set of activities (Mykhalovskiy and McCoy, 2002). I read individual practitioners' interview transcripts for common themes and to sketch institutional relations revealed in the interviewees' speech. I organised preliminary analysis of the key emerging themes and mapped out institutional relations that shape evaluation of and reporting on health promotion and community development activities in community health centres. These themes represented the challenging or difficult moments in the evaluation process as described by practitioners and contributed to identifying 'the problematic' of the research (Wilson and Pence, 2006; Campbell and Gregor, 2002).

I then examined such themes in more depth and from different angles using texts and accounts of various people involved in a particular 'theme' from their specific locations in the evaluation process. I paid attention to "the presence of traces of ruling discourses" in participants' narratives about what the evaluation process entails for them (Mykhalovskiy and McCoy, 2002: 29). The intention of my analysis was not only to identify and describe themes but to understand how and why such 'themes' emerge in health promotion evaluation. For instance, I sought to uncover the details and specifics of the process that facilitate the emergence of these themes. To further understand how evaluation process is institutionally structured, I adapted and applied a conceptual framework developed by Furubo and Vestman (2011), which describes six aspects of power in evaluation process (see Chapter 3).

Summaries of the key themes, including the description of the factors and conditions that facilitate the presence of such 'themes' in the evaluation process, were shared with the Research Advisory Team in regular monthly meetings. The views of the Advisory Team members further guided my data interpretation and helped in the preparation of materials and activities for group discussions to facilitate a deeper inquiry into the nature of and relationships between the themes. Sharing of the preliminary themes with the Research Advisory Team constituted an important validity procedure,

i.e., member checking (Creswell and Miller, 2000). I address validity procedure in more depth later in this chapter.

Findings on the evaluation and reporting process (Part I) are organized around three major topics: i) funding relations in the context of accountability; ii) epistemological and methodological challenges; and iii) equity and justice in evaluation of community health promotion initiatives.

Funding relations and accountability models lay a foundation for the 'evaluation problematic' to occur. The issues related to funding relations and accountability models have been presented in Chapter 1. The methodological issues related to evaluation practice are organised as *particularistic case studies,* where each case study is focused on a particular situation, event, program, or phenomenon related to evaluation of health promotion initiatives and presents an illustration of the key epistemological and methodological issues in evaluation process while telling the story of why and how such issues are structured at a system level (Merriam, 2009). Funding relations supporting a functional form of accountability facilitate a number of epistemological and methodological issues in health promotion evaluation that in turn impact health equity and justice. The lessons learned in relation to equitable evaluation practice provided a foundation for participatory action on the research findings of the evaluation process of Part I. Conventional research and evaluation are generally framed from the position of funders and administrators, yet it is the frontline workers and community members who experience evaluation and reporting as well as the consequences of the decisions made or not made in response to the information generated through the reporting and evaluation process. To reverse the top-down flow of the evaluation and reporting requirements, Part II of the research project focused on building capacity for program evaluation design among community activists involved in collaborative action on health equity and justice.

Part 2: Evaluating Participation in Collaborative Action through the Lens of Participatory Community Evaluation Framework

As the research progressed from evaluation analysis (Part I) to evaluation design (Part II), two distinct steps in Part II emerged: Step 1 - Supporting grassroot action:

designing community driven evaluation and Step 2 - Evaluating participation: Implementing a community designed-evaluation framework (see Figure 2 above).

Institutional ethnographic examination of evaluation practices (Part I) pointed to weaknesses and challenges inherent in the conventional approach of evaluation processes in community-based health promotion. It particularly showed how organizational and institutional structures impeded the application of participatory approaches and equitable distribution of power in evaluation. Part II of the research aim at transforming evaluation practice and power distribution in collaborative community-based action. Consistent with participatory action research's commitment to change social structures maintaining oppression and marginalization, including but not limited to extractivist forms of research, I designed the research to maximise knowledge mobilization at each step while minimising data extraction. While Part I on evaluation practices was focused on data collection, Part II was increasingly focused on knowledge mobilization expressed in its final phase as the implementation of research-informed action that directly involved community participating in the research itself.

Community activists associated with two community health centres participating in the data gathering of evaluation practices (Part II) were invited to a series of interactive workshops to assist them with designing evaluation frameworks for their respective projects, i.e. community initiatives. Three community groups, one from CHC A and two from CHC B, showed interests. Due to scheduling difficulties and the availability of group members, the group associated with CHC A dropped out of the research after the first workshop and data were eliminated from the research data pool. Community members representing the groups associated with CHC B remained in the research until its completion and were respectively referred to as "The Neighbourhood Table" and "Residents in Action". Members from each group joined the Research Action Team on Evaluation to participate in evaluation design workshops. Both groups participated in Step 1 establishing participatory design of a community-driven evaluation framework.

As the research continued, funding conditions affected the sustainability of the "Residents in Action" group. The group dissolved at the end of the Step 1 of the

research project,[11] and many of its members stayed involved with the "Neighbourhood Table" as 'resident-members' to continue their involvement in community action and in this research. Step 2 presents the implementation phase of the community-designed evaluation framework developed by the community members of the "Neighbourhood Table." It offers in-depth case study of the factors and conditions surrounding non-profit community partnerships enabling or impeding participatory approaches in community-based non-profit practice. As I was involved in the process of facilitating the implementation of community developed evaluation frameworks while being a researcher, I attempted to remain as transparent as possible about the extent and boundaries of the data collection and my involvement as a researcher. As of February 2019, I clarified that from this date the data that was collected as part of the "Neighbourhood Table" evaluation process are no longer part of my research data. However, my observations of the evaluation implementation process and the reflection on my role as a community-based evaluation facilitator are part of my data.

At the beginning of the design of an evaluation framework (Part 2), I developed a decision-making process worksheet to establish a common agenda and the decision-making process between the individuals of the Research Action Team on Evaluation, community groups they represent and supporting non-profit organizations. Both community groups contributed collectively to the worksheet. The responses to the decision-making worksheet contributed to a Memorandum of Understanding developed for each group.

Data collection for Part II on evaluating participation involved individual interviews with community members representing community groups as well as with staff from community-based non-profit organizations supporting them, including but not limited to CHC B. It also included participatory evaluation design workshops, community story mapping sessions, and community meetings. Table 3 below presents a summary of data collection methods with the number of participants involved in each method.

[11] The funding conditions I am referring to here relate to external funding and are not part of the research project funding. "Residents in Action" was funded as a short-term community engagement project designed to increase residents' participation in collaborative community action with the local non-profit organizations as part of the "Neighbourhood Table" initiative.

Table 3: Data Collection Methods for Evaluation Participation (Part II)

Method	Number of sessions	Number of individual participants
Individual interviews	8	8
Participatory workshops	5	8 – 14*
Community story mapping sessions	4	4 – 12*
Community meetings	8	4 – 16*

*The range indicates that the number of participants varied depending on a meeting/session i.e., the least and the greatest number of people who took part respectively in the data collection in each method.

In conducting interviews and participatory workshops, I followed the same principle as in the first part on evaluation research, i.e., coding research participants according to their roles as community volunteers, frontline staff, managers of non-profit organizations, funders or administrators.

Participatory workshops and community story mapping sessions included only community residents who are volunteers, i.e., who did not participate in community action in their paid capacity as a non-profit organization's staff with the exception of two members, one from each group who at the time of their involvement were hired by CHC B on a short-term contract to assist with the project coordination and administrative duties. These two participants were also long-time residents of the neighbourhood involved in various community-led projects in their volunteer capacity. The complexity and tensions inherent in the transient role of community activists, who are hired by the non-profit organizations on short-term project-based contracts, is addressed in subsequent chapters. The separation of community volunteers from staff was introduced to minimise the power differential and possibilities for marginalization that can occur within participatory processes as well as to centre on the experiences of community volunteers (Kindon, Pain and Kesby, 2007). Conducting the workshops exclusively for community members also reduced the potential bias towards views and perspectives of those participants who represent organizations. For the same reason, I conducted participatory workshops in a 'neutral' space that was not formally associated

with any of the non-profit organizations involved with the groups. I must acknowledge that the power differential was nevertheless present among participants due to the differences in their positionality, social location and experience with community work. During participatory workshops and group discussions, I had to pay careful attention to the dynamics and tensions between group members. I used facilitation techniques that encouraged participants to acknowledge their respective strengths and contributions and to clarify the areas of potential or existing misunderstandings in relation to their roles and the extent of involvement and perceived 'positions' within the groups. Such details are discussed and contextualised in Chapters 3 and 4 that specifically deal with issues of equity, power and privilege in participatory processes.

Participatory workshops were designed in a way that allowed building capacity in program evaluation among community activists with little or no experience in evaluation while supporting the discussion around goals, values, priorities and methodology of the evaluation process among workshop participants. Such workshop design is informed by participatory action research and seeks to replace extractivist models of social research that are aimed exclusively at data collection with a generative approach to benefit community members involved (Kindon, Pain and Kesby, 2007).

Findings on evaluation (Part I) were used to develop materials for participatory workshops (in Part II) and were presented to community members in an accessible format with the focus on their application in the context of participating community groups. Two additional community story mapping sessions with each participating group were conducted to capture the history of community groups as the timeframe of participatory workshops was not enough to accommodate a deep level engagement among community members with the community story mapping. The data from the community story mapping sessions related to the history of community groups and their relationships with the neighbourhood-based non-profit organizations became part of the dataset in Part II. The story mapping activity proved to be especially important for my understanding of the community history, the contexts and the history of community members involvement with local action aimed at social determinants of health, and the complexity of community volunteers' roles in collaborative participatory processes. It was also an exercise of a great value for community members as it enabled their

reflection on the previous action and led to the construction of new meanings related to their present and future involvement.

It became increasingly difficult to separate data collection from data analysis in the second phase of the research. As community group members were engaged in designing evaluation frameworks for assessing their respective initiative, the issues of power differential between community members and non-profit organizations involved in collaborative action with communities became more pronounced. The issue of the quality of participation and the importance of evaluating participation through community lens became the focus of evaluative efforts. Data collection and analysis became more iterative as I was processing the information community members shared during workshops and incorporated their goals, values, priorities and indicators into the evaluation frameworks. The iterative process of data collection and analysis, and the development and adaptation of methods and tools are discussed in Chapter 4.

To maintain continuous communication and knowledge exchange between community activists, non-profit organizations involved, and myself as a researcher, and as part of research validity strategy, I presented information and solicited feedback and input at community meetings with both community volunteers and the staff of non-profit organizations. Consistent with the vision of participatory action research, I approached these meetings as spaces for facilitating critical reflection and praxis development among community volunteers and the workers of non-profit organizations involved in collaborative action for health justice. Regular community meetings throughout the evaluation framework design (Part II) were a necessary step to ensure continuous dialogue and engagement with the co-researchers as well as the development of context appropriate strategies aimed at transformation of evaluation practice and critical reflection on power dynamics that impact participation (Kindon, Pain and Kesby, 2007). Community meetings became a space where I took the responsibility to voice community members concerns with uneven power distribution and to facilitate finding of a common strategy towards reducing power imbalance by implementing participatory evaluation of the quality of participation in collaborative action. My observations and reflection on the very process of discussing power and privilege through an intersectional feminist lens became part of my research praxis development and further

informed my understanding of the nuances of power distribution in community-based participatory processes. Collaborative research process, member checking, along with prolonged engagement in the field and continuous researcher's reflexivity are important validity procedures and are consistent with constructivist and critical paradigm assumptions (Lincoln and Guba, 1985; Creswell and Miller, 2000).

Table 4 below presents a summary of the research participants with their respective roles in Part I and Part II of the project. Note, the numbers include people who participated in an individual interview and/or in a participatory workshop and/or a group discussion. This number does not include other participants of the regular meetings of The Neighbourhood Table where I presented and discussed the research findings in Part II of the project.

Table 4: Total number of research participants

Role	Number of participants
Community volunteer	15
Frontline staff	6
Manager	3
Funders/Administrator	2
Total	**26**

The analysis of participatory processes in the context of non-profit community partnerships and action for health equity and justice culminates in the discussion of participatory evaluation and its role in facilitating reflective practice development and supporting a balanced accountability system presented in Chapter 4.

As I move the present the specific findings of my research, I am concluding this chapter with a short Intermission that presents a reflection on my research project as an intellectual and spiritual journey.

Intermission 2: From the Traveler's Notebook
Research as a Journey in Search of Authenticity

In many ways, I was not able to predict the specifics of the emergent research process and had to adapt to them rather than to guide the research from point A, 'the start', to point B – 'the end'. Thinking in terms of maps and navigation, I approached this intellectual journey with a general direction in mind and some key principles of how I would conduct myself as a traveller. I did not necessarily have a rigid plan for all the stops I was going to take, I did not map out one single straight route that allowed no deviations. I had to make unplanned stops and take detours as I faced obstacles in places where I initially thought there wouldn't be any. It is exactly those unplanned yet anticipated stops and detours that facilitated the 'emergence' of research design and provided the most valuable lessons during the journey. When conceived of in a linear way, such stops and detours appear as slowing one's progress towards the desired destination, but in case of my intellectual journey, they facilitated faster progress towards the destinations I pursued. Achieving one's learning goals as a destination should not be thought of as a linear process. Often, to get to the learning goal faster, one paradoxically must slow down. In learning, it is not the speed of the steps we take that brings us to the desired destination but the depth of the steps. 'Oh, and what is your desired destination?' you may ask. Within the parameters of this dissertation, it is the understanding of the role of the non-profit sector in facilitating effective and equitable community action for health justice. The ultimate destination in my life as an intellectual and spiritual journey (for I envision human life as such) is my truest self, unplugged from the social location configurated through the ruling relations in the hierarchy of power. Unplugged yet aware and cognizant of its existence. It is in my 'unplugged' state I am best able to invite others to join their respective journeys to their most authentic and truest versions of their humanity. We may take different routes, yet we follow the same direction. And what of intersectionality, institutional ethnography and participatory action research in all of these? Well, the intersectionality lens is like a navigation aid that helps identify the barriers, the obvious and not so obvious ones, on the way towards an authentic human potential fully realized. Institutional ethnography is a tool that helps to

bring down the matrix of power because it makes visible the system that connects and constructs the barriers, the system that makes the visibility of one barrier contributing to the invisibility of the other, and combines them in a way that masks that connection. That itself is not a linear process and cannot be understood when approached in a linear way and in discrete steps. And what about the participatory action approach? It is a set of guiding principles that allow a traveller to invite other travellers on the journey towards their most authentic selves. It is an approach to a journey that makes it worthwhile, ensures the depth of the steps, and eventually brings a traveller closer to the destination point. That destination point cannot be fully achieved, at least not within one lifetime, yet the ultimate failure is not the failure to arrive, but the unwillingness to try.

Chapter 3: Funding Relations, Reporting Requirements and Accountability

The non-profit sector is vast and diverse with organizations ranging from social service delivery and healthcare to trade associations and credit unions (Reed and Howe, 1999). The sector is defined as a cluster of organizations that do not return any profit to their owners or directors and therefore intends to benefit the public good, however defined through their activities. The sector historically originated in the religious and community spheres supporting the notion of charitable giving. In the second half of 20th century the voluntary sector rapidly progressed from a charity-based approach to one based on the concepts of civil society and social justice prompted by the rise of social movements that placed emphasis on advancing a social justice agenda through influencing public policies (Phillips, 2003). Committed to values of civic participation and social justice, the sector took a more prominent role as an advocate and enabler for marginalized communities to represent their interests and participate in policy.

The non-profit sector continues to offer a venue for collective articulations of interests other than profit-making and plays an important role in civil society. Yet, such a role is not without an embedded paradox. The fact that the sector is not for profit does not mean it is immune to the influences of the neoliberal capitalist logic of unfettered profit making (Joseph, 2002). The non-profit sector, as a social structure existing within larger capitalist structures of production and accumulation, often serves to exclusively support modes of social reproduction that are necessary for supporting undisrupted capitalist processes of production and accumulation. Just as other sectors and institutions of society, in particular the public sphere and the family, the non-profit sector has also been heavily subjected to neoliberal pressures and transformations. Social justice agendas have even been coopted by the neoliberal state and the limitations the capital (Joseph, 2003; Gilmore, 2007; Hawk, 2007; Rodriguez, 2007).

This chapter looks at how neoliberalism affects funding relations in the non-profit sector and how such relations transpire in reporting requirements that are biased in favor of upward-oriented functional or fiscal accountability, albeit often presented as neutral. Such a biased accountability model undermines downward-oriented

accountability to the sector constituents, as well as horizontal accountability to community of practice and to the internal values of equity and social justice.

The focus of my inquiry is on smaller scale community-based non-profit organizations that have community development and health promotion as part of their mandate and are engaged in supporting grassroots activism towards social change. Such type of work is built from the ground up and is aimed at tackling systemic issues such as poverty, youth unemployment, food insecurity, or environmental concerns at a community level. It is often referred to as 'systems change' and it has also been most recently described by the new non-profit buzzword 'social innovation'. For the sake of simplicity and transparency, I continue to use the term 'social justice' as to keep readers aware that social justice work is essentially about systems change and community building. Social justice is always about equity and sometimes it involves social innovation.

Discourses of Accountability in the Non-Profit Sector

In the late 20th century the social and the public spheres of major industrialised capitalist economies were subjected to the process of neoliberal restructuring often presented as 'new public management' (Evans, Richmond and Shields, 2005). Neoliberal restructuring involved the downsizing of the welfare state and shifting the responsibility for the provision of many social services to the voluntary or the non-profit sector, expanding already existing contracting regime (Wolch, 1990; Phillips, 2003; Fyfe, 2005; McBride and Whiteside, 2011). The relations between the non-profit sector and the state increasingly became structured as a contract-based relationship (Wolch, 1990; Phillips, 2003) with the non-profit sector often reduced to an instrumental role where its activities are increasingly streamlined to make them more compatible with and conforming to the neoliberal rationale that praises individual effort and responsibility while obfuscating systemic inequalities. Furthermore, the neoliberal discourse emphasises efficiency, professionalism and accountability to funders rather than to the sector's constituents. Such priorities re/shaped the practices of the non-profit sector as more elitist, professionals-led and technocratic rather than equitable, democratic and participatory (Evans, Richmond and Shields, 2005). The theme of accountability has

grown strongly in the non-profit sector during the post-Keynesian period and through the process of off-loading social responsibility from the government to communities, the voluntary or charitable sector, as well as the private sector. Accountability is a ubiquitous term noted for its complexity and often has been described as a multifaceted concept. The ambiguity increases when placed within a complex context of multiple responsibilities and actors of the non-profit sector. Despite its ubiquitous presence in the public discourse, the theoretical discussion of accountability in relation to non-profit sector is relatively recent (Ospina, Diaz and O'Sullivan, 2002; Williams and Taylor, 2013).

Accountability is a relational concept (Williams and Taylor, 2013). It is generally defined as a process within a principal agent relationship, where the agent is held accountable against certain predetermined standards by the principal (Baez Camargo and Jacobs, 2013). Such form of accountability is also described as conventional or functional and is often synonymous with fiscal and administrative accountability when the agent reports to the principal on the budget spent in relation to the agent's outputs. The direction of such accountability is vertical with an upward orientation within an organizational hierarchy (Larkin and Reimpell, 2012). Such orientation is reinforced through the contractual or legal locus of accountability, meaning that principal and agent are bound by an agreement within which the agent provides information requested as part of accountability process in exchange for funds from the principal. Such agreement is simply referred to as 'funding agreement' in the context of the non-profit sector. However, while the direction of accountability in a vertical hierarchy is upward with a purpose to increase administrative and bureaucratic control, it could also be downward with the purpose of increasing public control. Other forms of accountability are possible, most notably social accountability which serves to strengthen civic engagement and refers to formal and informal mechanisms that enable citizen to bring service providers to account (Malena, Forster and Singh, 2004; Baez Camargo and Jacobs, 2013). Social accountability is distinguished from conventional forms of accountability by the direct participation of citizens in activating and reinforcing accountability mechanisms (Malena, Forster and Singh, 2004). The locus of social accountability is moral as there are not necessarily formal institutional arrangements present to reinforce such accountability;

the accountability is reinforced through the beliefs and convictions of the participating parties (Murray, 1994). However, 'social accountability' is often a misnomer since it refers to a particular approach as a set of mechanisms and practices to achieve such accountability rather than a particular type of accountability per se (Malena, Forster and Singh, 2004). There is also the notion of peer accountability, where the agent is accountable to the principal who is peer-based on shared values rather than to a principal in a position of authority. Geer, Maher and Cole (2008) cite the notion of internal or value driven accountability (associated with felt responsibility) as the highest form of accountability as people are most accountable to what they believe in. This sentiment is echoed by Patton (2006) who states that for social innovators the highest form of accountability is internal. Internal or value-driven accountability challenges the external focus of conventional accountability models directed at external authorities and/or funders (Patton, 2006). Both internal and peer accountability are located on the continuum between legal and moral loci and depending on their formal arrangements, there may be a certain degree of legal reinforcement. For example, peer or professional accountability is often reinforced as part of organizational or institutional policy in relation to one's compliance to the standards of professional practice.

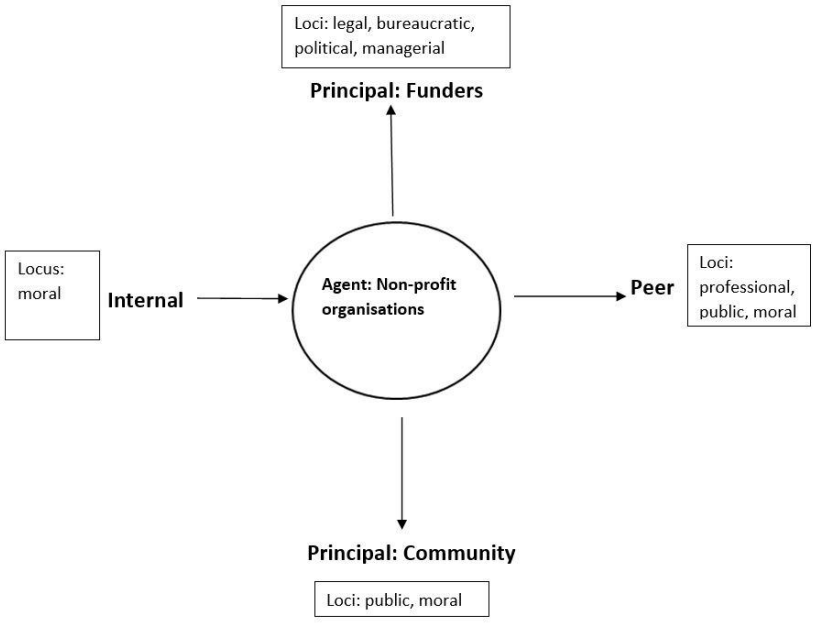
In the vertical agent-principal relationship, the non-profit organizations are peculiarly located between two principals: the funders and the communities. Although, non-profit organizations as agents are accountable to the community, the institutional hierarchy imposes an upward accountability orientation reinforced by the dependence of the grantee to the funder. To further complicate matters, the non-profit community-based agencies are often power-holders at the community level, representing institutions under which they function and having access to resources that they distribute within the communities. Their intermediary position puts non-profit organizations in a 'principal' role as well as in an 'agent' role. Such arrangements make non-profit organizations answerable to the community while simultaneously making the community answerable to them. Although it could be argued that such a circular arrangement strengthens social accountability through promoting the participation of community members in the activation of accountability mechanisms, in the hierarchical institutional setting only the upward orientation of accountability towards funders is

fiscally reinforced as the very existence of the non-profits depends on their accountability to funders.

The difficult position of the non-profits on the axis of accountability illustrates the multifaceted nature of accountability and its varying loci. Many scholars recognized that multiple levels and orientations of non-profit organizations' accountability (e.g., upward, downward and lateral/horizontal) may in fact conflict with each other (Williams and Taylor, 2013). In such multifaceted context, there is a danger in adopting narrow interpretations of accountability and there is an inherent equity issue in the reductionist approach consistent with new public management framework. Within the contractual regime consistent with new public management, accountability is reduced to fiscal and administrative forms of accountability to 'money-holders'. The new public management accountability model is based on market driven values and when applied to the public and non-profit sectors, it prioritises efficiency and performance measurements (Williamson and Taylor, 2013). Specific to the non-profit sector, O'Dwyer and Unerman (2008) describe the accountability framework between donors and grantees as hierarchical with the goals of controllability and performance measurements. Evans, Richmond and Shields (2005) point to the risks of such narrow interpretation of accountability. The moment when the non-profit sector is mandated to satisfy funders, who represent a very small segment of a much broader population, the concept of accountability is immediately in danger of cooptation. Upward-oriented vertical accountability in a hierarchical environment conflicts with other forms of accountability that are downward-oriented or more horizontally distributed as in accountability to peers and/or constituents, and/or inward-directed as in accountability to organizational values. In other words, in a hierarchical environment with the non-profit sector positioned between those who have power and resources (i.e., funders and donors), upward driven accountability undermines accountability to those with less power and resources (i.e., communities). The conventional accountability model emphasises satisfying funder-driven reporting requirements and quality improvement protocols where targets and benchmarks are established by funders and higher-level auditing institutions that do not necessarily reflect community priorities and needs. Funders may lack internal mechanisms to prevent such dynamic under the pressure to enhance and monitor fiscal

accountability. As a result, an increased emphasis on fiscal accountability and performance measurements might undermine the social accountability and answerability of the non-profit sector to its constituents, to their peers and even to their own goals and values (see Figure 3).

Figure 4: Forms, Directions and Loci of Accountability in the Non-Profit Sector



Reporting Requirements of Community Health Centres

Examining funding relations and reporting requirements for CHCs, I argue that reporting requirements of the core funder are consistent with a public management accountability model and prioritise the conventional form of functional/fiscal accountability with its goals of performance measurement. Such relations potentially limit other forms of accountability such as social accountability to constituents or peer and internal value-driven accountability that prioritise citizen participation, long-term outcomes and organizational learning.

Reporting requirements contribute to setting the agenda for evaluative and other activities of CHCs in relation to community health promotion. Yet, reporting is different

from evaluation in a sense that although it is used for evaluation or assessment purposes, it represents an activity that is narrower in scope than evaluation. Reporting is maintained to ensure fiscal and administrative accountability and collect data on the nature, the scope, the reach of the services provided, and resource allocations. The information collected through the reporting mechanisms is used for a high-level evaluation that may involve cost-benefit analysis, comparisons between individual organizations and/or between sectors, budget projections and so on. Evaluation as a process has a broader focus of understanding how and to what extent the services/activities and initiatives create an intended change, and whether it applies to individual conditions and behaviours or to a wider community and population contexts. The Canadian Evaluation Society (2015) defines evaluation as the systematic assessment of the design, implementation or results of an initiative for the purpose of learning or decision-making. The purposes of evaluation may vary and include making judgments of success or failure, new knowledge development, organizational development and learning, quality improvement and capacity building to name a few. Much of the evaluation work is carried out to fulfill funder reporting requirements and remains within funder mandated accountability systems. For example, performance measurements are the simplest form of evaluation that are directly tied to institutional accountability systems (i.e., reporting requirements), and are integrated as part of program and organizational management (Taylor and Liadsky, 2016).

Before delving into the complexities of evaluation processes in non-profit community-based organizations, it is both useful and necessary to look closely at reporting requirements applied to non-profit organizations. Reporting requirements set the backdrop for organizations' day to day operations and activities and the very existence of the organizations that funding is tied to fulfilling the requirements of reporting templates. As part of an institutional accountability system, reporting requirements are aligned with an institutional framework within which organizations carry out their respective activities including, but not limited to, evaluative activities. Although evaluations may go beyond reporting requirements guided by the intrinsic interest in organizational learning and practice development, in times of fiscal constraint, ever shrinking resources and pressures to increase productivity and efficiency,

evaluation is the reflective aspect of the practice that is most likely to be downsized. Reflection is not a 'unit-producing' service, nor can the results of reflection and learning be easily quantified as tangible 'outputs'. With lessened opportunities for evaluative learning and reflection, organizational evaluation practices are adapted to fit the reporting requirements. What does not fit the reporting requirements is not reported and therefore is not visible to the institution. However, what is not visible does not get funded and what is not funded ceases to exist as an organizational activity/output and eventually is offloaded to communities to deal with at the grassroot level.

CHCs are considered a healthcare service agency and are under the federal jurisdiction of Health Canada and the Canadian Institute for Health Information, and provincially under the Ontario Ministry of Health and Long-Term Care (MOHLT) and the Local Health Integration Network (LHIN). LHINs are planning, funding and coordinating bodies for home and community care services delivered through partnerships with hospitals, community support services, long-term care, mental health and addiction services, and community health centres (Toronto Central Local Health Integration Network, 2014). LHINs provide core funding for the services provided by CHCs across the province. To supplement LHIN funding, CHCs often seek additional sources from other non-profit foundations and governmental bodies to provide for initiatives that fulfill their community engagement mandate. Charitable foundations such as the Ontario Trillium Foundation and United Way often become the source of funding for project-based initiatives to support community development, capacity building and various other community-based initiative with a broader scope of addressing social determinants of health, often in partnership with other non-profit community-based agencies.

This section reviews reporting requirements from LHIN as the core funding agency and the Ontario Trillium Foundation (OTF) as the frequent supplemental source of funding in relation to how they shape and inform the evaluation of community health promotion activities. There are two types of community health promotion activities at CHCs: community initiatives and personal development groups. Fundamental differences between these two types of activities are important for understanding the breadth and depth of CHCs health promotion outputs. Community initiatives are defined as set of activities aimed at strengthening the capacity of the community to address

factors affecting its collective health through the active involvement of community members and grassroots groups in identifying and changing conditions that shape their lives and health prospects as a group (Association of Ontario Health Centres, n.d.). Personal development groups are defined as sessions intended to effect changes in individual participants' behaviours, knowledge or attitudes (AOHC, n.d.). The Community Initiatives Resource Tool developed by the Association of Ontario Health Centres describes community initiatives as non-linear in nature, with shifting participation, goals and objectives during the implementation process which focusses on the participation of community members and therefore might change the goals of community initiatives.

Personal development groups are, on the other hand, structured with content and activities defined in advance; they are open to a fixed, pre-determined number of participants, and led by CHC professionals. Personal development groups can also be unstructured and of indeterminant length, with open membership. To highlight the differences between the two types of initiatives, a comparative table from the Association of Ontario Health Centers (n.d., 4-5) is reproduced below.

Table 5: Community Initiatives vs. Personal Development Groups

Community Initiatives, generally	Personal Development Groups, generally
Seek collective and/or social, environmental, policy change	Seek individual change
Often have no predetermined time limit	Tend to be time-limited
Intended to benefit community or group as a whole	Intended to benefit individual participants (often a fixed number identified)
Key strategies include advocacy, community organizing, political action, etc.	Education is the key strategy
Involves working with community members and supporting Community leadership wherever possible	Professionally (or volunteer led)
Activities may evolve over time	Activities/content defined in advance

Community initiatives are focussed on facilitating community participation in a collective action aimed at transforming a wide range of environments (physical, social, economic and political) impacting community health and wellbeing. Overall community initiatives can be described as social innovations operating at the community level and aimed at systemic changes. Their sensitivity to local contexts and their adaptive capacity explain their 'emerging' nature. Community initiatives are closely aligned with health promotion goals and objectives as outlined in Ottawa Charter for Health Promotion (1986), which states:

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

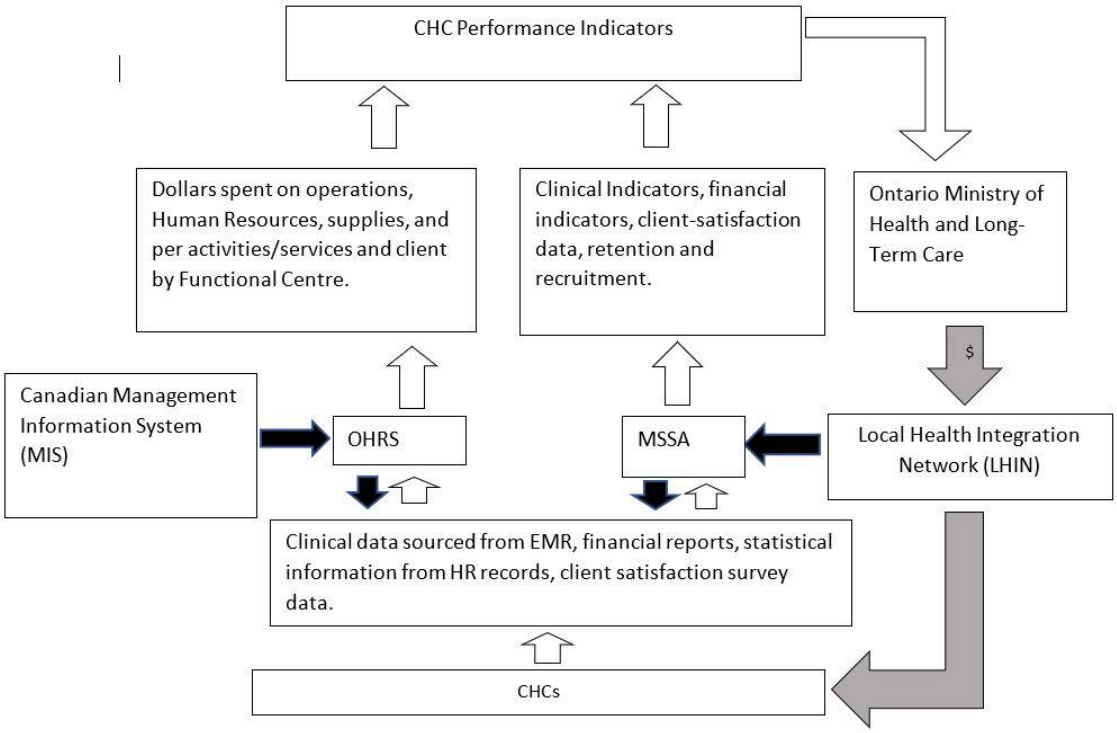
Most importantly, community initiatives are an important part of the evidence-informed Model of Health and Wellbeing developed by the Alliance of Healthier Communities (formerly AOHC) to guide the delivery of care by community-governed primary health care organizations such as CHCs. Within such model, health is defined as *"*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 2017).

Local Health Integration Network Reporting Requirements

The two key documents guiding the reporting for CHCs are Multi-Sector Service Accountability Agreement (MSAA) and Ontario Healthcare Reporting Standards (OHRS). The purpose of both documents is to ensure the financial accountability and performance measurements of the health service agencies, including but not limited to CHCs. The MSAA also establishes the funding and service relationships between health services providers and the Local Health Integration Network (LHIN). Both documents comprise the reporting system reinforced and supervised by the Ontario Ministry of Health and Long-term Care through Local Health Integration Networks. In 2017, there was fourteen regional Local Health Integration Networks across the province, but as my research is focussed on urban CHCs in Toronto I am therefore

referring here primarily to Toronto Central LHIN. A Multi-Sector Service Accountability Agreement (MSAA) is signed between CHCs and Local Health Integration Network (LHIN). Figure 4 below describes the flow of data in exchange of funding. The black arrows demonstrate the origins of the reporting requirements, the white arrows indicate the flow of data in response to the reporting requirements and the grey arrows indicate the flow of funding in exchange of data.

Figure 5: Community Health Centres Reporting Requirements and Flows of Data



CHCs are required to submit OHRS-compliant financial, statistical and balance sheet account information in a trial balance format to Ontario Healthcare Financial and Statistical (OHFS) database on a quarterly basis. In addition to data collected through OHRS, MSAA indicators are generated by two streams of data: financial and statistical data from OHRS and clinical data collected through the Electronic Medical Records system, as well as client recruitment, retention and satisfaction rates (AOHC

administrative staff, 2017). The two streams of data inform CHC performance indicators as outlined in MSAA. My understanding of OHRS and MSAA documents is informed by a close reading, formal interviews and additional follow up conversations with two higher-level administration staff working at AOHC in order to better understand what kinds and levels of data are reported about community health promotion.

Ontario Healthcare Reporting Standards

The Ontario Healthcare Reporting Standards (OHRS) is the main document that guides provincial financial and statistical data collection for all health care organizations for reporting purposes. OHRS are classified as a data source for financial, statistical and data usage information, and are part of the Ontario standards for Management Information System in Canadian Health Service Organizations (hereafter MIS Standards). The MIS standards apply to all health service organizations and are a set of national standards for the gathering financial and statistical data on day-to-day operations of health service organizations, while also providing a framework for integrating clinical and financial data (Ontario Ministry of Health and Long-term Care, 2012).

Healthcare organizations required to submit data through OHRS include public and private hospitals, Community Care Access Centres, Children's Treatment Centres, Community Mental Health and Addictions Organizations, Community Support Services, Long-Term Care Homes, and CHCs. The reporting standards dedicate a chapter to CHCs, and the OHRS version 10.1 (2017: 4) "has been developed to address matters that are unique to Community Health Centres or for situations where it is appropriate to provide different requirements for Community Health Centres." The wording of the document recognises the preventative aspect of CHCs' work and their mandate to address social determinants of health:

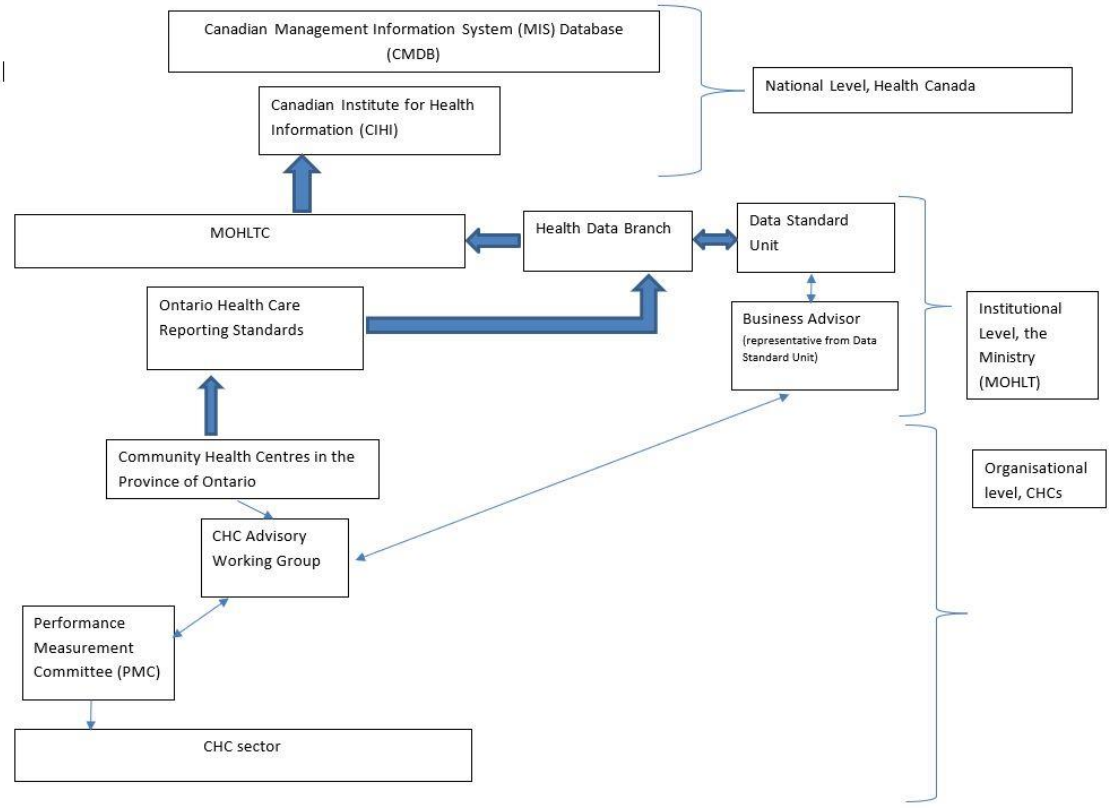
> CHCs are not-for profit, community governed organizations that offer a range of comprehensive primary healthcare, health promotion, and community development services in diverse communities across Ontario. Services within CHCs are structured and designed to eliminate system-wide barriers to accessing healthcare. Working through a health equity lens, CHCs focus on care that is comprehensive; accessible; client and community-centered; inter-professional; integrated; community-governed; inclusive of the social

determinants of health; and grounded in a community development approach. Programs and services are delivered by inter-professional teams working in collaborative practice (OHRS, 2017, 4-5).

Each health care organization reporting to OHRS has an advisory committee or working group with representatives. For the CHCs, it is generally an CHC Advisory Working Group. According to OHRS (2017: 6), [f]or the CHC sector recommendations on the relevant data elements and definitions, data collection rules, and reporting requirements are brought forward by the CHC Advisory Working Group for review and discussion at the Data Standards Review Working Group in the Data Standards Unit, Health Data Branch."

Figure 6 depicts the levels and relationships between the different levels of reporting requirements for healthcare organizations. The thick arrows indicate the flow of information, and the thin arrows indicate communication taking place between advisory groups representing various levels in the reporting hierarchy.

Figure 6: Reporting Requirements and Flows of Communication



A CHC Advisory Committee Working group communicates with Data Standard Unit via a 'Business Advisor' as well as with the Performance Measurement Committee that representatives from the CHCs. The flow of communication is mostly in a top-down direction where Performance Measurement Committee is mostly informed about the decisions made at the Ministry level (Administrative Officer, 2017).

The main purpose of OHRS is fiscal accountability to the Ministry of Health and Long-Term Care (hereafter the Ministry) and the primary focus of OHRS reporting is on cost/benefit analysis. The cost/benefit calculations apply to 'functional centres', the main units for analysis in OHRS. Understanding the meaning and the purpose of a 'functional centre' becomes imperative to be able to read and make sense of OHRS as a text.

The ministerial Health Analyst's Toolkit defines functional centres as subdivisions of an organization that are used to account for revenues, expenses, and statistics pertaining to the function or activity being carried out, and which are used to capture the costs of labour, supplies, and equipment required to perform specific functions (MOHLTC, 2012). There are four functional centres dealing with health promotion under the CHC: community health; promotion; education; and community development. These functional centres are intended to capture and track costs and activities associated with health promotion, illness prevention, and community development initiatives that address social determinants of health and that take place in group and community setting and thus do not include any direct service provision (OHRS, 2017).

As it became evident through interviews with administrative staff and the analysis of the OHRS text, the use of the functional centres in CHC context is problematic for a number of reasons. The concept of a 'functional centre' was created for health service agencies that are more clinical in nature (e.g., hospitals, Children Treatment Centres, Community Care Access Centres) and where activities target individuals with identified pathologies or disabilities, whether permanent or temporary. As an administrative officer (2017) explains, "CHCs must report the level of activity they are producing within a functional centre, and a functional centre… [could be] an equivalent to a department."

Only the individuals with 'registered client' status with a CHC are counted under each functional centre. Therefore, "group activities with non-registered clients will not be

counted in under functional centres. The LHIN only wants the account of the number of people that are registered to the CHC" (Administrative Officer, 2017). OHRS captures only registered clients while community initiatives usually involve residents in the community regardless of their registration status with a CHC. Moreover, for the functional centre that addresses community engagement and capacity building, the Ministry requests only data related to expenditures on community initiatives. The Ministry processes the data in the isolation from the outputs and outcomes of community initiatives. There is simply no box in the template to report community initiatives related outputs and outcomes. Such arrangement peculiarly exists only for the specific functional centre that applies to community initiatives with a broad focus and addressing social determinants of health rather than individual lifestyles and behaviours. As an administrative officer (2018) explains:

> OHRS right now is not asking us any data on community initiatives, there is only an account on OHRS that has any relation to community initiatives and it only asks for budget, so money spent on the community initiatives and no information about community information whatsoever… The only thing that counts in OHRS in relation to community initiatives are the money you spend. You can't put in any account of clients, or activities, all they want to know is how much money you spent on it.

The matter is clearly structural because the current reporting structure simply does not allow entering information in relation to outputs of community initiatives and what one cannot enter in the reporting template is not counted.

Other functional centres in the health promotion category apply to structured personal development groups that address chronic disease prevention and individual lifestyles/behaviours and target registered clients. Unlike in the functional centre that deals with community initiatives' budget, both costs and activities are captured under these functional centres.

Functional centres as a key element of the OHRS reporting structure are problematic for CHCs for many reasons. Firstly, reporting structures pathologize CHCs clients and activities as it is easier to fit the activities within a 'functional centre' when those activities are focused on a pathology or a disease rather than on a broader concept of wellbeing. Secondly, functional centres prioritise activities with 'registered

clients' rather than with broader community thus framing community members as 'clients' or 'patients' rather than citizens or active participants in the processes that enable people to take control over the conditions that shape their health. Thirdly, functional centres preclude interdisciplinary work by structuring the work along professional boundaries. Much of the community health promotion work is interdisciplinary in nature, whether taking place in a structured format of personal development or in a more flexible format of community initiatives. Such work relies on members from different teams, including the clinical team. Involving clinicians in community health promotion works is likely to be interpreted as 'expensive' as such work does not produce individual encounters but increases the costs for the functional centre.

Multi-Sector Service Accountability Agreement

The Local Health System Integration Act (2006) requires that the Ministry and each LHIN enter into an accountability agreement in respect of the local health system. Currently, reporting relationships between CHCs and LHIN are covered by the Multi-Sector Service Accountability Agreement (MSAA) 2014-2017. The purpose of the MSAA is to establish the respective performance obligations of the Ministry and LHINs relating to key operational and funding expectations.

According to the 2014-2017 MSAA, there are two types of performance indicators: core indicators for all health care agencies and sector specific indicators for each health care service sector, including CHCs. In addition to core performance indicators there are also explanatory indicators that provide contextual information for the core indicators but do not have numerical performance targets established. However, once the Ministry sets the performance target, the explanatory indicators may become core indicators. Core performance indicators are informed by functional centres data in OHRS and emphasise the financial accountability and the efficiency of clinical service delivery.

It appears that none of the performance indicators in MSAA reflect the community health promotion aspect of the CHC activities. The 'non-primary care activities' indicator of CHCs is misleading as it only pertains to non-primary care

activities carried out by primary care staff. The indicator description states that "[t]he Full-Time Employment proportion of Medical Doctors, Nurse Practitioners and Physician Assistants time spent on non-primary care activities… includes time spent in clinical management, teaching/research, and or community development activities" (Multi-Sector Service Accountability Agreement, 2015: 115). The 'comments' section then explains that non-primary community development activities may be "other activities such as broad community outreach activities, personal development activities, advocacy, management, research activities or other activities not specifically related to client care" (Multi-Sector Service Accountability Agreement, 2015: 116).

Although primary care staff may be occasionally involved as guest speakers in personal development groups or in research activities and other activities not related to primary care, the bulk of non-primary care work is carried out by the primary health care and allied staff, such as community dietitians, social workers, community health promoters/health workers and community development workers. However, none of the roles and activities related to such roles can be found in the MSAA.

One of the indicators that has clear implications for health equity is the 'non-insured clients' category capturing the number of people without Ontario health insurance having access to health care through CHCs. Yet, it is an explanatory rather than a core indicator and its purpose is to explain to the Ministry why CHCs may not be at 100% of their panel size describing the nature of other activities involved in primary care provision, e.g., health education, advocacy, and interdisciplinary work.

Discussing Reporting Requirements from the Core Funder

The analysis of OHRS and MSAA documentation demonstrates that reporting requirements for CHCs from their core funder, i.e., LHIN and the Ministry, are shaped in a way that intends to capture clinical outputs of CHCs activities but not their community health promotion related outputs, including both personal development groups and community initiatives. It is clear from MSAA performance indicators that they are focussed on registered primary care clients only, i.e., those who are rostered clients with a physician or a nurse practitioner. The indicators do not reflect the work of CHCs done with the broader community and especially the work around community initiatives

addressing social determinants of health, health equity and justice work. Yet, the implications for CHCs when they are not meeting MSSA indicators are significant as their funding is tied to MSSA performance indicators and the flow of data in exchange of funding as depicted earlier.

OHRS and MSAA are part of the reporting system that is focussed on the value for money, and it applies what an administration officer (2017) describes as “matching principle” where in most cases healthcare organizations report on the activities and services delivered in relation to the money spent. While this principle applies to clinical services and health education programs, it does not apply to initiatives related to social determinants of health.

Reporting requirements are structured in a way that captures only expenses in relation to community initiatives, and CHCs that implement significant number of these initiatives look like ‘big spenders’ as they have to report on the money spent but have no account to report on the activities in relation to these investments. OHRS only captures the budgetary amount spent towards community initiatives, i.e., the costs of staff time facilitating community meetings and ensuring access by providing space, food, childcare and transportation subsidies but it does not capture the activities in relation to those expenses. Moreover, even in the case of structured health promotion initiatives such as personal development groups where CHCs can report the number of registered clients and non-registered clients, if any, all costing analysis is based on registered clients only. Constrained within inadequate reporting templates that seem to have missing important ‘boxes’ for capturing significant portion of CHCs work related to health promotion, CHCs are not able to demonstrate the full scope of their work. As an administrative officer (2018) contends:

> Now this is where we don’t fit in their box, we are the round peg in the square hole. They try to get us into the same system as them and we never fit, and we keep having to change the standards to meet our needs, now when they analyse our data, they are still analysing them the way they analyse other ones, our costs look so high. Because we really don’t fit in there.

CHCs that spend a significant amount of their resources working with populations that are hard to register, e.g., people with precarious immigration status, homeless or near homeless people, and/or running community initiatives targeting

social determinants of health at community level are likely to look ‘frivolous’ in their expenses compared to the CHCs that limit their services and programs to those purely clinical in nature and directed only at registered clients.

In the absence of the appropriate ‘boxes’ on reporting templates that would allow CHCs to enter data respective of all their activities, CHCs try to modify their activities to make their ‘outputs’ more compatible with the reporting system and to reorient their activities towards those that are focused on registered clients and are more structured in nature, targeting specific health issues, lifestyles or behaviours. Yet the fundamental premise of the CHC Model of Health and Wellbeing is to serve the whole community. This unique aspect of CHCs model of care that stands them apart from other health care organizations is acknowledged in the most recent report of the Auditor General of Ontario (2017):

> CHCs stand out from other models of primary care... because they deliver medical services under the same roof as health promotion and community programs… The goal of CHCs is to keep people in the communities where they live in good health" (quoted in AOHC, 2017: 180, 184).

Contrary to the CHC Model of Health and Wellbeing, the reporting requirements are based on a clinical model and biomedical view of health, as an ‘absence of disease’ where being a client means being a patient who presents a disease, illness or any other form of pathology. As an administrative officer (2017) notes:

> [t]he OHRS concept is based on a clinical model. For those working in clinical model they are all registered clients, and this is why they don’t have this issue. The people they are going to be spending their money on are people who come to their centres for the treatment. That’s where they don’t understand that we go beyond that.

The inadequacy of such reporting requirements is not new to the sector. The issue of community health promotion outputs is brought up regularly at various advisory tables. However, historically the decisions related to the implementation of the performance indicators specific to community health promotion outputs (described in the sector as community initiatives) were constrained by the LHIN Provincial Strategic Framework and Logic Model (LHIN, 2014). Section 1 of the framework, titled ‘Snapshot of the System Priorities for Ontario’ sets three provincial priorities: i) support to become

healthier; ii) faster access and a stronger link to family health care; and iii) the right care at the right time in the right place.

At this level CHCs fit right in as organizations that provide community based primary health care services and programs to support people to lead healthier lives. In the next level on the framework there are four 'System Imperatives', which are: i) leading with quality and safety; ii) strengthening and enhancing access to primary care; iii) enhancing coordination and transitions of care; and iv) maintaining achievements in access, accountability and safety. Perhaps here is where some of the CHCs woes originate. CHCs are not focussed on exclusively 'primary care', which is the access to family physician, nurse and/or a nurse practitioner. CHCs provide access to an expanded team defined as 'primary health care' that include other health care providers, such as dietitians, social workers or therapists, chiropodists, occupational therapists, physiotherapists to name only a few. These health care providers address health related issues that are outside primary care scope of practice. In addition, CHCs employ community health workers, health promoters, youth workers, and community development workers addressing social determinants of health at the community level. Such expanded teams involved in interdisciplinary work ensure a holistic approach to health care within CHCs.

The third level on the framework, 'Continuum of care' cuts through the stated priorities and system imperatives. There are three stages on the continuum: 'Prevention and Promotion', 'Acute', and 'Recovery and Maintenance'. Not knowing the details of OHRS and MSAA reporting, one would assume that community health promotion or community initiatives related outputs of CHCs fall under the first continuum stage of 'Prevention and Promotion.' Yet the next layer identifies the following areas of focus under each stage of the continuum:

- Chronic Disease Management
- Seniors Strategy
- Health Links
- Mental Health and Addictions Strategy
- Palliative Care
- Standardisation and Sustainability
- ED/ELC (Home First, etc.)
- Wait Times Strategy.

It is surprising to see ‘Chronic Disease Management’ but not ‘prevention’ under the Prevention and Promotion stage of the ‘Continuum of Care’ as if the framework assumes that chronic disease *prevention* falls outside the scope of health care sector. But perhaps it is assumed that the health care system deals with sick people, so why would the health service agencies pay attention to those who is not yet formally recognised as being in the state of ill health?

The areas of focus are organized around nine health system attributes:

- Accessible
- Effective
- Safe
- Patient-centered
- Equitable
- Integrated
- Efficient
- Population health focus
- Appropriately resourced.

Further the framework outlines three intended health system impacts:

- Improve Population Health
- Improve Experience with the Health System
- Improve Sustainability of the Health System.

The CHC Model of Health and Wellbeing (formerly known as CHC Model of Care) goes a step farther of the current provincial framework by being not only ‘patient-centred’ but community centred and by focussing on the needs of the whole community and not only on the needs of its registered clients, or formally recognised ‘patients’ of the CHC.

Section 2 of the framework provides “A Provincial Roadmap for Measuring and Achieving Health System Priorities”. This part of the framework identifies pathways to achieving health system impacts identified above through short-term and long-term outcome objectives established for each area of focus and aligned with four system imperatives.

Perhaps the inadequacy of the reporting requirements for CHCs work is best explained by the fact that the LHIN provincial framework and logic model does not

contain intended system impacts related to health promotion and equity. Surprisingly, the only outcome objective that relates to health equity, '[t]o improve access to population focused networks of care', is listed under 'Improve Experience with the Health System' impact and has two CHC specific indicators 'the access to care for non-insured clients' and 'cultural interpretation'. Yet neither of those are performance indicators, they are explanatory to the Access to Primary Care as a core indicator. While these indicators are undoubtedly important for demonstrating CHCs work with the most vulnerable community members, they alone do not reflect the breadth and depth of the health equity and justice related activities, especially those kinds of activities that enable access for non-insured people to CHC services in the first place.

There are unfortunately no categories in the framework where community health promotion fits. The framework is premised on the 'primary care' model aimed at individual ill health. There is little room in this framework for prevention at the community level and expanded primary health care model that accounts for care delivered by the expanded team of professionals that includes social workers/therapists, dietitians, chiropodists, or occupational therapists. There are no categories in this framework to include the work of the health promotion program staff, such as community health workers, youth workers, and community engagement workers who along with the primary health care team help to weave stronger networks for community health and wellbeing. In sum, there is no room in the LHIN Strategic Framework to include categories for those aspects of CHC work that make CHCs what they are, i.e., organizations that provide community-centred, interprofessional, integrated services and programs in primary care, health promotion and community wellbeing while addressing social determinants of health (CACHC, 2018).

The Strategic Framework and Logic Model apply to all health service agencies in the province. Most of them are clinical, focussed on clinical service delivery, and aligned with the biomedical model of health. While it may sound ambitious to suggest expanding the framework to accommodate preventative and community centred aspect of the CHC Model of Health and Wellbeing, the reality is that CHCs are at risk of losing their cutting edge while attempting to fit the biomedical and clinical mold of the current framework. The current framework has not been expanded to accommodate aspects of health

equity and health promotion of CHCs work, instead through the imposition of biomedical view of health and strictly clinical indicators, health promotion is shrunk to fit the framework.

Ontario Trillium Foundation Reporting Requirements

The Ontario Trillium Foundation (2018), or 'Trillium' as it is often referred to, is an agency of the Government of Ontario and one of the leading Canada's granting foundations supporting healthy and vibrant communities in Ontario. The foundation awards about $100 million in provincial grant money annually (Smith Cross, 2019). Trillium was funded during early 1980s during what is described as "difficult economical time" and not surprisingly coincides with the ascent of neoliberal policies of austerity, the dismantling of publicly funded services and the offloading of social responsibilities to communities and families (Ontario Trillium Foundation, 2019). In 1982 the concept of a foundation funded though government lotteries but managed and directed by volunteers was developed among representatives from nine charitable organizations and the Ontario Ministry of Tourism, Culture and Sport. Private charitable lottery licences were deemed as a means of generating revenues for the charitable initiatives. Trillium was created by the Government of Ontario as an arm-length agency through which to allocate funds to social services. Trillium's Board of Directors is made up of volunteers appointed the Ministry of Tourism, Culture and Sport.

Although Trillium is positioned as an arm-length's government body, the provincial government exercises significant authority over the decision-making of operations. For example, in February 2019, after the election of the Progressive Conservative Party in Ontario in June 2018, the provincial government revoked the appointments of several accomplished and well-regarded members of the board and appointed three new members who have close connections with the Progressive Conservative Party (Smith Cross, 2019). The government also cut $15 million from Trillium's base. This decision has significantly affected many provincially funded non-profits.

As of 2015 Trillium's funding priorities are organized into six action areas:

- Active people – initiative that foster more active lifestyle;

- Connected people – initiatives that work towards building inclusive and engaged communities;
- Green people – encouraging people to support healthy and sustainable environment;
- Inspired people – enriching people's lives through arts, culture and heritage;
- Promising young people – supporting the positive development of children and youth;
- Prosperous people – enhancing people's economic wellbeing.

Community initiatives implemented by CHCs often fall under these areas and many have been funded on a project basis through Trillium. My sources of information for understanding Trillium's reporting requirements in relation to community initiatives were a Trillium grant officer, my own experience of coordinating Trillium funded community-based health promotion project, interviews with health promotion practitioners, and the review of two Trillium-funded project reports.

In 2015 significant changes were introduced to the Trillium's grant program and reporting templates. Trillium includes funding priorities and results-based measures, such as pre-and post-survey metrics for measuring some of the grant results. My personal experience with Trillium's reporting requirements and the experience of the practitioners I spoke with is based on Trillium's older reporting guidelines in place before 2015. I therefore refer to those reporting templates even though they do not include mandatory pre- and post-survey metrics more recently introduced by the funder in 2015. The new grant results and metrics are available on Trillium website and were reviewed for the purpose of this research. However, none of the practitioners I interviewed had experience with the new metrics at the time of the interviews.

There are two key levels in an evaluation of a Trillium grant. The first level is the evaluation of grant results as reflected in Trillium's reporting templates issues to grantees. The practitioners I spoke with and my experience as a project coordinator refer to this level. The second level is the evaluation of aggregated data from the grantees' reports. This level evaluates how the investments into activities of grantees helped Trillium to achieve its priority outcomes. There is also, of course, a third,

somewhat elusive level, at which funders evaluate their own evaluative strategy. The grant officer I spoke with also alluded to that level.

The reporting templates for the individual projects are the mechanism for fulfilling evaluation priorities and are guided by the goals of summative evaluation, assessing to what extent the grantees' activities have met the intended grant results. The reporting templates of this first level of grant results are also structured to support priorities of the second level evaluation to collect data necessary to assess to what extent grantee activities contribute to the achievement of priority outcomes under each action area. According to the diagram outlining the most important changes and indicators in Trillium's impact measurement strategy, the priorities for evaluation at the second level of aggregated data are to capture best practices and innovations that help to achieve priority outcomes and to understand what grantees learn from their experience. A Trillium grant officer (2017) gave more explanation on to evaluation priorities:

> I think we're all looking at our strategy to figure out are we on the right track? Do we need to make any adjustments? Are we doing the things that we thought would come out of this strategy actually coming to fruition? So, I think as we see the reports coming in from our grantees, we're always looking to see like is our master plan working? Are people achieving the results that we had in mind when we set up this framework? I think I think we're always learning on that front; is our strategy working?

The reporting requirements/templates for grantees are influenced by the funder's priorities to capture results on one hand, and to support learning and innovation on the other as Trillium wants to know "what works" in order to inform the decisions on future grant applications. A Trillium grant officer (2017) spoke about creating enough room to talk about learning in the reporting templates for grantees, and at the same time described some of the challenges related to capturing that learning and "tracking the hard impact" breaking down not always tangible learning outcomes into quantifiable units.

Trillium's reporting templates certainly reflect the intention to capture learning among its grantees as it starts with a section titled 'Learning from your grant' with the subsections asking to provide more details in relation to the most important change that happened as result of the grant and the learning that occurred during grant

implementation. The reporting template itself does not provide many guidelines or prompts on how to discern the main lessons learned. Overall the section asks for descriptive information about ‘what happened’ in terms of project outcomes during the reporting period but does not ask about ‘why’ and ‘how’. The questions are also focused on the grantees asking specifically “Is there anything *you* would do differently the next time?” but these questions do not prompt the grantees to address the underlying reasons for doing something differently.

Yet, the review of two reports on Trillium funded projects show similar themes in terms of what affected their project implementation: sustainability and consistency of resources outside Trillium funding, e.g., staff turnover, changes in partner organization, and communication between partners.

The reporting requirements also request grantees to demonstrate the impacts of the grant using tracking and measuring indicators that were outlined in the grant proposal in relation to Trillium priority outcomes. Through reporting requirements grantees are requested to measure impacts beyond grant dollars by tracking the number of volunteers and by providing a dollar estimate of the number of hours volunteers contributed to the project support. Economic impacts of a project are measured in the number of employment positions provided through Trillium grant and an estimate of the in-kind contribution provided by the organization-grantee itself and its partners. Grantees report on expected results and progress measures against the pre-defined deliverable as per their original grant application. The section ‘Anticipated Changes’ asks to describe any changes that are anticipated in respect to project activities, expected results, timelines and approved budget for the next reporting period. The reporting template concludes with financial report tables.

In addition to the reporting template, Trillium also requests a free-form evaluation report from grantees to be supplied in addition to reporting templates. At the time of this research, no specific evaluation methods and tools were mandated by the funder. However, such tools were introduced recently and are available on Trillium’s website. The survey tools are now mandatory for tracking grant results in relation to priority outcomes. They are presented as embedded evaluation tools to assist grantees with measuring the results of their activity.

The analysis of Trillium's reporting requirements shows that they are guided by a results-based approach. Analysing Trillium's reporting requirements against accountability typology provided by Williams and Taylor (2013), the accountability model embedded in Trillium/grantee relations falls under the hierarchical or functional model described by O'Dwyer and Unerman (2008) with goals of controllability and performance measurement.

The results-based approach applied within functional accountability model treats grantees as 'units' producing certain outcomes, i.e., results that contribute to Trillium's priority outcomes. With the focus on controllability and performance measurement, the grantees and their projects are treated in isolation from a broader socio-political-economic environment that may cause changes in specific contexts of projects that hinder the achievement of results yet are not reflective of the grantees' effort and commitment. The obligations to demonstrate intended results may reduce the opportunities for flexible and responsive approaches that are required for supporting experimentation and encouraging learning if the results are treated independently from the contexts that impact the achievement of the results (Eyben, 2013). Still, there remains a certain flexibility embedded in the design of reporting requirements of Trillium, which remains intentional and persistent in its attention to discerning grantees' learning during project implementation. Yet, the reporting requirements/templates for grantees are influenced by the funder's priorities to capture results on one hand, and to support learning and innovation on the other, as Trillium wants to know 'what works' in order to inform their decisions on future grant applications. A Trillium grant officer (2017) spoke about creating enough room to talk about learning in the reporting templates for grantees and notes the importance of a certain degree of flexibility necessary in the reporting templates to support the application of mixed approaches to data collection to inform learning and development:

> So, we really try to allow the room to talk about learning in the report… I think it's about having a flexible reporting form that allows people different ways to talk about the impacts of their project. I think we are still learning…

The requirements for project evaluations to be included as part of the reporting and the focus on learning outcomes and project impact are consistent with social and

internal accountability of grantees. Overall, I conclude that although Trillium's reporting requirements are still biased towards a hierarchical/functional model of accountability, there is a discernable movement towards developing a more holistic model with the goals of long-term impact, stakeholder empowerment and responsiveness (Williams and Taylor, 2013).

Conclusion: CHCs and 'The Birth of the Clinic'

According to the Alliance for Healthy Communities (2018), there are 1189 community initiatives across 68 CHCs in Ontario. Community initiatives are focused on building skills, knowledge and awareness, organizing and supporting communities, building social support, and outreach (Alliance for Healthy Communities, 2018). Community initiatives are essential for ensuring that CHCs stay connected with the communities they serve in order to develop services and programs informed by local needs and to support community advocacy necessary to influence the political, institutional, economic and social decisions driving health inequities (Cheff, 2017). In other words, all these initiatives make CHCs what they are, community-based non-profit organizations focused on the delivery of medical service and health promotion and community programs.

There is a serious gap in the Ministry of Health and Long-term Care/LHIN reporting requirements, which are designed to capture inputs such as staff time in relation to community initiatives, but not initiatives' outcomes that such inputs enable. The emphasis in LHIN reporting requirements is on the registered client of the CHCs, therefore activities aimed at a broader community, including community members who are not CHC clients, are not counted as part of the CHC outputs. The invisibility of community initiatives to funders and higher-level decision makers (e.g., board members) to the core funder, The Ministry of Health and Long-term Care, is largely constructed through the reporting requirements and levels of reporting hierarchy. Such constructed invisibility of community health promotion may lead to an actual obliteration of community health promotion from CHC activities. To better fit the biomedical mold imposed on them, CHCs may start modifying their activities as they attempt to improve their performance indicators and/or look more efficient in terms of the service delivery.

Interviews with health promoters, managers and grassroots activists illustrate how CHCs may respond to such situation in various ways. First, there is an attempt to make health promotion visible by designing strategies and tools that allow an easier quantification of outcomes and impacts. Other attempts to respond include restructuring CHCs' work to emphasise service delivery and to mandate client registration process for all community members interacting with CHCs staff. Often in practice, it becomes a mixture of all three approaches and all these decisions have profound impact on practitioners and community members. These adaptive responses may lead to scaling down community initiatives or attempting to register community members who are part of community initiatives as individual CHCs clients. The increased pressure to register clients contributes to a more complex intake process that is intended to collect individual data necessary to fulfill registration requirements. Such complex process may feel intrusive for the more vulnerable community members and may in fact turn people away affecting their access to and participation in programs and services.

A managerial research participant (2017) noted there is no 'pressure' in relation to health promotion outputs or outcomes as compared to the 'pressures' in terms of cost efficiency. At the same time, there is no clear benchmark for what is considered cost-efficient in health promotion. The MSSA provides clear guidelines regarding clinical indicators but nothing in relation to health promotion. It is therefore up to individual CHCs to determine the budget dedicated to health promotion activities. Individual service delivery gets most attention from the executive leadership as individual service providers are 'unit producing providers' as per performance indicators for CHCs in MSAA.

The common theme that transpired through interviews is that there is less emphasis on community initiatives designed to address health equity at a broader community level while the attention shifts towards health education programs around behaviour/lifestyle changes and chronic disease management that target individual behaviours. Community health promotion shrinks to health education applied as a 'treatment kit' in a community context. Such view of health promotion is grounded in the biomedical model of health that is dominant as an institutional framework through which reporting requirements are structured. Through current reporting requirements and

upward directed accountability, CHCs become more of ‘health centres’ focused on primary care provision, having less of ‘community’ aspect to their practice. Yet, it is the community aspect that essentially makes CHCs what they are and gives them a ‘cutting edge’ in health care by enhancing the range of comprehensive services and programs they provide to vulnerable and marginalized communities.

CHCs are trapped within a biomedical framework reinforced through reporting requirements that are part of upward oriented hierarchical/functional form of accountability that prioritises cost-effectiveness and performance measurement. Such funding relations undermine other forms and orientations of accountability, most notably downward oriented accountability to the actual communities served by CHCs, and social and value-driven accountability. Ultimately, accountability should create trust between stakeholders and the transformation within the sector should start with the movements towards more balanced models of accountability where answerability to one group of stakeholders (e.g., funders) does not undermine answerability to another (e.g. community members). The case of the CHCs reporting requirements from the core funder LHIN demonstrates how the gap between an organization’s mandate and practice is facilitated through accountability systems that are skewed towards the funder. In comparison, the Ontario Trillium Foundation’s reporting requirements demonstrate that a more balanced accountability system in donor/grantee relations can be achieved when reporting requirements support learning, stakeholder engagement and impact evaluation.

As a vibrant part of the non-profit sector, CHCs are immersed in a subordinate funder/grantee relationship within institutional hierarchy. In such structure, internal mechanisms should be embedded within reporting requirements that support equitable accountability to ensure that accountability of non-profits is not only to government agencies and major donors but ultimately to the public, the constituents of the non-profit organizations. There are promising models offered in the literature on non-profit sector, most notably "360-degree" accountability system feedback model proposed by Behn (in Williams and Taylor, 2013: 566-567) that calls for a move from accountability as antagonistic relationship between the agent and the principal towards collective responsibility that should replace upward directed hierarchical methods. Yet, how and

with what means can a more balanced accountability model in the sector be achieved? Williams and Taylor (2013) argue for deliberative dialogic approach to each situation during which non-profits must establish key actors in order to reach collaborative decisions regarding the meanings and goals of accountability. In the following chapter, I discuss *participatory evaluation* process as a possible means to facilitate such deliberative dialogue.

Intermission 3: Evaluation Puzzle, mixed-media collage (by the author)

The mixed media collage photographed here was created as a result of my reflection on the challenges of reporting and evaluation in health promotion. It shows the juxtaposition between reporting requirements on one hand, as presented by the reporting form coming out of ‘the machine’ - a vintage typewriter that is spewing out numbers. The visual metaphor is used to reflect the key question guiding the reporting requirement of functional accountability system - “how much money did you spend?”. However, there are community stories, voices and everything else that are not quite captured by the reporting requirements, and therefore stay invisible to ‘the system’. These elements are presented as the images of birds, butterflies and everyday paraphernalia, such as teabags and buttons. The contrasts, the incompatibility of two views, or frames of references, are expressed as two parts of the puzzle that don’t fit together, with the exception of one piece with a penny attached to it. The collage employs the elements of steampunk design to convey the ideas of industrial revolution and the logic of ‘mechanisation’ and ‘automatization’ inbuilt into the machine of functional accountability systems. At the same time, the steampunk aesthetics convey the potential of discovery, curiosity and imagination.

Chapter 4: Evaluating the Evaluation in Health Promotion

This chapter discusses evaluation as a means to facilitate reflexive practice and deliberative dialogue necessary to move towards a more balanced accountability model in community health promotion as a subset of the non-profit sector. In a balanced accountability model, legal and moral loci are aligned through a strengthened downward-oriented vertical accountability axis, as well as horizontally positioned peer and internal accountability. The analysis and the discussion below are informed by the experiences of frontline health promotion practitioners and community members.

I start by situating evaluation in the context of health promotion, outlining the salient issues in evaluation practice. I discuss three key approaches to evaluation and their suitability to community health promotion context. I then present research findings of four case studies aligned with salient issues described in the literature. Reflecting on the lessons learned from the case studies, I conclude the chapter with a discussion on how evaluation can be used as an intentional and deliberate process for strengthening a holistic accountability model in community health promotion.

In the previous chapter I argue current reporting requirements create a gap between CHCs' mandate and practice with respect to health promotion activities. Evaluation practice in community health promotion illustrates such gap. Through the imposition of a narrower clinical framework, evaluation practice is structured in ways that are inconsistent with the guiding principles for evaluation in health promotion that emphasise participation, empowerment, an interdisciplinary approach and appropriateness to the context (McQueen and Anderson, 2001).

This chapter evaluates personal development groups and community initiatives using the examples from two participating CHCs, referred to as CHC A and CHC B (for anonymity purposes). The examination of evaluation practice in health promotion is guided by the following questions (Eyben, 2013):

- What institutional discourses and organizational practices enable or impede the application of methods and tools that are consistent with key principles of health promotion?
- Why and under what conditions may evaluation practices mutate into a coercive instrument?

- What are methodological principles in evaluation that support change in power relations?

Drawing on Smith's (1999) theorising of 'objectified forms of knowledge', I examine evaluation in community health promotion as an objectified form of knowledge or a structure within a structure that does not begin and end with a participation of each individual but requires different actors at different levels to re-enact what is known as the 'evaluation process.' Such a process is largely mediated in texts by encapsulations of objectified knowledge, which as Smith (1999: 60) argues coordinate "the acts, decisions, policies, and plans of actual subjects as the acts, decisions, policies and plans of large-scale organizations."

Defining and Framing Evaluation Within the Context of Accountability

Building on various perspectives of multiple actors involved in the evaluation process, I assemble a picture of the evaluation process, describing how this process unfolds at each step and level in the organizational hierarchy. Program evaluation in health promotion is a process that assesses health promotion activities unfolding at the community level. Program evaluation is coordinated through texts, such as frameworks, guides, policies, and templates, most of which originate elsewhere outside the community realm. Texts that guide and frame evaluations are funneled down to the community from the top of the institutional structure, represented by the government and professional administration, down to the level of community practice where these texts take the form of action, or specific 'evaluation activities'.

Evaluation practice and its role in constructing knowledge

The role of evaluation practitioners involves implementing those texts in everyday work; they participate in the re-enactment of texts from the position of their own unique location in the process. How practitioners participate is also structured by other actors in this process from their point of location in the organizational hierarchy. What practitioners may have to re-enact as reality following guiding texts may contradict what they know based on their lived experience or their intimate knowledge of communities

they work with or what they think may make sense based on that knowledge. Yet because such a significant part of the professional training is dedicated to the correct following or reading of the texts, we are often compelled to apply those texts into everyday actions even when they may make little sense according to our subjective knowledge. We are trained to subjugate our ‘subjective’ knowledge to the ‘objective knowledge’, whereas the ‘objective’ and ‘valid’ knowledge is the one constructed at the top of the hierarchy and does not necessarily draw upon the experiential knowledge of reality of its intended users. Both evaluation and reporting processes play significant role in the construction of knowledge, providing what is considered ‘evidence’ to inform decision makers at organizational and institutional levels. The consequences of decisions made at institutional and organizational levels unfold at a community and individual level, affecting people’s lived experiences. However, actualities of the lived experience or ‘subjective’ knowledge may not necessarily be captured or recognised during the production of the ‘objective’ knowledge when people with lived experience have no or little opportunity to take part in the construction of knowledge.

Table 5 below illustrates multiple levels in the production of texts that guide evaluation and shows different texts produced at different levels of institutional and organizational hierarchy that guide evaluation practice in community health centres. Notice how at the level of community, at the level of those who are intended beneficiaries of health promotion programs, the input into what is considered as ‘objective knowledge’ is limited to ‘providing data’ according to criteria developed at the upper levels that define what is considered data, i.e., what is worth knowing about their experiences.

Table 6: Hierarchy of the Documents Guiding Reporting and Evaluation

Level	Actors	Texts produced/re-enacted
Federal Government	Health Canada, Canadian Institute for Health Information (2019)	National Management Information System Information forms the basis of management reporting, including: annual general-purpose financial statements, financial ratio analysis, and operational budgeting
Provincial Government/ Fund	Ministry of Health and Long-Term Care	Ontario Healthcare Reporting Standards (OHRS)
	Local Health Integration Network (LHIN)	Multi-Sector Service Accountability Agreement (MSSA)
	Ontario Trillium Foundation (OTF)	OTF Reporting Templates, mandatory surveys
Management/ Administration	CHC Advisory Working Group	Recommendations on correct data entry Recommendations on data quality
	CHC Executive Director and the Board	Organizational policies on data collection
	CHC Management/Data Management Coordinators	Policies and procedures for data collection Organizational data collection protocols
Frontline staff	Health Planners, Health Promoters, Health Promotion Team Leads, Project/Program Coordinators	Evaluation frameworks Evaluation plans, methods and tools for data collection (e.g. survey questions, interview guides, focus group designs) Evaluation reports
	Frontline community workers (e.g. health promoters, community development workers, community health workers, youth workers, community dietitians)	Evaluation plans, methods and tools for data collection (e.g. survey questions, interview guides, focus group designs) Small scale evaluation reports Data collection and entry
Community	Community members, including community volunteers/grassroots activists.	Responses to forms, surveys, focus groups and interviews.

Types of health promotion programs in community health centres practice

As stated earlier, there are two types of community health promotion programs in CHCs: personal development groups and community initiatives. Personal development groups are defined as "a set of sessions intended to effect changes in individual participants' behaviour, knowledge or attitudes" (AOHC, n.d.). Personal development groups are focused on one particular topic, the content of the group sessions is usually predetermined, and the participation in the group is limited to a certain number of people with predefined characteristics, e.g., parents of young children, seniors, people with chronic disease, etc. Participation in a personal development group is based on a fixed number of people and new members do not join the group when the group is in progress.

Community initiatives are defined as a set of activities aimed at strengthening the capacity of a community to address factors affecting its collective health through active involvement of community members and grassroots groups in identifying and changing conditions that shape their lives and health prospects (AOHC, n.d.). The Community Initiatives Resource Tool produced by AOHC describes community initiatives as non-linear in nature, with shifting participation, goals and objectives during the implementation process. As the process itself focusses on community members participation, the participation is open to a broad community and may change at any time. Community initiatives seek small but pervasive changes at a community level and embrace a multi-level and multi-strategy vision of individual change by targeting wider social contexts that are assumed to influence people's health (Potvin and Richard, 2001). Such initiatives often deal with complex social problems tied to systemic issues, and such problems are often identified as 'wicked problems' that are influenced by various dynamic socio-political, economic and biophysical factors (Gamble, 2008; Hurlbert and Gupta, 2015). Community initiatives are examples of system change and social innovation unfolding in the neighbourhood context. Systems change, emerging, innovative, participatory, and non-linear are keywords that can be used as descriptors for community initiatives.

Both personal development groups and community initiatives rely on interdisciplinary collaboration between various CHC staff (including clinicians) and on the participation of community members in program design and delivery. They often involve partnerships with other non-profit organizations and public agencies working in the community. Involving multiple partners and unfolding within unpredictable and complex environments, the dynamic and complicated practice of community health promotion requires a great deal of critical reflection by its practitioners. Evaluation of such initiatives involves asking critical question about what works, for whom and under what conditions, and moving beyond simple adaptations to organization or institutional requirements of the system to systems change work[12] supporting action for health equity and justice. The ability to step outside templates of action imposed by the system in order to critically examine the system and to assess what needs to be addressed in the system itself in order to advance the goals of health equity and justice calls for 'double-loop' learning. Double-loop learning is described as going beyond identifying and 'treating' a problem to questioning assumptions, policies, values, and practices within the system that led to the problem in the first place and addressing these particular aspects of the system (Patton, 2010; Hurlbert and Gupta, 2015). It is therefore fair to assume that evaluation in community health promotion should support reflexive practice or praxis development[13] and equitable involvement of a wider range of actors.[14] The following section examines whether such evaluation is possible in current reporting requirements and funding conditions specific to the non-profit sector in general and community health promotion in particular.

[12] Systems change work is defined as work aimed at changing the systems that produce complex social problems, much of health promotion work is grounded in systems change albeit the 'systems change' language is relatively new term while health promotion has emerged as a distinct field of practice although not a discipline in 1970s.

[13] Reflexive practice or praxis, a process of 'bending back' on one's practice reflecting upon social forces and structures that influence one's choices, the dynamic interaction of action and thinking about action (Barndt, 2011).

[14] Throughout the document I use the term 'actor/s' to indicate participants of the process. I prefer this term to the term 'stakeholder/s' whose origins are in the for-profit sector and that has been part of the market driven discourse that permeated the non-profit and public sector as part of 'new public management' or neoliberal restructuring.

Key issues in health promotion evaluation practice and approaches to evaluation

The contracting regime with governments rolled out as part of the new public management strategy applied to public and non-profit sectors created numerous managerial problems related to financial uncertainty, ambiguity in administrative rules, imbalances in the distribution of power, and consequently issues of trust between the non-profit sector and communities it serves (Carman, 2011). In the evaluation literature, Taylor and Liadsky (2016) identify three main challenges related to evaluation in the non-profit sector: i) focus on functional accountability; ii) mismatch between approach and expectations regarding evaluation process; and iii) lack of adequate funding and communication regarding knowledge sharing and utilisation.

Issues of evaluation in health promotion generally reflect overarching key issues specific to evaluation in the non-profit sector. As a field, health promotion is a very broad and relatively new area. It is a multidisciplinary field drawing from several disciplines, most notably public health, clinical sciences, biology, behavioural psychology, adult education, and public policy/political science to name only a few (Gendron, 2001; McQueen and Anderson, 2001). The World Health Organization (WHO) European Working Group on Health Promotion Evaluation defines four core features for evaluation of health promotion initiatives that are consistent with key guiding principles of health promotion (Rootman et al., 2001):

- *Participatory*, with particular attention to participation of members of the community whose health is being addressed;
- *Interdisciplinary* to draw on a variety of disciplines informing health promotion to ensure a holistic approach and a broad range of data collection methods;
- *Empowering* with attention to capacity building of all actors involved; and
- *Appropriate* to complex nature of health promotion interventions.

Numerous issues described in the literature on evaluation of health promotion initiatives illustrate the challenges of aligning evaluation practice in health promotion with its guiding principles (Sanderson, 2000; McQueen and Anderson, 2001; Potvin, Haddad and Frohlich, 2001; Springett, 2001; Eyben, 2013; Raphael, 2000; 2001; Brassolotto, Raphael and Baldeo, 2014; Patton, 2016). Such challenges derive mostly from what House (2006: 119) describes as “methodological fundamentalism” or the

uncritical acceptance of some methods such as randomized controlled trials and quasi-experimental design as the only credible methods of discovering truth. Other methods of producing evidence are generally deemed less valid. In the context of evaluation, the positivist hierarchy of evidence, when combined with the demands of functional accountability that prioritizes measurements and quantitative indicators, transpires as a top-down evaluation designed to satisfy upward oriented vertical accountability to funders. Before delving into the issues of evaluation practice in the context of community health centres, general approaches to evaluation and their differing epistemological roots are reviewed.

There are three key approaches to evaluation connected to two epistemological traditions. The conventional approach is closely aligned with traditions of scientific positivism and natural sciences, while participatory and developmental evaluation extend their theoretical orientation to hermeneutics traditions that are more aligned with social sciences. The primary difference between conventional and developmental approaches concerns methodology and purpose. The purpose of a conventional evaluation is to produce judgment about a worth or merit of an established intervention while the purpose of developmental evaluation is to support experimentation and innovation in situations of complexity and uncertainty.

Participatory evaluation, which is also known as ‘empowerment’ and ‘democratic’ evaluation, is concerned with the redistribution and decentring of power in evaluation process rather than on methodology. Such approach advocates for the inclusion of all actors in a deliberative dialogue (Handberger, 2004; Springett, 2001; Springett and Wallerstein, 2008; Patton, 2018). Springett and Wallerstein (2008) describes participatory evaluation as a way of working based on a set of principles rather than a particular methodology. In terms of data collection both developmental and participatory approaches are not limited to quantitative information and expand the range of evidence to include qualitative information advocating for methodological pluralism rather than methodological rigidity.

Both developmental and participatory approaches to evaluation are focused on knowledge creation and the development of local theory in the context of practice (Springett, 2001; Gamble, 2008). Such perspective is rooted in an hermeneutic rather

than a positivist epistemology and assumes that knowledge creation does not belong exclusively to 'experts'; people themselves can generate knowledge when collaboratively involved in a systematic inquiry built around relevant categories and frameworks (Springett, 2001). A participatory approach therefore can be applied to both conventional and developmental approaches depending on its purpose (Gamble, 2008). While the conventional approach to evaluation precludes a developmental approach due to their differing goals and purposes, both conventional and developmental participation can and should be participatory in health promotion context.

Potvin and Richard (2001: 222), drawing on postpositivist principles derived from a modern epistemology, identify principles for evaluation practice in community health promotion to ensure the alignment of an evaluation process with key health promotion principles.

- There is no universal methodological recipe that works in all situation, i.e., nothing is completely generalizable;
- A plurality of critical perspectives and evidence is necessary to form scientific knowledge, i.e., it is imperative to have a wider range of actors involved in planning and executing evaluation;
- Transparency and accountability in decision-making about methodological issues are necessary ingredients of validity and rigour in evaluation, as opposed to conventional traditions of rigour as in experimental or quasi-experimental design.

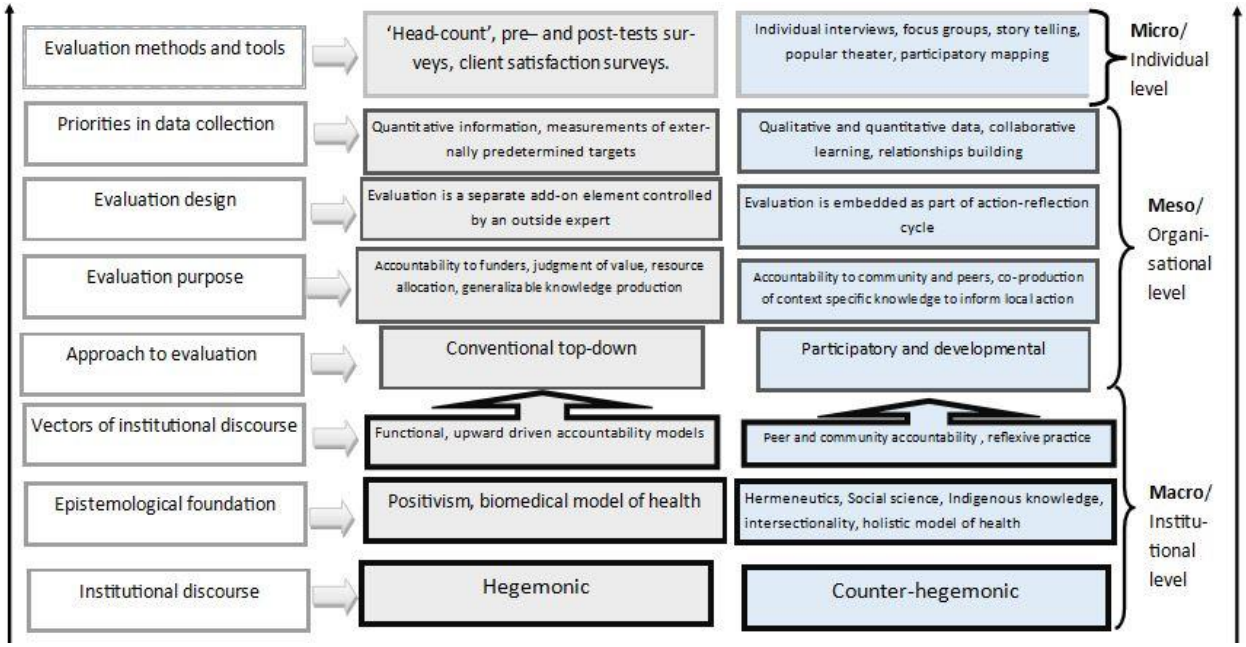
The above characteristics position participatory and developmental approaches to evaluation as the most appropriate in community health promotion work. Yet, the dominant institutional framework marginalises developmental and participatory evaluations and favors top-down conventional evaluation.

In health promotion practice, epistemological hegemony and "methodological fundamentalism" are evident through a pervasiveness of a top-down conventional approach to evaluation where the key purpose and goals of evaluation are to satisfy accountability requirements to funders, inform resource allocation, explain success or failure, and generalizable knowledge for standardization purposes (Springett, 2001). Other epistemologies, such as hermeneutics and Indigenous ways of knowing, become marginalized in the field of community health promotion through a prevalent positivist

epistemological framework. Constructed as 'marginal,' such epistemologies nevertheless support approaches to evaluation that are consistent with a holistic model of health and general principles of health promotion, such as participatory and developmental approaches.

Figure 7 describes evaluation practice in community health promotion as an institutionally structured process and shows how marginality of participatory and developmental approaches to evaluation is institutionally structured in evaluation practice. It shows various elements of evaluation process at three levels, starting with the macro- or systemic level produced by institutional discourse at the bottom, followed by the meso- or level of organizational practice, and finally the micro-level of individual practice at the top. For each level, key influencing factors shaping evaluation practice and identifiers and descriptors of evaluation practice in the context of community health promotion are presented.

Figure 7: Evaluation as an Institutionally Structured Process



Source: Sanderson, 2000; McQueen and Anderson; Springett, 2001; Potvin, Haddad and Frohlich, 2001; Potvin and Richard, 2001; Strega, 2005; Gamble, 2008; Eyben, 2013; Raphael, 2000; 2001; Brassolotto, Raphael and Baldeo, 2014; Patton, 2016.

At the macro- or systemic level, evaluation practice is heavily influenced by reporting requirements that embed on conventional or *functional* form of accountability. Operating as vectors of institutional discourse, reporting requirements and functional accountability reinforce epistemological foundation consistent with the hegemonic discourse. Prevalent institutional epistemology is rooted in principles of positivism and clinical science (and the biomedical model of health).

At the meso-level of organizational practice such epistemological foundation transpires as the prevalence of a top-down conventional approach to evaluation with goals of summative judgment and functional accountability to funders, where funders determine the parameters for 'success'. Evaluation design informed by positivism and clinical science generally favours quantitative methods and randomized controlled trials as the 'golden' standard of evidence. At this level of organizational practice, such institutionally structured epistemological bias is experienced as the preference for quantifiable information that is associated with technologies of measurements and as an ever-diminishing resource base for supporting those forms of evaluation that are consistent with participatory and developmental approaches.

At the micro-level of individual practice, this is experienced as an organizational and/or self-inflicted pressure to apply quasi-experimental design, such as pre- and post-test surveys in the pursuit of quantifiable data as the best evidentiary base to judge the success or failure of the interventions (McQueen and Anderson, 2001).

Methodological fundamentalism and its implication for health promotion evaluation

Methodological rigidity poses a problem for program evaluation in community health promotion. The main debate in the health promotion field is still centred on methodology and limitations of implementing standard scientific criteria that proved useful in clinical research (Raphael, 2000; Potvin and Richard, 2001). Health promotion initiatives are highly context-specific and the requirements that are necessary for experimental or even quasi-experimental design that demand control over variables are quite impossible to achieve. The contextual nature of health promotion activities has implications for what is then considered valid evidence. McQueen and Anderson (2001)

consider health promotion as a field of study on the continuum between pure science and applied research, thus the evidence in health promotion vary with its purpose. However, due to institutional pressure expressed through reporting requirements and internalized hierarchy of evidence, many practitioners in health promotion tend 'to put the cart before the horse' by letting the research methodology drive the investigation rather than focussing on a theory and conceptual underpinnings of the phenomena in their inquiry. As a result, practitioners tend to apply quasi-experimental methods that are "inappropriate for many complex social phenomena often found in health promotion research" (McQueen and Anderson, 2001: 73). For this reason, many community-based organizations struggle with developing evaluation systems that satisfy requirements imposed by a functional accountability framework while remaining meaningful within the context and goals of their activities (Carman, 2007). Positivist approaches consistent with the biomedical model of health still permeate health related policies and by proxy the health promotion field. To negotiate the tension between positivist and hermeneutics traditions in health promotion evaluation, many authors advocate for a multifaceted evaluation design and methodological pluralism, building on the notion of complementarity between quantitative and qualitative methods, broadening of the epistemological framework, increasing transparency about the purpose of evaluation and the role of evaluators, as well as allowing for a greater involvement of those on the receiving end of the evaluated programs and services (Gendron, 2001; McQueen and Anderson, 2001; Raphael, 2001; Springett, 2001).

Criteria for rigour and validity in health promotion initiatives in CHCs essentially stem from a positivist tradition that insists on a detached role of a researcher as an observer, control over variables achieved through an isolation of a studied 'sample', and on compartmentalising the studied phenomena into distinct measurable parts. The result is a loss of its holistic lens starting from breaking the vision of community and community health into individuals and their individual health problems. The individuals are then pathologized through the system of data collection, as they are organized according to 'what is wrong with them'. Such a filter does not allow to encounter for everything that may be quite right. This is described by one of the interviewed health promoters as a 'pathologizing' framework that does not allow for describing a client's

situation holistically and that does not provide enough room for capturing data outside of 'pathology' framework.

> I think we pathologize everything... because we are working in this clinical environment, so it is really hard as a health promoter to put those kind of data [positive aspects], it's not there and another thing, it's just for programs but community development? We don't even have a process for how we collect [data]? If you ask me about programs, it's easy, I can give you example - this is what we collect, this is how we do evaluation, but for community development we don't have those tools, it is not yet there (CHC B, Health promoter, 2018).

How can practitioners and especially those with 'framing' power, such as health promotion coordinators or team-leads responsible for the evaluation design, approach the tension between reporting templates, resource constraints, and their knowledge of community, as well as professional training? How are criteria and indicators for progress and/or success established and what get recognised as evidence? This is a complex terrain to navigate given that both evaluation and health promotion are not distinct disciplines but rather multidisciplinary fields of knowledge and practice. To further complicate this situation, both present a convergent point of epistemological, ontological and methodological issues. So how do health promotion practitioners navigate the theoretical and epistemological conundrum when evaluating their activities? Rootman et al. (2001) suggest that despite the fact that the field, the practice, and the theory of health promotion are far from monolithic, there are key guiding principles that define what health promotion is. Such key principles are *empowerment* and *participation* embedded in a broad range of activities aimed at improving the health of individuals and communities. But how do practitioners find appropriate ways of evaluating these activities consistently with values embedded in health promotion?

In the previous chapter, I discussed how the reporting requirements have the power to shape evaluation processes, especially in those situations where there is little or no resources to support data collection beyond those needed to satisfy reporting requirements for funders. Being part of an institutional accountability system, reporting requirements play an important role as vectors of institutional discourse. However, evaluation efforts at the organizational level are guided not only by the reporting requirements but they are also shaped by the goals of quality improvement,

organizational learning and practice development. However, as the hegemonic discourse of functional accountability and performance measurement takes over, the goals of reflective practice necessary for organizational learning and development and the goals of greater accountability to community members often go against the grain of hegemonic discourse supporting epistemologies that are marginalized within the dominant framework.

In clinical science, experimental design with the control sample is still considered as the 'golden standard' and anything less than that may be questioned for credibility. McQueen and Anderson (2001) argue that careless applications of the term 'evidence' closely associated with 'rigour' and 'experimental design' deflect health promotion practice from evaluation methods that are consistent with health promotion values. Such applications, according to McQueen and Anderson (2001) may lead those who are not familiar with the epistemological base of health promotion into expectations that derive from a clinical science base and are not necessarily appropriate to evaluation in the health promotion's context where health promotion teams often work with clinical professionals. Due to power differentials within multidisciplinary teams, standards of clinical sciences become applied to health promotion, even though health promotion itself is not a clinical science in its 'pure' form. Such dynamics create a tendency to approach health promotion programs as 'treatment kits' applied to communities and evaluate their effectiveness using methods emulating clinical methods with an emphasis on pre- and post-test surveys or assessments. While I am not questioning the validity of clinical sciences, I raise a point about *appropriate* or *relevant* evidence. Clinical methods and indicators applied to situations that are not clinical in nature and scope rarely make sense. Clinicians know well about the importance of matching diagnostic methods and tools to specific symptoms or characteristics a condition presents. To put it simply, wrong methods and tools will lead to an incorrect diagnosis and treatment. But somewhat similar situation unfolds in health promotion. Unsuitable methods and tools are applied for the assessment and they may lead to wrong conclusions.

Examining Key Issues in Health Promotion Evaluation

Case Studies

The following four case studies discuss how health promotion practitioners navigate the evaluation process and what strategies and conditions support or constrain their ability to apply approaches and methodologies appropriate to the context. This section examines how the institutional discourse shapes evaluation practice in relation to both types of activities at CHCs, i.e., community initiatives and personal development groups.

The first case study 'The tale of two evaluations' examines overarching methodological challenges in connection with epistemological bias by focusing on the experiences of practitioners applying different approaches to evaluation in the broader context of health promotion activities. The next two case studies 'The Food Space Initiative' and the 'Neighbourhood Table' examine evaluation practice in relation to community initiatives. The fourth case study 'The Diabetes Education Program' looks at the evaluation in the context of a personal development group.

Case study 1: The tale of two evaluations - conventional vs developmental approach

This section presents a comparative analysis of conventional and developmental approaches, focussing on the utility and appropriateness of the methodology within each approach in the broad context of community health promotion activities.[15] As stated before, the conventional approach describes an approach to summative evaluation that has been prevalent among evaluation practitioners and is largely influenced by natural and clinical sciences (Springett and Wallerstein, 2008). Derived from the positivist thought, a conventional evaluation emphasises measurement of predetermined programme outcomes in isolation from the context within which the programme unfolds with the aim of standardization. A conventional evaluation design is

[15] I use the term 'conventional' to describe what Patton (2006) labels as 'traditional' approach because in the Canadian context, 'traditional' often signifies Indigenous or Aboriginal traditions.

based on the program's logic model or the theory of change that guide measurement and data collection. It is defined by the following key characteristics summarized by Potvin and Richard (2001) and Patton (2006):

- evaluation is meant to produce definitive judgments of success or failure;
- evaluation measures success against pre-determined goals that are not supposed to change over the time of program/project implementation;
- evaluation is designed based on linear static cause-effect logic models (or 'theory of change');
- accountability in the process is oriented towards funders or another external authority;
- evaluation is aimed at validating best practices generalizable across time and space.

In contrast to conventional evaluation, developmental evaluation acknowledges the complexity of social environments within which evaluated activities take place. Developmental evaluation looks at evaluated programs in connection to their contexts and does not aim for 'isolating' them from contexts in order to minimise 'variables' per the experimental design method. One of the aims in developmental evaluation is to learn from observing interactions between the programme and its environment. Introduced as a type of evaluation design or an approach to evaluation by Michael Quinn Patton (2006), developmental evaluation supports adaptive development in complex and dynamic environments. According to Patton (2006), the primary characteristics of the developmental approach are as follows:

- evaluation is designed to enable individual and organizational learning to support innovation and system change;
- evaluation is designed to capture learning resulting from the process of program/project implementation;
- evaluation acknowledges the complexities and interconnections of the process that are not liner in nature;
- accountability is oriented towards program participants and organizational values;
- evaluation allows developing new measures and monitoring mechanisms in response to changes during program implementation;
- evaluation is embedded as part of the whole process of program implementation and itself is part of the intervention (i.e., is not a separate 'add-on' piece at the end of the program); and

- evaluation is aimed at reaching context specific understanding of a program/initiative to inform ongoing adaptations and innovation.

Developmental evaluation is designed to support social innovation, where social innovation is defined broadly as any kind of emergent, creative, and/or adaptive interventions for complex social problems (Patton, 2016). Many community initiatives happening within CHCs are precisely that – emergent, creative and adaptive interventions implemented in highly complex environments subject to frequent and unpredictable changes. Such environments demand agility, flexibility, sensitivity to change in the environment, and an ability to address a problem differently and in a new way.

Considering different goals for evaluation and conflicting frameworks where a conventional approach is designed to support external accountability and performance measurements while the developmental approach is value-centred and supportive of innovation and adaptation in complex environments, how do health promotion practitioners approach the framing of their evaluations?

Reflecting on reporting requirements and organizational culture or environment that in many ways set the parameters and establish the structures for evaluation in the non-profit sector, my research is motivated by whether there is a gap between what health promotion practitioners are required to do in terms of evaluative activities and what they internally believe they should be doing based on the intimate knowledge of their work and the context within which they operate.

Based on Patton's (2006) comparative table of conventional vs. developmental evaluation I proposed two spider diagrams. Highlighting the characteristics of each approach, the diagrams were used for a mapping activity with practitioners to reflect on the applicability and the relevance of each approach to evaluation. During their development the mapping were tested with the Research Advisory Team members and based on their suggestions some modifications were made to the diagrams. Statements were shortened and rephrased in plain language to make the mapping more applicable to community work context. Figure 7 and 8 below show the final maps for each approach to evaluation.

Figure 8: Conventional Approach to Evaluation

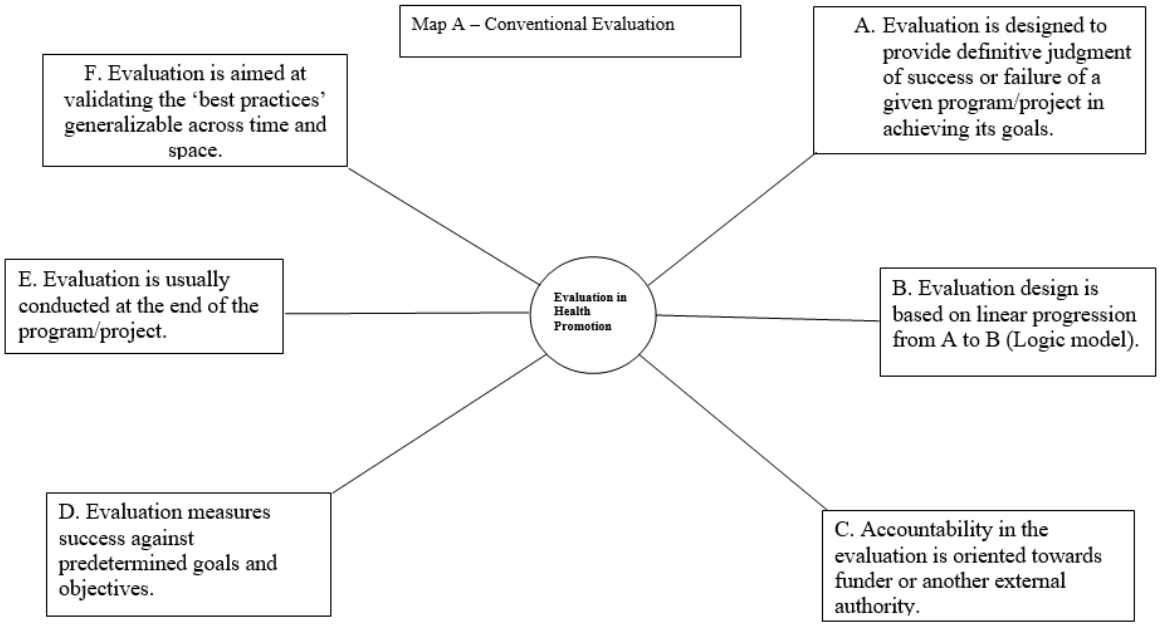
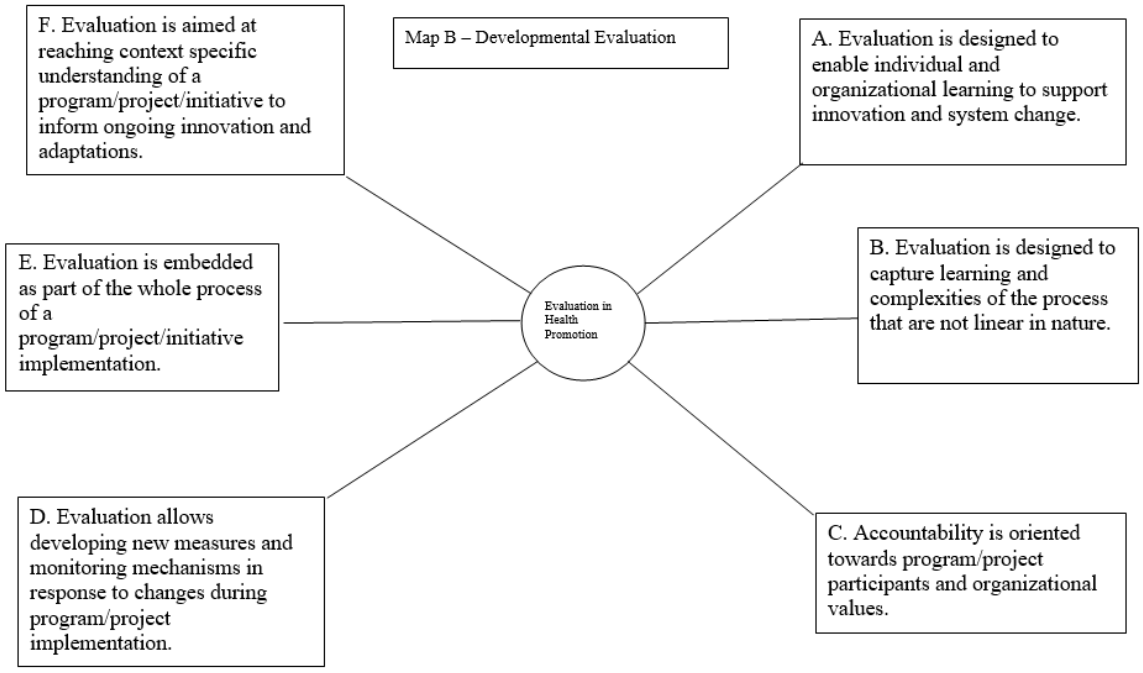


Figure 9: Developmental Approach to Evaluation



During the participatory mapping activity, participants were invited to select one concrete example from their community health promotion practice. Evaluation mapping was structured as a two-step activity. Firstly, practitioners were invited to think to what extent each statement on Figure 7 and 8 reflected what they currently do as part of their evaluation in health promotion. They were invited to place a green dot on each axis to indicate the extent to which the statement reflected their actual practice. The more the statement reflected the real situation the closer the dot was to be positioned near the centre. Secondly, participants were asked to think to what extent each characteristic of the evaluation approach was applicable or desirable in the context of the program or initiative they reflected upon and to place an orange dot on each axis following the same principle. The closer the dot was placed near the centre, the more desirable or applicable such characteristic in their evaluation.

The group then had a discussion on points of divergence between what practitioners feel they must do versus what they believe would be appropriate in the context of their practice. We also discussed issues emerging from the placing of the dots, where close to the center expressing a situation or approach aligned with what practitioners believe is relevant in community context, i.e., ‘makes sense’ and is consistent with key principles of health promotion. Seven individuals (one health promotion manager, two health promotion coordinators, two community volunteers and two frontline health promoters) participated in the evaluation mapping activity. Figures 10 and 11 show the final outcome of the mapping of conventional and developmental approaches respectively as experienced and discussed with collaborators.

Figure 10: Results of the Mapping Activity: Conventional Approach

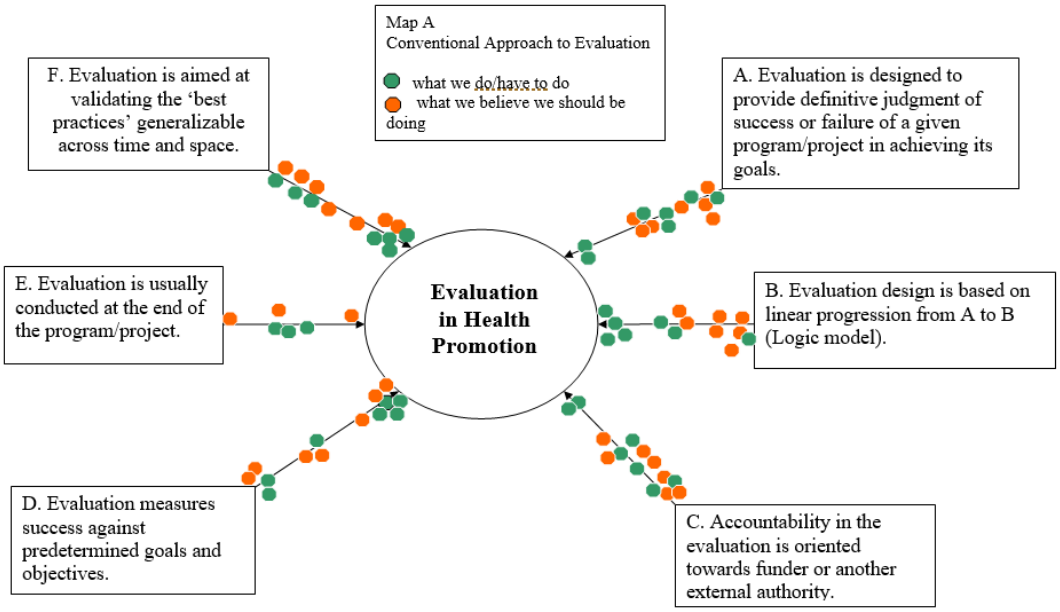
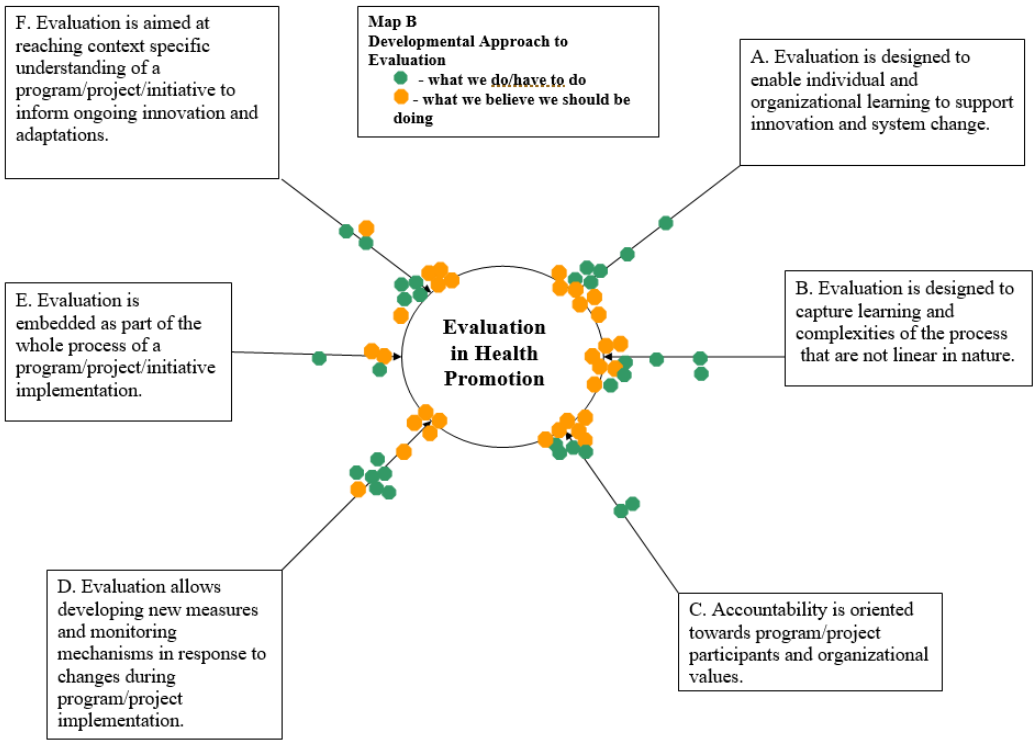


Figure 11: Results of the Mapping Activity: Developmental Approach



The responses to each mapping somewhat varied depending on the respondent's location in the evaluation process (e.g., manager vs. community volunteer). Yet, the general response to the mapping suggests that, in the context of community initiatives, the developmental approach to evaluation was considered the most appropriate - even though practitioners felt they were not always able to apply it. However, the conventional approach to evaluation was discussed as an approach that practitioners often apply in their practice to some extent, even though they did not consider it most appropriate to the context of their work. This tension is illustrated by the many orange and green dots located mid-way or away from the centre, or on the outer end of the axis, showing that the conventional approach is something practitioners do not necessarily apply in health promotion evaluation nor something they believe they should be doing. For example, the health promotion manager describes the conventional approach to evaluation as "not helpful because it does not help inform our work." From the perspective of a frontline staff and evaluation coordinator, the summative judgment inherent in conventional evaluation is counterproductive to learning. Yet, from a managerial perspective it is valuable to see a story attached to the numbers to understand what is happening in a given context.

Two community activists mapped their response to evaluation approaches in the context of the initiative for which no formal evaluation has been conducted yet. Their responses to conventional evaluation look almost identical to those of the frontline staff and evaluation coordinator as it is not something they do, nor applicable to the context of their initiative bringing together a multi-partner network of agencies and residents working to create more connected community in the neighbourhood.

These reactions also illustrate the tension specific to the situations when practitioners feel they are pressured to justify a linear methodology or process (Point B) that does not quite fit within the context of a community health promotion's initiative. Measurements against predetermined goals and objectives (Point D) is considered appropriate in the context of structured health education programs (aka 'personal development groups') but not necessarily in the context of loosely structured and

emerging community initiatives. Practitioners also experience some tensions in relation to funder-driven accountability (Point C) as they are intentional about using evaluation as part of the accountability system to community members and peers in community health promotion.

In response to developmental evaluation representing a developmental approach (Figure 11), practitioners agreed with features of such evaluation design and describe them as applicable in the context of community health promotion even though it is not necessarily something that they are always able to incorporate into their evaluation practice.

For example, the health promotion coordinator sees the orientation of accountability to program or project participants (Point C) as highly desirable in community health promotion and yet, it is not something that is reflected in everyday work since the organizational accountability towards funders takes a priority. One of the community activists noted how much easier it was to align with a developmental evaluation as expressed by the dots gravitating towards the centre showing more alignment between what a practitioner is expected to do and believe is relevant to the context of community initiatives.

Overall, the choice between conventional and developmental approaches to evaluation is influenced by the training health promotion practitioners receive, which is often training in public health or health sciences. It is also influenced by reporting requirements favouring progress measurements against predetermined goals and objectives. However, within the context of community-based, this reporting approach is less supportive of fostering evaluative thinking, innovation and adaptability to a constantly changing environment. The conventional approach is something that practitioners apply in their practice, even though it is not necessarily the most fitting. It raises an issue of values as criteria and measures against which community health promotion initiatives are evaluated often derive from clinical medicine and health sciences rather than the interdisciplinary field of health promotion (Springett and Wallerstein, 2008).

Practitioners generally find the developmental approach to be more compatible with the contexts of community-based work and especially applicable to less structured,

community grounded initiatives. This approach is seen as especially relevant for community activists involved in supporting residents-driven initiatives and working in collaboration with local community agencies. Within community initiatives, the developmental approach to evaluation is perceived as more useful because evaluation design informs learning and development and also supports accountability not only to funders and other external authorities but also to the organization and its values, as well as to the community it serves.

Developmental evaluation has been recently adopted as a form of evaluation suitable to the context of social innovation[16] and organizational learning (Patton, 2006; Gamble, 2008; Dozois, Langlois, Blanchet-Cohen, 2010). Although rarely recognised as 'social innovations' in the academic literature, community initiatives nevertheless are an example of small scale, locally based solutions to complex social problems developed through experimentation and collaboration among multiple actors. Community practitioners, including frontline workers and grassroots activists, often deal with complexity and uncertainty and their work is often described as 'messy' and not necessarily following a linear order even within the context of what is classified 'personal development groups'. Being innovative in nature, many community health programs present an iterative process of experimentation, learning and adaptation (Patton, 2006). However, when top-down conventional approach to evaluation design is imposed in such context, it is not able to foster the reflective thinking and evaluative learning required to support the cutting edge and fluidity of community health promotion. Conventional hierarchies of evidence that put randomized controlled trials and clinical research at the top do not necessarily work within social determinants of health context (Raphael, 2000; WHO, 2008). Isolation from the outside context is almost always impossible to achieve in community settings and the successes and challenges of community initiatives often depend on their environments. Most importantly, some of the context specific variables *are* the target of community health promotion efforts. It is no surprise that there have been challenges with evaluating community initiatives with an application of standardised metrics aimed at the assessment of predetermined

[16] Social innovations are described as new ideas, programs and services that meet social needs and involve multiple actors working collaboratively (Murray, Caulier-Grice and Mulgan, 2010).

outcomes. Such a rigid approach to evaluation of community initiatives cannot capture their ‘cutting edge-ness’ let alone nurture the required flexibility and agility in response to the changing context. Rather, the conventional evaluation framework rigidly applied to community initiatives more often restricts growth and development.

This tale of two evaluations illustrates the importance of choosing an appropriate framework for evaluation, one that is contextually appropriate. Driven by the biomedical framework persistent in the reporting requirements and through professional training, practitioners tend to perceive evaluation designs other than conventional as less valid. House (2014) argues that an inappropriate framework can lead to incorrect findings, hence the importance of reflexive practice for heightening the awareness about what implicit lens we apply when framing evaluation.

The conventional approach might be suitable in community-based health promotion in the context of structured programs, such as established health education trainings and workshops, especially those that are more clinical in nature. However, it should not be treated as the only credible approach available and should always promote elements of participatory evaluation design involving community members who are the intended beneficiaries of programs.

The developmental nature of community initiatives falls outside the boundaries of conventional evaluation frameworks and for this reason the very planning or the ‘framing’ of evaluations present a challenge. In practice, health promoters face a challenge attempting to apply developmental and participatory approaches within the boundaries of a top-down conventional approach that is prevalent in the institutional setting. Such challenges often position evaluation of community initiatives outside of the formal health promotion evaluation framework. Within the current institutional framework, evaluation of community initiatives is often marginalized at the organizational level due to the lack of resources and staff time as both are directed towards activities mandated by funders. The account of a health promotion coordinator below conveys how community initiatives although integral to health promotion, do not fit easily into the organizational framework:

> The first thing that I did was to create a health promotion framework that really kind of captured what are our main objectives are and how our existing work kind aligns with that. So, based on that document that has

> been created then we established more of evaluation framework that doesn't really necessary apply for community initiatives work per se, it's more specific to more of our programming, our ongoing programming… With our community initiatives it definitely is considered to be part of our work and everyone in health promotion is involved in some form of community initiative... I just don't think it is evaluated necessarily in the same way as we do for programming...

When comprehensive evaluation of community initiatives takes place it often happens due to an additional budget secured through other funding sources, or evaluative efforts exist on the margins and stay unrecognised institutionally. Below, the second case study 'The Food Space Initiative' highlights what conditions and processes enabled a useful and comprehensive evaluation process in the context of community initiative. The third case study of 'Neighbourhood Table' demonstrates the institutionally constructed invisibility of evaluative efforts that are not consistent with prevailing institutional framework.

Case study 2: 'The Food Space Initiative' evaluation: "Because we had funding!"

The Food Space Initiative is a mixture of service delivery and community led programs and projects. The Food Space Initiative aims to meet the immediate needs of the community members in food security as a well as building a sense of community and educating community members on the systemic issues around food security, poverty, affordable housing and social justice. The initiative was initially funded by the Ontario Trillium Foundation. The Food Space is governed by an Advisory Council that consists of five representatives of local agencies and five community members. The Food Space initiative conducted a comprehensive summative evaluation at the end of their 3-year project grant in order to assess the extent to which the initiative has met its goals and objectives. Their evaluation design combined conventional and participatory approaches. Four general methods of data collection were used: focus groups, interviews, surveys and photovoice. The Advisory Council reviewed and approved all recruitment and data collection materials and methods. The evaluation report highlighted issues of access to programs and services, volunteer opportunities, and

transparency of communication. The report also made recommendations regarding the structure and process improvement for the Advisory Council.

The extensive and comprehensive evaluation of The Food Space Initiative was made possible through additional resources accessed through the Ontario Trillium Foundation. The initiative was led by the frontline health promoter supervising a student in a Master of Public Health program, who was responsible for the evaluation design and implementation.

The use of photovoice as a method ensured a participatory approach to data collection and analysis. It was particularly valuable as a method when evaluating a particular objective related to using food as an educational tool to discuss systemic issues around food security, poverty, affordable housing and social justice. According to the evaluation report of The Food Space Initiative (2015: 29):

> By using photovoice as one of the methods for this evaluation, people who are members of the Food Space are not only involved in the co-creation of the knowledge outlined in this report but are also able to highlight and create critical discussion around systemic issues related to food security during the public gallery showing of the photovoice results.

Photovoice as participatory method emerged early in the process of evaluation planning. As the frontline health promoter (2017) explains:

> Part of the objective or one of the objectives of the Food Space is that it is very community minded space and the idea was that we wanted to encourage community ownership of the space etc., so we wanted to have an evaluation process that reflected that, and it was sort of a bottom up instead of top-down.

From interviewing the health promotion coordinator and the frontline health promoter, I learned that this participatory aspect and focus on informing further action made this evaluation particularly useful. As explained by the health promotion coordinator (2017):

> The Food Space has an Advisory Council that is composed by residents. From the onset there was a lot of feedback that was given in terms of the process and also getting those residents engaged in the process but also connecting to their networks that access the space as well. For instance,

> there was a focus group that happened with clients that are accessing the space through different programs. It was also an opportunity to connect with residents who were interested in being part of the photovoice experience and then it was an opportunity to talk to volunteers and staff who were part of the day to day activities of the Food Space. So, at the end we really were able to identify when the project started three years ago these were the identified objectives that we set out to accomplish, and then all the feedback that was collected and the data that was collected essentially was to be able to assess have those objectives been accomplished. Some were, and some were not. So that was an example of a really important evaluation process for us because now when we have thought the expansion, or not even the expansion, but what are the next steps we looked back to that report, to identify what we did not accomplish and how we were successful in what we did. And as a result of that we now secured multiple new grants and added more positions to support that work but essentially this where we are at right now was a lot based on the direction that we knew and was identified through that evaluation.

The photovoice component of The Food Space Initiative's evaluation turned out to be the most impactful for ensuring the sustainability of the initiative facing the imminent loss of access to a community centre that hosted The Food Space. As the frontline health promoter (2017) explains:

> [t]he Food Space is like a community food centre but run through partner agencies and we are housed in a community centre... in a room in a community centre and essentially we were about to lose our space in this community centre, so we were… looking for alternatives that had to be affordable. During the evaluation, we did a photovoice evaluation, there were community members who have been involved .... at the event where we revealed the photovoice project that the city councillor attended and as a result, we were able to get a space in a different community centre, so that was amazing...

This health promoter (2017) also shares how photovoice helped make the story of The Food Space Initiative visible, by putting a face to the statistical information and numbers in quite a literal sense:

> I think it was the way... partly that the photovoice project was detecting... it was very, very emotional, right? I think it was a beautiful story... about how people directly in the community we are serving were struggling. I think

> that really impacted the councillor, and they could see through that journey and that story we were depicting in the pictures…

The evaluation of The Food Space Initiative also illuminated some previously unaddressed barriers to food security, such as access to transportation and transportation subsidies for the most marginalized community members. As the same frontline health promoter (2017) shares:

> One of the biggest things that came out of the evaluation in terms of recommendations was that people were having trouble in terms of access to community food bank… For all the other programming we had TTC to provide to community members we would give TTC tokens, but the Community Food Bank was seeing such a large number of people… I forget how many households a month, 12 hundreds… or more than that. In the evaluation, one of the largest barriers, one of the recommendations was that in the future moving forward we should try and find funding to provide TTC tokens for the community food bank, to people who attend the food bank… Because this was one of the biggest barriers, because people live… in the catchment area for the food bank but they are not within walking distance away… and they have to spend money on transit to get to the food bank, which is a big barrier… which we didn't realise. We figure that if they are in the catchment area, they would be able to access…

These findings illuminate directions for further development of The Food Space, and according to a health promotion coordinator (2017), "that was an excellent example of an evaluation that really kind of informed and set the stage for the next phase in terms of where everyone wanted to see the work develop." Various aspects of the evaluation design ensured the 'usefulness' of evaluation:

- findings immediately informed action that helped expand The Food Space initiative;
- evaluation was more than a tool for data collection for accountability purposes, it was also a tool for community engagement and education;
- the evaluation design was participatory and action-focused or 'utilisation-focused' (Patton, 2016; 2018);[17]

[17] In a community-based context, 'action-focused' evaluation is a more relatable term (consistent with the principles of participatory action research) than the term 'utilisation-focused evaluation' used here less frequently in quotation marks.

- and finally, the evaluation became part of the initiative incorporated as part of the other activities of The Food Space Initiative.

In sum, it is the *participatory* and *action-focused* aspect of the evaluation design that made this evaluation process useful. In understanding The Food Space Initiative's evaluation, it is important to note what made it a useful evaluation but also to discern what factors and conditions enabled useful aspects of the evaluation design. There are, of course, apparent factors such as increased capacity due to additional human power (e.g., student as a lead evaluator, community volunteers) and expertise (e.g., student expertise and training provided to community participants). Less apparent but of no less importance are the existing relationships and trust among organizational partners and community members. It is because of the trust built with partners and community prior to the evaluation process that all actors saw evaluation efforts as something that was worth investing their time and energy in. These factors are apparent in the narrative of a health promotion coordinator (2017):

> There were challenges but I think what made it possible [is] the same vision that needed to be had by the three organizations because there were a few challenges with some of that initial kind of planning work… So, I'd say definitely organizational buy-in, the second thing was around the expertise, and the additional resources that come with that. So it is an additional body that kind of is able to take on that work, the fact that our staff was very much very hands on, and very involved, and the staff member had a lot of background and a lot of context around not only what we hope the Food Space would be but also what it had been in the last three years or so... [t]hose were essentially the pieces that helped to put it together, but I think the success of it is really [in] the ability to get residents to want to be part of that initiative and to want to be able to participate. Because you can have all the resources and expertise in the world but if no one was going to be wanting to support that initiative then it doesn't make sense... So I think having that relationship with residents and making it not only something that we as organization are going to benefit because we get a better understanding of what's going on but also seeing it as a capacity building and skill development opportunity and a way to engage and to connect.

When asked what made such comprehensive evaluation of The Food Space Initiative possible, the frontline health promotor (2017) also emphasises the importance of planning ahead for the evaluation process and embedding it in the program budget. In their view, it is important that the evaluation exercise becomes part of the overall project and not just an afterthought at the end of the project: “We had money! Because we had funding! You put money [for evaluation] in your budget when you are applying for the grant”.

In this case, the funder and their accountability requirements for an evaluation report encourages applicants to think about future evaluation processes in terms of planning ahead and coming up with an evaluation design early during the project implementation (Ontario Trillium Foundation, 2017). However, to design and implement an extensive evaluation always requires additional resources. As stated by the health promotion coordinator (2017), “I feel like the more extensive and more creative kind of evaluation has happened with projects because there is an added resource and expertise to kind of be able to bring that lens forth.”

Having additional resources, including money and expertise, enabled not only the depth and breadth of the evaluation process but was also instrumental in addressing equity issues in participation. Community members who participated in the photovoice project were reimbursed for their time and efforts, which is essential for enhancing equity in participatory evaluation. As the health promotion coordinator (2017) puts it: “the residents who participated were paid to participate.” The participatory aspect of the evaluation design ensured that the evaluation process itself was consistent with values of empowerment and equity embedded in the evaluated initiative. This is an example of when the evaluation becomes a tool for education and advocacy.

The example of The Food Space Initiative showed how evaluation, embedded as part of a funder-driven accountability system, supports a more comprehensive evaluation design that was highly participatory in nature. A participatory aspect and the expanded scope of evaluation was achieved mainly through the availability of additional resources secured through an Ontario Trillium Foundation grant. In this case, reporting requirements as vectors of the institutional discourse worked in synergy with vectors of a counter-hegemonic discourse i.e., community and peer accountability and

organizational values. Such combination enabled the expansion of the dominant epistemological framework to include epistemologies positioned as ‘marginal’ and to enable a design evaluation that was more holistic, participatory and equitable.

Case Study 3: The Neighbourhood Table – An Invisible Evaluation

To further illustrate the challenges and promising practices in the evaluation of community initiatives, I present a third case study, The Neighbourhood Table, a community initiative supported by CHC B.

The Neighbourhood Table is a neighbourhood-based network that includes representatives from local community-based organizations, public agencies and residents working together to address community priorities and to inform the development of services and programs of a neighborhood which prior to 2014 was identified as a ‘priority neighbourhood’ and currently going through a revitalisation process led by the City of Toronto. The Neighbourhood Table has been closely supported by CHC B over the years, as well as by other non-profit organizations in the neighbourhood, organization through in-kind contributions, organization as well as by residents volunteering their time and skills. At the time of this research, there was no formal evaluation process yet for The Neighbourhood Table. However, there has been a new workplan developed with intended outcomes and indicators outlined for different areas of work or ‘action areas’ identified by The Neighbourhood Table in consultation with community residents. This workplan was envisioned as a basis for the future evaluation framework that will be designed to track to what extent outcomes of the workplan were achieved.

At the time of interviews, the discussion about the potential evaluation of The Neighbourhood Table activities was in a very early stage. The fact that there was no evaluation process for The Neighbourhood Table was perceived as a major disadvantage, one that could potentially jeopardise its very existence due to its inability to show evidence for outcomes of their work. As explained by the health promotion program manager (2017), “in terms of evaluation of community initiatives, we have done very little… The Neighbourhood Table is supported by a number of different agencies. The Neighbourhood Table itself does not have an evaluation process that they are

currently working on." A community resident-volunteer with The Neighbourhood Table, who at the time of the interview was directly involved in supporting the organization's coordination as a contract staff, spoke about the absence of a formal evaluation process:

> At the moment I am really not sure what evaluation looks like from The Neighbourhood Table. What we are doing is capturing the number of people attending meetings, really looking at how many residents and agencies would be present at an action committee meeting, which is where community priority is… [b]eing addressed through some collaborative efforts of residents and partners. We have six of those, so we are really trying to get a sense at least in the early stages, how many people are attending meetings, in action committee meeting, and how many of those are residents. Beyond that we really only capturing the conversations in the form of meeting notes or minutes, to at least have some records of what is being discussed. The only other piece is that we have developed, or are developing, the draft work plans... that would at least outline some objectives... in a standard workplan format, actions and strategies to implement the objectives and then at some point to capture what the outcomes were, and that's I think the basis at least, of evaluation data (staff/community volunteer, 2017).

Contrary to the accounts of the health promotion program manager and the frontline worker, this community volunteer (2017) who has been involved with The Neighbourhood Table since its inception, spoke about a participatory process of reflection on action that has always been present in The Neighbourhood Table albeit not formalized:

> I don't know... if we really evaluated in the formal sense of evaluation... but I think every year because we had an AGM [annual general meeting], we do different types of mapping and ask what we did last year, what worked, what didn't work, or where we need to make those changes? And how do we make those changes? And who do we need to bring on board to support those changes? So, I guess in that respect it wasn't as formal as taking data and looking at the data. We didn't do that type of assessment, but every year, because we have an Annual General Meeting, we did assess what we did a year before and asked myself, ok where do we want to go from here? And what do we need to keep, what need to let go and then what we need to bring back in?

Here is how the inclination to top-down conventional framing of evaluation in relation to 'formal' evaluation process becomes apparent in the narratives of practitioners involved with The Neighbourhood Table. For example, in relation to evaluating the participation of resident-members and organization/agency-members in The Neighbourhood Table, indicators of participation were thought of as primarily numerical. Data collection was perceived as capturing primarily outcome-related data. That by itself is not problematic and is expected in terms of both process and outcome evaluation. What is troubling, however, is that the evaluative learning process that has been present at The Neighbourhood Table is not recognised as 'evaluation' due to the absence of the internal/organizational infrastructure to support such process in a formal capacity.

Such participatory reflective and action-focused process is not necessarily formalized as part of The Neighbourhood Table's official 'evaluation' and nor was it included in the workplan. The account from frontline health promoter who has been involved with supporting The Neighbourhood Table as part of health promotion activities, provided more details about how institutional invisibility of the existing evaluation process was partly structured at the organizational level (per the conventional evaluative approach depicted in Figure 9). The frontline health promoter (2017) spoke about the underdeveloped infrastructure at the institutional level in terms of both reporting requirements and data collection systems that are not able to support systematic collection and analysis of evidence about outcomes and impacts of the community initiatives supported through the community health center's efforts:

> Because we are working in this clinical environment, it's really hard as a health promoter to put those kind of data [referring to positive aspects of a client as opposed to 'deficiencies'], it's not there and, another thing, it's just for programs but community development!? We don't have data... If you ask me about programs, it's easy, this is what we collect, this is how we do evaluation, but for community development we don't have those tools, it is not yet there… With programs it's easier, with services it's easier, but with community development it's not easy, we put lots of resources with our [Neighbourhood Table], but we don't encounter all these kinds of things. Because of that, and unless you collect data, it's really hard to show the impacts of the program, when you do evaluation, you want to say whatever resource we put in is worth it, that's what we

> want to say. We have lots of stories to tell about that program but to do that in order to go through evaluation, we don't have the tools.

Further conversation with the frontline community worker/volunteer (2017) supporting The Neighbourhood Table describes the impacts of the 'absent' evaluation on the local community initiatives involving community housing residents[18] and reflects on the impact of access to local community housing space for supporting residents' leadership:

> For the period that we had residents involved in our community development efforts alongside partners, residents were given ownership to some extent, of the spaces, access to our community rooms, without going through this kind of [formal] application process... All of these things, working closely with partners, having the opportunity to lead events and different initiatives in community, encouraging the involvement of the young people and our youth leaders as well, there were changes in the overall behaviour of the community. Did we see changes in the critical incidents in the community? Absolutely. Have we seen increased involvement of residents at community meetings? Yes. We've seen all these changes, so I would say there have been some changes in behaviour but again it is not documented, it's really just the lived experiences of the residents to say yeah my children are feeling more comfortable being outside, playing in the playground, using the facilities, and these types of things without being concerned that there is going to be a drive by shooting. Those are so valuable to really look at why are residents' efforts are needed you know... in the work but we don't have anything to prove that.

The examples of the frontline community worker experience with community housing agency illustrate the impacts of the missing evaluation component and its implications for equity and justice. Having access to the spaces within a community housing complex was central for community engagement work with residents. Resident-leaders had access to community spaces where they could organise community meetings and gatherings while providing an open, safe and welcoming space for

[18] This is an example of an even smaller scale community initiative specific to community housing complex in the neighbourhood supported through The Neighbourhood Table as an overarching/umbrella initiative.

community members. Over time, risk management and liability issues took priority for community housing agency administration and rules regulating access to community spaces were tightened. Such restrictions affected the ability of residents to self-organise and exercise their leadership. The impact of restricted access to a community space had a disempowering effect on the residents of the community housing complex. The results of the resident-led group work, their story, the impact of having access to space, and the lack of such, were never formally documented. In retrospect, the interviewed frontline community worker (2017) thinks that if there had been a resident-led formal evaluation process, they would have been able to demonstrate both the positive effect of locally ran groups on the residents of the community housing complex and the negative impact of restricted access to a community space. In their view, such information could have been used in advocacy efforts with community housing agency administration:

> [Community housing agency][19] has been over the last three to four years very much limiting that access that not all residents, but resident leaders have been able to have. However, had we been able to go back to the agency and say 'listen, when you allowed these, and these kind of structures were in place that enabled residents to be able to take some ownership of spaces, we had an increased number of programs, we had an increased number of participants in the programs, we were community building, we've seen things like more residents involved in tenant council, voting, like all of these things that they want to measure on tenant engagement on. What would be valuable for us is to be able to say, 'this directly impacted us'. And when you removed this, this is what has changed. Because we had lots of difficulties going back, because when they are talking risk management, the agency is talking risk management liabilities on one side of the scale, and we are saying change in behaviour, residents' engagement, all these things have been influenced by this, we have very little to prove [this change] (frontline community worker, 2017).

From the narratives of the four interviewees approaching the evaluation from the different points of location in relation to their involvement with The Neighbourhood Table, the following lessons in relation to the evaluation of community initiatives arise:

[19] The name of the actual public agency is changed for a generic 'community housing agency' to preserve the confidentiality of research participants.

- Evaluation is not formalised as part of the existing data collection in relation to community initiatives, and is not included as part of the overall workplan;
- Formalized evaluation is perceived as measurements against predetermined goals and objectives as per The Neighbourhood Table's workplan;
- There has been ongoing evaluative process present in the form of participatory action/reflection process at The Neighbourhood Table. Such process contributes to reflexive practice but is not recognized as 'evaluation' per se through the institutional lens;[20]
- Institutionally structured invisibility of evaluation compounds the 'lack of evidence' regarding impacts and outcomes of the initiative.

In sum, the 'absence' of an evaluation process at The Neighbourhood Table, the ongoing evaluative efforts that are largely reflective and participatory with a focus on immediate action are not recognised as evaluation and are not formalised at the level of organizational practice. Referring to Figure 6, evaluative activities of individual practitioners at the micro-level of individual practice are not recognised at the meso-level of organizational practice and thus are perceived as 'absent' and therefore not captured in the top-down conventional approach to evaluation favoured by the dominant institutional discourse.

Using the case of The Neighbourhood Table as a community initiative, the key question is how the absence of a formalised evaluation process may impact its present and future? At a time when there is much emphasis on 'evidence-based' decision making and practice in non-profit and public sectors, what is recognised as 'evidence' within the institutional discourse and how the 'absence' of evidence may in fact be institutionally structured becomes of crucial importance. The matter of 'evidence,' or the lack of such, lays the ground for a familiar scenario where the outcomes produced as a result of community initiatives are dismissed for 'lack of evidence' while efforts invested

[20] Other agencies supporting The Neighbourhood Table may possibly have some sort of systemized data collection and analysis in accordance with their specific reporting requirements, however, these specifics are beyond the scope of this research.

in community work are perceived as avoidable and excessive expenses and are often cut in the pursuit of even greater efficiency and fiscal accountability. Thinking in terms of implications for community health centers' evaluation practice, how should the sector address the reporting and the evaluation of community initiatives?

The desire on behalf of the practitioners to introduce 'formal' evaluation process is understandable. Yet, the question of formalising the evaluation process is tricky. Does 'going formal' involve adapting evaluation activities to fit the preferred conventional top-down evaluation approach consistent with positivist epistemologies and changing methods and tools to fit quasi-experimental design? Or, does it involve expanding epistemological foundation to accommodate approaches that are presently constructed as 'marginal', to include participatory and/or developmental approaches along with a range of methods and tools currently not recognised within the institutional systems of data collection? Health promotion practitioners assume that 'capturing' the data within an institutionalised framework provides the evidence necessary to secure support from funders and policymakers while omitting the fact that the dominant framework may not be compatible with the complexity and fluidity of community initiatives. There is danger that once the data collection for community initiatives becomes part of a formalised reporting process, the evaluation may take shape of a top-down conventional approach consistent with the epistemological framework prevailing in reporting requirements even though it might not be most appropriate to the context of community initiatives.

The case studies discussed demonstrate the following priorities for an evaluation design process specific to community initiatives:

- Evaluation design is grounded in participatory approach to ensure involvement of community members, who are the intended beneficiaries of community initiatives;
- Where possible, developmental approach, consistent with emerging and fluid nature of community initiatives, is applied;
- Evaluation provides rapid results sharing to inform action, also known as shorter 'feedback loops'; and
- Evaluation activities are embedded as part of the current workplan.

Case Study 4: Diabetes Education Program – Evaluation Outside the Box.

> If we focus just on diabetes and not look at the other aspects, it's going to be such a dull program (Program manager, 2017).

The final case study looks at the Diabetes Education Program (in CHC A) to understand how evaluation practice is structured with respect to personal development groups. It shows how the diabetes education program team uses the evaluation process to support the goals of reflective practice development and through that achieves program quality improvement and enhanced performance. The evaluation process, in this case, is not mandated by funder requirements but is supported by the organizational values of equity, accountability to community, and a commitment to quality improvement.

The program manager of the Diabetes Education Program spoke about the importance of evaluation process for planning and coordinating health education activities related to diabetes prevention and management workshops. From their perspective, evaluation in the form of feedback from program participants provides an important evidence for the team based on which the manager initiates dialogue to inform future activities and the team's workplan. The evaluation process is embedded as part of an action-reflection cycle in the team's reflective practice. As explained by the program manager (2017):

> As a program manager I wanted to do the holistic kind of coordinating program, I believe that there should be… pre-planning coordinating, coordinating, implementation. This will all be futile if I don't reach this evaluation stage because only then can I bring back to the team how we can improve and get the buy-in, there is something that I need to implement, there is evaluation piece, something that we can maybe discuss together. [i]t is important for me to have this evaluation piece, however simple, for us to discuss. For me the evaluation piece means the program does not end in implementation, there should be a follow up – there should be monitoring, evaluation and follow up, for me it is like a circle.

Such an approach to evaluation goes well beyond fulfilling reporting requirements, as the evaluation piece is not requested by the funder. The evaluation

report is part of the information that the program manager submits as an important supplement information to the workplan reflecting the team's approach to practice rooted in reflection-action cycle:

> Although there isn't any funders' evaluation form, piece that's required from us... there are two pieces of reports that are required, there is quantitative piece around stats, numbers and the qualitative piece which is workplan. There are three goals in the workplan, and each goal has activities. So, part of the workplan I submitted to the funder would always include some evaluation (program manager, 2017).

What I found most striking in the program manager's account is the role played by the evaluation process in program development. Ultimately, the continuous and consistent approach to collecting feedback from program participants and analysing it together with the team members to inform workplan development fostered a collective culture of evaluative learning and reflexive practice. This culture of reflective learning led to an expanded, holistic approach to program development. This is how the Diabetes Education Program was able to broaden the range of topics to include stress management, glycemic index and fasting with diabetes. As explained by the same program manager (2017),

> Initially the motivation was just for each diabetes program across the sector to go after statistics because our funding is based on the number of clients, we serve... Initially as most diabetes education programs, we just focused on diabetes per se, diabetes management and diabetes prevention. But then we saw that it will be good to expand and address social determinants of health, you know poverty is related to diabetes in a way when you are not able to actually access healthy food, which more often than not is very expensive compared to fast food then it affects your health and diabetes, right? You eventually get diabetes from that. So we started trying to... move out of the box, and just look at the ways in how we can address... providing healthy living lifestyle information to our clients just so they don't get diabetes and if they are at risk they don't progress to having diabetes, and if they already have diabetes, they won't have to go to emergency and be able, through a community provider, to address their health concerns right in the community.

In the narrative of the program manager, the recognition of a narrow focus on an individualized lifestyle/behaviour approach is apparent. In the account below the same program manager (2017) spoke about how evidence gathered through evaluation processes informed program development and was key to expanding the focus of the program to include social determinant of health:

> I was telling about how we are capturing the comments verbatim, right? Word for word as is. There are some questions like ‘what other topics you are interested in’. You would be surprised by the variety of topics that our participants would come up with. Some would talk about sleeplessness, the reason why we came up with stress management it’s because a lot of people who have been diagnosed with diabetes have anxiety and are in denial, they are having diabetes and do not do anything about it. We thought it will be good to talk about stress management and we came up with that. There were those topics as well as around cardio health, hypertension, cholesterol and we do know that of you have hypertension and high cholesterol that you are at the very high risk for diabetes, so we thought let's talk about this, because if they have cardio health issues, we don’t want them to proceed to having diabetes, so we might as well talk about this and help them to be informed. Physical activity is important, healthy eating is important. For cooking sessions, cooking demo, we have limitation around whether the venue, a site would have a certified kitchen, but then we make do with 'dry demos', so we would have someone pre-slice vegetables and our dietitian would just do a demo mixing these vegetables coming up with a healthy salad that is affordable, and also without having to use a certified kitchen for them to learn how make these things at home, even for newcomers. Newcomers are more focused on putting food on the table, finding work [and therefore] health conditions are not a priority for them, the priority is to put the food on the table... So, they should learn how to be able to access food and be able to know where to go for help if they need any. It's very interesting how we come up with these new topics based on what we got from our evaluations.

Qualitative feedback solicited through the ‘Voice of the Clients’ survey provided the information regarding the breadth and depth of health-related issues community members experience. The Diabetes Education Program team shaped programs in response to these needs. How did this process take place? On a micro-level of individual practice, practitioners made a decision to collect client qualitative feedback, in

addition to measuring changes in confidence level in relation to diabetes management, exercise and blood-glucose levels through pre- and post-program surveys. Qualitative information was added to numerical data to reach context specific understanding of a program impact/effectiveness. At the organizational level, such evaluation was driven by the goals of quality improvement in combination with organizational values of the CHC that emphasise equitable access to culturally relevant and client-centred services, as evident in the objectives of the workplan specifying “using client and community feedback to better understand and address barriers to equitable access; [and] center[ing] on the client by encouraging self-management, personal goal setting, and using client feedback for continued improvement” (Diabetes Education Program, Anonymous CHC, 2017: 2-3).

This case is a concrete example of the impacts of a reflective practice for program development, where the program manager speaks about how continuous reflection on the needs and priorities of the community informed the development of a workshop on diabetes management during Ramadan, a fasting period in Islam during which practicing Muslims abstain from food and water between sunrise and sunset. This workshop addressed an important gap in health education as the information on diabetes during Ramadan was not easily available except in the form of a standard advice from doctors to avoid fasting during Ramadan for people with diabetes, which was not culturally appropriate for observing Muslims. Reflective action-focused evaluation enabled the team to develop a very specific workshop for a previously underserved group of people in response to the concerns of the community the team served. As the program manager (2017) explains:

> We do have a lot of community residents who are Muslim brothers and sisters, and we do know among Muslims there are South Asians and this is a risk for diabetes and most of them have diabetes, and in this location, there are mosques… so we do know there is a need for [information] because when you have diabetes and when you are fasting your doctor would normally advise you not to fast because it can affect your diabetes management. So obviously, because they don't eat during the day and they eat during the night, there is a lot of changes around medication, and even administration of medication and diet. So, it's more like environmental scoping or scan, knowing that there are people who would

> need this particular service, and so that's where we started. We actually expanded it [the diabetes education program] to different mosques, and we've got as far as Markham, there is a lot of different places where we've gone to. But we focus more on the residents in the community within our catchment area. It's been sort of like a signature topic for our Diabetes Education Program.

The program manager (2017) also discussed how the team's efforts to address a whole person rather than focusing on diabetes alone were integral for building trust and good relationships with community members:

> Diabetes is a chronic condition and we want to make sure that there is continuum of care. We can't just be there one time for a group session, we want to make sure that we are there for them as well in other aspects. Especially in one-on-one counselling there are a lot of aspects that come up during counselling where they [practitioners] would at some point find out that the clients would need social assistance, they [clients] talk about homelessness, or they talk about substance abuse... because these things come up and so we should be able to make that connection to other providers in the community or within the centre, to make sure that there is continuum of care within the community… If we focus just on diabetes and not look at the other aspects... it's going to be such a dull program! [laughter]... We have somehow look for other ways and how we can entice them back because we want to continue the care we provided for them.

If driven solely by accountability requirements to funders and goals of summative judgement, the Diabetes Education team could have easily dismissed requests for 'other' topics as they are outside the program's mandate, or solely work towards 'managing clients' expectations', or even choose not to solicit such feedback at all. Yet the team persevered in addressing the issues raised by program participants in relation to diabetes and other health issues. This account highlights the value of reflexive practice approach for organizational learning and development, as well as for quality improvement in connection with organizational values.

Although the Diabetes Education Program focuses exclusively on diabetes management, and such focus is consistent with the biomedical model of health, the team nevertheless uses the results of evaluation to address health concerns other than diabetes, using reflexive practice as a vector of discourse. This is supported by

organizational values of equity and community engagement as reflected in the local CHC's strategic plan seeking to increase community engagement activities (e.g., delivery and evaluation of programs and services) and to "focus on health equity by reducing barriers to accessing services (e.g. physical, transportation, language, stigma, etc.)" (Anonymous CHC, 2017).

Although not fully framed as participatory as clients of the Diabetes Education Program did not have input into the survey design development per se, this conventional evaluation nevertheless created a space for clients' voices in the program development by ensuring that clients have opportunities to provide feedback outside the pre-determined response options in the survey. The following conditions support such approach at an organizational level because

- Evaluation is embedded in program development as part of an action-reflection cycle with a goal to develop context specific knowledge to inform action/practice; and
- Evaluation purpose is not limited to summative judgment and accountability to funders but includes accountability to community members (i.e. clients) and peers (i.e. community of practice) as well.

Reflexive practice development supported by organizational values of equity and justice works as vector of counter-hegemonic discourse aligned with the epistemologies marginalized by the dominant institutional discourse. By expanding outside of the dominant epistemological box to include marginalized epistemologies, the team also contributed to building trust and good relationships with community members.

The reflexive practice component of the evaluation process enhances and is simultaneously supported by peer accountability among the team members, and downward-oriented vertical accountability to the program's clients. As explained by the program manager (2017),

> I guess you gain respect from your team members if they see that whatever it is that needs to be done, has to be delivered, is based on not only what the funder requires but also based on your knowledge, holistically what should be done to be successful as Diabetes Education Program, what do we want to do. We want to take care of our clients, our community residents, within the community, we want to be able to provide the service to them within the community so that they won't have to go to

> the hospital to emergency for every little thing that they feel. We want to be able to give them empowerment and also self-confidence in managing their condition so that they won't have to go to ER, and you know how costly that would be. So, looking at that and making sure that we are able to provide the service to the community residents in a way that should be is I think, very motivational for us, and also the respect that we have in the evaluation piece is the big part of that...

The Diabetes Education Program evaluation process also helps satisfy upward-oriented accountability requirements to the funder as the evaluation process supports service delivery. The increase in numbers of clients served is evident in quarterly report submissions (Diabetes Education Program, Anonymous CHC, 2017).

Such a comprehensive approach to evaluation, supported at the level of organizational practice goes nevertheless against the grain of the dominant institutional discourse. By stepping outside of the box of conventional approach to evaluation and asking qualitative information with the commitment to use that information for program development, the team was able to achieve improved quality of service and to satisfy both funders and community members. Yet, because this kind pf evaluation is not sourced and/or requested by the funder, it is also a component of practice that is most endangered because it is marginal and is highly dependent on the available resources and the commitment of the program manager. Should these conditions change, the reflexive practice component will suffer, as evaluation may shrink to a narrower data collection mandated by the funders reporting requirements.

Conclusions

The four case studies illustrate the challenges and promises of emerging practices in health promotion evaluation. Methodological fundamentalism present in the prevailing institutional discourse and epistemology often restricts evaluation to the conventional top-down approach with limited opportunities to incorporate comprehensive participation of a broader range of actors involved. The prevailing epistemological framework is aligned with the biomedical model of health, and as such prioritizes quantifiable information where the evaluation process is often conflated with performance measurements resulting into a summative judgement of success or failure.

Such interpretations of evaluation have been strengthened by the existing contracting regime between non-profits and their funders and reinforced through a phenomenon described by many as the 'accountability movement' (Carman, 2010). Altogether these trends undermine key health promotion principles of participation, interdisciplinarity, empowerment and appropriateness/responsiveness to the context.

With respect to community initiatives there are no effective data collection tools at the level of the CHC sector that would allow to comprehensively describe and track the outcomes and impacts of the initiatives. With respect to both personal development groups and community initiatives, the existing data collection system pathologizes individuals as it is focused on deficiencies and is informed by the biomedical model of health.

Evaluative efforts taking place outside of the conventional top-down framework may not even be recognised as 'evaluation.' They oftentimes exist on the margins of organizational practice and resource allocation to support such efforts is easily jeopardised due to changing strategic priorities and funding cuts. In sum, a comprehensive evaluation practice that is aligned with health promotion guiding principles exists on the margins of the system. Yet, it is an evolving area of practice and there are promising emerging solution to this challenge. For every vector of hegemonic discourse, there are vectors of counter-hegemonic discourse. Community and peer accountability and reflexive practice development supported by organizational values of equity function as vectors of counter-hegemonic discourse shaping the evaluation practice as more consistent with health promotion guiding principles. Such practice calls for the expansion of the epistemological framework to involve hermeneutics, critical social studies and Indigenous knowledge traditions that are more closely aligned with a holistic model of health. Such an approach supports participatory knowledge creation in collaboration with community members involved in evaluation design and implementation. At the level of organizational practice, participatory and developmental approaches to evaluation exist with the purpose to generate context specific knowledge, inform local action, and support deliberative dialogue in order to maintain accountability to and connection with community members. Yet, such an empowering and democratic evaluation practice takes place within an environment where the lack of resources is a

perpetual concern that endangers the very principles of practice that support equity and deliberative dialogue. Rather than subjugating evaluation practice to austerity measures, and through that further contributing to the rhetoric of 'scarcity' and marketization of the non-profit and public sectors, I appeal to funders, administrators, evaluators and a broad range of health promotion practitioners to push back against the mentality that endangers reflexive practice development and participatory approaches, and thus threatens the key health promotion values. Accountability skewed in the upward direction towards funders and administrative decision-makers suppresses democratic deliberative dialogue between actors involved in the process, subjugating the voices and perspectives of those at the bottom level of the institutional hierarchy.

There is danger for practitioners of evaluation to fall victims to the institutional hierarchies and pressures, unless the practice itself is involved in critical examination of its principles and values. In his book *Facilitating Evaluatio*n, Patton (2018) drawing on the original framework proposed by Ernest House (2014), writes about *truth, beauty* and *justice* as the inspirational principles for evaluation. While House (2014: 31) suggests that *truth* means "attainment of arguments soundly made," truth is multifaceted and must include the truth of those who are most likely to be excluded from the decision-making concerning evaluation and its use. In the context of community-based non-profit work, it means "those whose lives may depend on the quality of the services they receive" (Patton, 2018: 170). In the community-based context, it means those who experience first-hand the consequences of austerity measures on public and non-profit sectors, inflicted by those who are inspired by profit accumulation. Thus, seeking *truth* inspires evaluators to focus on the pursuit of participation of a broader range of actors, while *justice* transpires as a conscious and consistent effort to involve those who are most likely to be excluded from participation in the framing of the evaluation process due to their existing marginalization. Finally, *beauty* refers to a well-crafted process that brings all actors together in a deliberative dialogue.

Adherence to such principles, I suggest, may help practitioners to navigate a complex terrain of conflicting goals and priorities among multiple actors, all of whom have varying degrees of power and involvement in evaluation process. In the community health promotion context, evaluation is more than a set of technical tools to

assess resource allocation and the achievement of the outcomes pre-defined in a top-down manner. It is a process to ensure a more balanced accountability system, while supporting learning and action.

At the level of funders and policy makers, my recommendations for strengthening the alignment of evaluation practice with health promotion principles are:

- Incorporate requirements for context-appropriate evaluation as part of reporting requirements, e.g. requesting examples of how evaluation informed learning and program development;
- Ensure a designated budget for evaluation activities;
- Request evaluative learning plans included as part of submitted project proposals/work plans;
- Assess evaluation strategies proposed for their appropriateness to the context and alignment with health promotion key principles; and
- Build capacity for participatory evaluation, within funding agency, as well as among grantees.

At the level of organizations' administrators (CEOs, management, Board), the following actions seem appropriate:

- Strengthen the balanced accountability system through supporting reflexive practice development aligned with organizational values of equity, anti-oppression and accountability to community;
- Ensure a designated core budget to support comprehensive participatory evaluations;
- Embed evaluation activities as part of organizational workplans and overall planning cycle;
- Build organizational capacity for participatory and developmental evaluation; and
- Educate clinical practitioners and program staff on key principles and evaluation strategies in health promotion when involving in multidisciplinary work.

Finally, practitioners could achieve a better evaluative process upon considering the following recommendations:

- Embed a participatory approach in all forms of evaluation, including both conventional and developmental, formative and summative;

- Involve a broader range of actors in evaluation planning and implementation, emphasising the involvement of people with lived experiences;
- Ensure the equitable participation of community members by compensating participants for their time, skills and knowledge; and
- Stay committed to reflexive practice.

When evaluation is approached as a process focused on reporting to fulfil funder-driven accountability requirements, it may prompt organizations to implement adaptive responses that not are necessarily consistent with the core principles of social justice and equity. Such responses may contribute to creating a gap between organizations' internal values and practice. Linking the evaluation process with learning and reflexive practice development helps organizations to avoid creating such gap between their values and practice, while strategically engaging with other non-profits, state and private actors.

Non-profit organizations are not static entities, they are important participants in the civil sphere. As such, the sector is involved in the process of negotiation between three major forces represented by civil society, state and market. Darby (2016) discusses reflexive practice as an important element in the dynamic resistance of the sector responding to shifts in power relations imposed through the neoliberalization of the public and non-profit spheres. Simple adaptive responses on behalf of the sector, such as resilience and resourcefulness in the face of challenges arising from interrupted funding and pressures to increase service delivery, carry the dangers of cooptation when practiced without attention to the core values of non-profit organizations (Darby, 2016). A participatory approach to evaluation supports such necessary expansion of the evaluation process beyond reporting to engender learning and values-based practice. By engaging various actors, participatory evaluation fosters deliberative dialogue, which is central for creating a more balanced accountability system. By placing deliberative democracy at the centre of the process and ensuring that the voices of the actors who are most likely to be marginalized are included, participatory evaluation is intentional in its efforts to de-centre power (Springett, 2017).

Building on the understanding of the challenges and strengths of the evaluation practice in community health promotion context, the following chapter examines to what

extent evaluation can be *participatory*, and how it is understood and practiced by the various actors involved in health promotion.

Intermission 4: Learning from the Garden

I keep a garden. I grow a garden. I tend to my garden. No! It is the other way around. My garden keeps me, my garden nurtures me, my garden tends to my body and my soul, and my garden grows me into a better person. This is my personal Garden of Eden where I am free to gorge on the fruit of knowledge, enjoying its every bite…

There is nothing like the end of summer to remind one about the time fleeting, days and hours rushing by, slipping away. How come it is August 20th?! Where did the time go? Yesterday I was just planting the garden, revering the Earth awake from her winter sleep, and greeting every tiny spear of grass poking through a chilly surface, carefully sowing the seeds and worrying that they may not sprout… Now the garden is a jungle, and those fragile pointy ends turned into a towering entangled mess. The mint family has committed yet another onslaught on its more modest neighbours, and the beans once again have produced a prolific number of curvaceous pods swelling up with pride. The 'weeds' that I decided to let grow on the 'hügelkultur' bed so that I become more familiar with local plants and their properties, flourished into a formidable display worthy of a botanical garden, just to remind me that there are so many plants I am yet to learn about.

I looked at my garden after two weeks of being away from it, and at first, I shook my head in grief: "If there was a picture of neglect in gardening books, this must be it"… Everything looked so overgrown and overcome by a jumbled mess of green stuff blooming, setting seeds, climbing, creeping, fruiting, rotting, and taking over whatever the illusion of 'structure and order' I was trying to maintain. And then I stepped back and took a different look…, yes, there was no

conventional system in place, but everything was filled with life in its different stages. Overripen fruit was feeding hordes of bugs, beetles and worms, the seeds were preparing themselves for overwintering so that in the next season they will multiply into more plants and more seeds. The garden itself was literally buzzing with life, with the actual buzz coming from the numerous insects feasting on the flowering plants, many of which in conventional gardens are referred to as 'weeds', and many of which were supposed to be eliminated or suppressed by the 'system' before they had a chance to flourish. I've never seen so many bees and other pollinating insects in my garden, it turned into such an insectarium…or should I say "insect-sanctuarium"? This time I thought "If there was a picture of abundance, this must be it", and despite my failure to harvest all of tomato crop this year, I felt proud of the garden once again. So, let this be a reminder that by trying to organize things excessively, that by imposing a very rigid system very early, and 'weeding out' too much, too early, in order to come to a pre-determined result, we risk losing the abundance, we risk eliminating potential learning opportunities, we suppress feeding and breeding ground for some perhaps unanticipated yet positive outcomes.

August 20, 2018

Chapter 5: Participatory Evaluation in Community Health Promotion

> The fight against disparities can be won only if the most oppressed communities can be fully engaged as partners in exploring and in taking action to address the health and social problems about which they – not experts as outsiders- care most deeply (Minkler and Wallerstein, 2008: 12).

In the previous chapter I discussed four case studies to illustrate key epistemological and methodological challenges to context appropriate evaluation in community health promotion. The case studies illuminate promising practices in relation to advancing evaluation consistent with foundational principles and values of health promotion i.e., participation, empowerment, interdisciplinarity and appropriateness to the context. Participatory knowledge creation and reflexive practice development are integral to this process. This chapter starts with the general discussion of issues pertaining to participation and power, and then proceeds to the analysis of power distribution within an evaluation process through the lens of a conceptual framework developed by Furubo and Vestman (2011). The chapter describes and reflects on the experience of facilitating a participatory process for bottom-up evaluation design and discusses issues pertinent to participatory evaluation in the context of community-based health promotion initiatives.

Participation, Power and Empowerment

I first discuss connections between the notions of power, participation and empowerment. I problematize participation and argue that without attention to power redistribution among multiple actors who exercise different degrees of decision-making power in participatory processes, participation may be co-opted by those and for the benefits of those who are positioned higher up in the organizational hierarchy. Unproblematized participation carries the risks of further marginalizing already vulnerable actors excluding them from processes that would allow marginal actors to incorporate their priorities into agenda setting and to pursue goals that matter to them (Cornwall, 2008). Such issues become of the utmost importance in the context of community development and health promotion work, where non-profit organizations are

strategically positioned between community and the state. The neoliberal state acts as a buffer between civil society and the market and is inherently biased towards capital. Such bias is explained by the necessity of the state to secure its own legitimacy within pro-market ideology and for-profit economy (Coburn, 2006). The neoliberal state has increasingly aligned its interventions in civil society with market forces and has assumed the role of regulator of civil society institutions to serve profit accumulating functions (Meade, 2012; Fursova, 2016). Positioned between the market, state and civil society as represented by communities, neighbourhood-based non-profit organizations attempt to address grassroots community participation by facilitating various collaborative actions intended to respond to local needs and priorities.

Darby (2016) suggests approaching non-profit organizations as relational actors who are involved in dynamic processes of negotiations between civil, state and economic powers. Non-profit organizations are often mandated to convene *community participation,* framed in terms such as community, client, or resident engagement. Community participation in this context is defined as a voluntary process of taking part in any formal or informal activity or an initiative designed to improve community life, services and resources (Wagemaker et al., 2010).

There are many typologies of participation developed and adapted to different contexts of participatory processes. Most notable are the ladder of citizen participation by Arnstein (1969), a typology of participation by Pretty (1995), the adaptation of Arnstein's ladder in the context of children and youth participation by Hart (1997), and a typology of different forms of participation by White (1996). These typologies are useful for understanding degrees, levels and forms of participation. I focus on Arnstein's (1969) and White's (1996) typologies for they are most pertinent to community development and to participation.

Arnstein's (1969) ladder became the most well-known and widely used tool in community development. It includes eight levels and three degrees of power, reflecting the quality of citizens participation, where partnership, delegated power and citizen control are positioned as corresponding with higher levels of citizen power, and therefore higher degrees of participation. Arnstein (1969) argues that real citizen participation is impossible without sharing and redistributing power.

White's (1996) typology of participation demonstrates the differences in interests invested in participatory processes between those who initiates participation and those who are invited to participate, considering power differentials between the actors approaching participation from the 'top-down' level and those entering participatory processes from 'bottom-up.' White (1996) identified four forms of participation: nominal, instrumental, representative and transformative. Her typology connects each form of participation with the interests of the actors with more power (i.e., top-down) and with those who are less powerful (i.e., bottom-up); each form of participation is also connected with its primary function. According to this typology, a nominal form of participation is intended to display or placate; instrumental form of participation is used by the more powerful actors as a means to achieve efficiency. Representative form participation is sought to gain voice. Only transformative form of participation is associated with 'empowerment', which becomes both means and end in the process, and where both types of actors have 'empowerment' within their interests.

Empowerment has become one of the most widely used terms in the community development sector, but unfortunately its meaning became vague and diluted with its increased usage. Within the context of neoliberal politics of austerity, empowerment (or its variation of self-empowerment) and 'self-mobilisation' often conflate and are narrowed down to 'do-it-yourself' approach for program and service delivery at a community level. The terms 'participation' and 'empowerment' may become co-opted into yet another mechanism for individualising the social, consistent with neoliberal policies of minimising the state and shifting its responsibilities to individual citizens (Cornwall, 2008). If participatory processes ignore power differential among actors, even 'transformative' form of participation with goals of empowerment may in fact be an 'instrumental' form, masquerading as transformative. Conversely, when there is attention to decentering power through expanding the range of actors involved in a process, representative participation can take a transformative form once participants take part in actively negotiating their terms of involvement (White, 1996). Clearly, participation itself does not necessarily guarantee empowerment; participation is empowering only when it is approached with an explicit focus on addressing power inequities among those who participate (Laverack, 2001).

Any framework or typology for participation faces the dangers of co-optation if depoliticised. The lack of critical interrogation of power differential among actors invited to participate creates a foundation for potential misuse of the concepts of participation and empowerment. Tensions between actors, terms of involvement, and the context within which participation takes place, inevitably create a *politics of participation*. White (1996) discusses such dynamics of power in participation focusing on the dynamics of power within and between 'top-down' and 'bottom-up' actors to demonstrate how such dynamics shape and are also shaped by the forms and functions of participation.

Arnstein's (1969) ladder shows that participation at the lower levels of 'manipulation' and 'therapy' can be disempowering. Yet, even participation at higher levels on the ladder in an action without serious implications for the process brings less empowerment than participation at the informing rung in relation to a specific action that has more profound consequences for those who participate (Cornwall, 2008). Much depends on the context and the scale of the process open to participation. Tritter and McCallum (2006), discussing Arnstein's ladder in the context of health care service-user participation, argue that Arnstein's model ignores several aspects of user involvement by failing to differentiate between method, category of users, and intended outcome of the involvement. Tritter and McCallum's (2006) critique is to some extent valid when Arnstein's ladder is used in the contexts of healthcare services in relation to patients, caregivers and staff. Different forms of participation are desired in healthcare decision-making depending on a situation, and often it is not realistic to accommodate the highest levels and degrees of the Arnstein's ladder in a clinical context. The most relevant aspect of Tritter and McCallum's (2006: 57) critique of Arnstein's ladder in the context of community health promotion is its "failure to consider the essential role of users in framing problems and not simply in designing solutions."

Bilodeau et al. (2019) present a similar argument on the importance of participation in developing options for action rather than participation only in the implementation of action. Specific to an evaluation process, the importance of participation in *developing options for action* speaks to the significance of involving community members in stages of evaluation that precede and succeed data collection stage such as setting agenda for evaluation, developing indicators, deciding on

methods of data collection, as well as data analysis and knowledge mobilisation. Similarly, the depth and breadth of participation matter. For a more diverse group of participants, participation on the lower rungs on the ladder, e.g., on the informing rung, may result in more equitable participation than participation on a higher rung for a selected few who do not reflect the full diversity of the community (Cornwall, 2008). To address such aspects of participation a considerable amount of time and resources are required to develop trust, build capacity for effective participation and consensus around shared goals and objectives for the process inviting participation (Laverack, 2001; Tritter and McCallum, 2006).

Cooke and Kothari (2001) discuss participation as a form of power that can contribute to strengthening existing power relations when approached uncritically and from a utilitarian perspective. This proposition echoed Laverack's (2001) argument that participation is only empowering when it has the goal of transforming existing inequitable power relations. Power, inherent in any participatory process, can be and should be used to counteract more domineering power structures by drawing on marginalized frameworks in order to destabilise dominant forms of power (Kesby, 2005). Power is not necessarily a negative feature; what matters is how we use power and what we mean by this rather elusive notion.

Defining power

There are utilitarian, functional and conceptional definitions of power. Utilitarian power is described as a commodity concentrated in the hands of a few and as an instrument to maintain dominance through oppression of marginalized groups (Kesby, 2005). Such power is synonymous with supremacist power grounded in the notion of scarcity and the assumption that in a world of limited supply of resources, one must seize the control over what is considered valuable (Suarez, 2018). In its functional sense, power is discussed as a necessary function of social organization through which people learn to act effectively together (Menzies, 2014). Foucault (1982) describes power as a less tangible force of 'discourse' that permeates social relations as a combination of language, cultural and institutional practices that constantly reinforces and reproduces itself through normalization of the hegemonic assemblage of what at

any given moment in time constitutes ‘common sense’ and through which power is put into action (Kesby, 2005, Felluga, 2011). Following Foucault’s (1982) conceptualisation of power, governmentality theorists argue that in its discursive form, power extends beyond the state and its institutions by permeating mass consciousness and public discourse and thus enlarging and maximising state power (Taylor, 2007). At the same time discourse is not only a form of representation, it is connected to and shapes a set of material conditions that enable and constrain public imagination (McHoul and Grace, 1995).

The language of Foucault and governmentality is not easily transferrable into participatory processes unfolding on the ground and outside of the academic realm. When approaching issues of decentering and sharing power in participatory processes, it is very important to clarify what we seek to reclaim and share. Power is not simply a commodity; it does rely on the existence and inequitable distribution of commodities to reproduce itself. Intangible as it may be, it is still embedded in materiality. I approach power as a relational combination of institutionally valued and recognised skills, knowledge and expertise (i.e., those that constitute hegemonic discourse) coupled with access to decision-making and resources (i.e., material aspects). In the community development context involving multiple actors, sharing power involves the sharing of skills, knowledge, and expertise, and it must also involve sharing access to resources to exercise decision-making. Otherwise, sharing knowledge and skills in participatory processes may result in abuse and misuse of power by those who have greater access to resources. I continue this discussion with this definition of power in mind and a premise that the value of participatory processes lies in their ability to equalize power among actors.

Understanding ‘participation’ in participatory evaluation

Participatory evaluation is an approach consistent with principles and values of health promotion practice. Participatory evaluation advocates for decentring power in the evaluation process and promotes the inclusion of all actors in a deliberative dialogue, especially those actors who are systemically marginalized (Handberger, 2004; Springett, 2008; Patton, 2018). Unlike the conventional approach to evaluation,

participatory evaluation is concerned with facilitating the participation of communities involved in evaluation process as co-creators of knowledge produced as a result of evaluation - assuming that “people can generate knowledge as partners in a systematic inquiry process based on their own categories and frameworks” (Springett and Wallerstein, 2008: 204). Participatory evaluation is described as particularly relevant to the community-based context for its explicit commitment to changing power relations by allowing marginalized groups to have more control over the evaluative process that assess initiatives impacting community health (Springett, 2001; Springett and Wallerstein, 2008). Wagemaker et al. (2010) underscore the value of community participation in the effectiveness of the evaluation of programs that address social determinants of health. Participatory evaluation commitment to decentering power in the evaluation process also contributes to improved accountability as it reduces the vertical accountability bias inherent in institutional hierarchy and supported through top-down conventional evaluation process (Guijt and Gaventa, 1998).

A frequent pitfall in participatory evaluation is community involvement only at the stages of data collection or the limited involvement of community members that corresponds with lower rungs of the ladder of participation like consultation (Guijt and Gaventa, 1998; Springett, 2001). A truly participatory evaluation process is one that involves the participation of the actors generally excluded from decision-making into all stages of the process with an aim to build capacity and to inform decision-making regarding each step (Springett, 2001; Bryant, Raphael and Travers, 2007; Guijt, 2014; Springett, 2017).

Given the challenges existing in the evaluation practice at the CHCs level that derive from constraints imposed by the biomedical framing of health and functional accountability systems, I set to explore to what extent evaluation practice is participatory within the community health centres context? Considering *empowerment* as being just as central to health promotion practice as *participation*, I look at the intersection of these two concepts with the focus on power distribution in order to understand to what extent evaluation is participatory, what actors, and why and how are involved in different stages of evaluation process (Guijt, 2014).

Mapping Decision-Making Power in Evaluation

This section discusses power distribution within the evaluation process at the meso- or organizational level by drawing on data from individual interviews and group discussions conducted in two participating CHCs. Using institutional ethnography, I examine how decision-making power over the tasks comprising the evaluation process is distributed among various actors participating in evaluation. I analyze evaluation process as an event happening at the organizational level but orchestrated within an institutional hierarchy and carried out by various individual actors who, from their respective locations in the process, exercise varying degrees of decision-making power over different tasks related to the evaluation process as a whole (Furubo and Vestman, 2011).

To understand power distribution in evaluation, I apply the conceptual framework developed by Furubo and Vestman (2011), which describes six aspects of power corresponding with six discrete steps that comprise the evaluation process. I adapt six original aspects of power suggested by Furubo and Vestman (2011) to the terminology and tasks specific to the field of community health promotion. For instance, the aspect of “structuring power” as originally suggested by Furubo and Vestman (2011) was renamed ‘framing power or framework development’ referring to the power to design the guiding structure for the evaluation itself or what is known among practitioners as the *evaluation framework*. I also added a seventh aspect of power, knowledge mobilisation/utilisation, separating it as a distinct task from ‘knowledge sharing’ specified in the original framework. I also develop a set of critical questions related to each aspect of power in the evaluation process, and a summative eighth cluster. This adapted framework is presented in Table 7 below.

Table 7: Framework for Analysing Power Distribution in Evaluation

Aspect of Power	Evaluation Task	Critical Questions
1. Agenda setting	The agenda setting task, designing what to evaluate or what is worth knowing about what	▪ How agenda for evaluation has been decided upon? ▪ Who makes decisions about what is worthwhile to know/study?
2. Framework development	Creating the guiding structure for evaluation, determining an approach to evaluation, designing evaluation framework, and selecting key evaluation questions.	▪ What kinds of assumptions, premises, expertise, experience and knowledge inform evaluation framework? ▪ What types of actors give input into the design of evaluative questions?
3. Selecting values and criteria for evaluation	Selecting criteria for evaluation, defining what the 'success' of an initiative looks like.	▪ What are the indicators of 'success'? ▪ What assumptions/premises and rationale inform the very notion of success? ▪ How the criteria against which to evaluate were selected? ▪ Whose opinions informed the selection of criteria?
4. Evidence gathering	Selecting methods and tools for gathering and analysing information (i.e. designing what data to gather, how to gather the date and how to make sense of them).	▪ What is counted as 'evidence' in evaluation? ▪ What methods and tools for data collection are used? ▪ Are certain methods and tools preferred over others? Why? ▪ Are the methods and tools appropriate and relevant to the program/project context?
5. Knowledge Sharing	Deciding what information to share, with whom, and when.	▪ With whom evaluation results are shared, when and how? ▪ How the decisions are made regarding evaluation findings dissemination?
6. Knowledge mobilisation/ utilisation.	Taking action as informed by the results of evaluation(s)	▪ Who makes the decisions/implement action in response to evaluation results? ▪ Who is likely to be affected/impacted by these decisions/actions? ▪ What are the venues for input into the decision-making concerning evaluation for those who are likely to be impacted by the decisions made based on the results of evaluation?
7. Defining parameters for participation	Deciding on the range of actors involved in evaluation, i.e., who to include in evaluation and how (as 'evaluators',	▪ Who participates in evaluation process? How and in what capacity? ▪ Who is included and who is excluded from evaluation process?

	‘advisors’, ‘respondents’, ‘audience’, etc.).	▪ What are the opportunities for capacity-building in evaluation for different types of actors?
Summary		▪ To what extent diverse actors are included in different steps of evaluation process? ▪ Where do we have the most diverse input, and what areas are lacking diversity? ▪ In what ways the missing actors can be brought in to participate? ▪ How we can use those areas where we exercise most decision-making power to leverage participation of those who are the least included in shaping evaluation?

The framework was adapted as a tool for participatory mapping activity during reflective group discussion. The purpose of the activity was to map power distribution in the evaluation process among different actors. Seven practitioners representing two community health centres took part in the activity. Table 8 below shows participant roles in respect to organizations and groups they represented.

Table 8: Participant Roles in the Evaluation Process

Participants role	**Organization/group**
Community Volunteer 1	The Neighbourhood Table, community engagement initiative supported by CHC B
Community Volunteer 2	Residents in Action Group, community engagement project supported by CHC B
Manager, Community Engagement Project	CHC B
Manager, Diabetes Education Program	CHC A
Frontline Health Promoter	CHC B
Health Promotion Coordinator	CHC A
Frontline Health Promoter	CHC A
Total	7

The participatory mapping activity entails the assessment of the extent of power each actor exercises over different tasks of the evaluation process using colour-coded dots. Consistent with the principles of participatory action research, the assessment scale was developed in collaboration with research participants to reflect the degree of their participation in the evaluation process via the extent of decision-making power they exercise when participating in program evaluation. The decision-making power was conceptualized as the degree to which individuals participate in the decision-making concerning the tasks of evaluation process, combined with skills, expertise and access to resources. Practitioners participating in the activity reflected on power distribution by assigning a certain number of dots on each task. The assessment scale for decision-making power was measured by a dot system.

- Three dots reflected full control over a specific aspect of the evaluation, equivalent to executive power that also comes with the resources necessary to exercise the decisions made, such as budget, knowledge, skills and human resources (i.e., staff time needed).
- Two dots indicated considerable extent of decision-making power, where the final decision requires input from peers and supervisors to ensure resources necessary for evaluation are secured.
- One dot reflected very limited decision-making power where 'participation in evaluation' mostly means implementing evaluation related decisions that were made by other actors in the process, for example, conducting interviews according to a developed set of questions or distributing surveys.
-
- Finally, half a dot reflected none or very little decision-making power, meaning passive participation that is limited to responding to surveys, interviews, feedback forms with no other input into evaluation process.

The assessment scale was linked to participants location in the evaluation process, i.e., participants were assigned a colour-code based on their particular role in the organization (e.g., manager, frontline health promoter or community volunteer). Participants were also invited to share a story to illustrate how they are involved in each tasks of evaluation process.

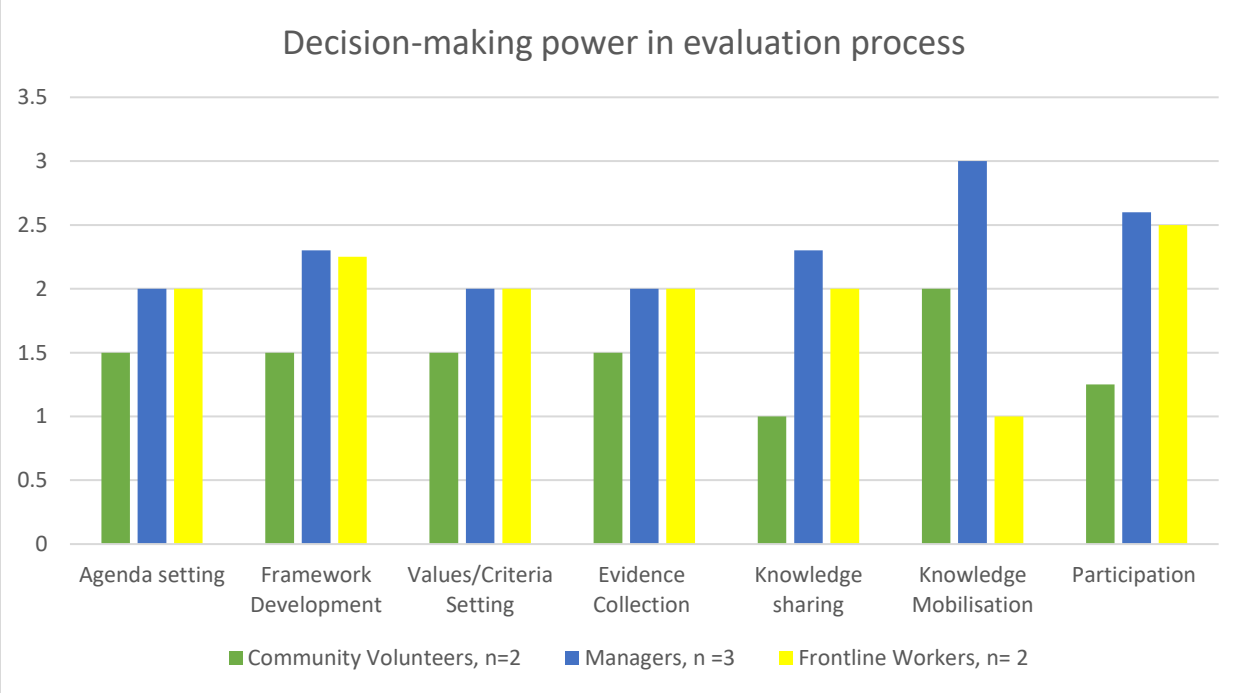
The degree of decision-making power over the aspects in an evaluation process influences the quality of participation for each group of participants. Although all

participants were involved in the evaluation process, simply being involved in a process is not equivalent to having one's voice count when the decisions are made (Cornwall, 2008).

The primary purpose of the framework and the power mapping exercise was to encourage reflection on equitable power distribution among the practitioners involved in evaluation. Although the framework and the activity were designed for qualitative data collection to illustrate power distribution in evaluation, I quantify the responses of the participants, where the value of one was assigned to each dot, therefore the least extent of decision-making power is equivalent to half and the greatest is to the value of three.

The graph below shows how power is distributed in evaluation between different actors and on each aspect of evaluation. The values in the chart are the average value of the dots on each aspect of evaluation for each respective group of participants, e.g. community volunteers, managers, frontline staff.

Figure 12: Decision-Making Power in Evaluation



Among practitioners who took part in the mapping activity, managers exercise most decision-making power in the evaluation process, followed by frontline workers and community volunteers. This is not surprising as it reflects power distribution in the institutional hierarchy at an organizational level. What is interesting, however, is the power differential within each aspect of the evaluation process and the stories that participants shared to illustrate the number of dots they used to assess their decision-making power in evaluation. The least degree of decision-making power for participating community volunteers across all aspects of the evaluation process indicated that when they are invited to participate, they do so according to the terms and agenda developed by the inviting actor, in this case a non-profit organization. Stories shared when discussing the decision-making process on each aspect of the evaluation shed more light on how the process is structured and what factors influence a degree of decision-making power in evaluation for community members.

When community members are invited to participate in advisory groups concerning program evaluation, it increases their decision-making power in the evaluation process and contributes to a more inclusive and context-appropriate evaluation. A community volunteer, who assessed a considerable degree of decision-making power (valued at 2 dots for most of the aspects), expanded on the value of her involvement at all stages of the evaluation process.

> I'm involved in tools for information gathering, to give others ideas on how to interact with residents, what would work best. Not everyone will sit down to do a survey, I give the group doing the evaluation ideas of what might work, what might not work. Try to get the people doing the evaluation to accommodate for the different communities. So, I'm also involved in developing tools (community volunteer 2, CHC B, 2017).

Yet the degree to which community members can influence the agenda setting, framework development, or identifying values and criteria for evaluation as well parameters for evidence remains limited. One of participating community volunteers explains the lower rating of half or one dot, which she assigned to the degree of her decision-making power in all steps of the evaluation process as reflecting the dominant role of 'the agency' in the decision-making concerning evaluation, where community advisory committee's role is to rubber stamp the decisions that have already been

made. As this community volunteer 1 in CHC B (2017) explains: “It’s usually the agency that takes the stronghold in these things, so even as a steering committee we rubber-stamp what agencies push for.”

At an organizational level, it is funders’ agenda that dominates the framing of the evaluation process and influences the essential resources available, including staff time. The evaluation framework provides a scaffolding structure for evaluation that determines the values, criteria and evidence for evaluation, and when creating such scaffolding structures, managers and frontline health promoters often align the priorities of the evaluation process with those of funders. Yet, such priorities may not necessarily reflect the priorities of community members in relation to knowledge development about programs and projects implemented in the community. As community volunteer 1 in CHC B (2017) asks: “Why do funders fund things the way they do? It doesn’t make sense. Instead of seeing what the community needs are, they [the funders] decide what the needs are. It’s very top-down. You have to decide to put your round peg in their square box and in doing that a lot of things get lost.”

As a manager of a community engagement project in CHC B (2017), sharing their reflection on how voices at the advisory tables may be valued differently depending on where such voices come from, remarks: “If a resident brings something to the table, there’s less buy-in than if an agency proposes it.”

Community volunteers commented on the limitations of their involvement in decision-making concerning knowledge mobilisation and participation. For example, community member 2 CHC B (2017) noted that “an agency has more power depending on who is in charge and also who they would like to participate.”

Frontline workers and managers observe the lack of involvement of community members into the evaluation design. Participatory evaluation was often conceived in terms of the evaluation design that provided more opportunities for qualitative data collection, opening an opportunity for program-participants to share feedback via less structured methods of data collection such as open-ended questions in the feedback forms, interviews, and/or focus groups. However, the involvement of program participants into other steps of the evaluation process was very limited, with the exception of some specific project evaluations such as ‘The Food Space’ project

evaluation described previously. The lack of time and other resources to enable such an extended degree of participation in the evaluation process was cited as a barrier. For example, when asked about existing opportunities to involve community members/program participants in the evaluation design, a health promoter in CHC B (2017) stated: “Yes, in theory I agree. But in practice I have never done that. In theory even though I agree, time is a factor. It’s really hard to bring people in design evaluation and design of the overall program.”

Decision-making power distribution in evaluation reflects the organizational and institutional hierarchy where community members have the least decision-making power in different steps of the process. Such limited power is expressed as lack of resources directed at supporting participation at the level beyond representative and beyond an instrumental purpose.

Limited community participation in tasks of agenda setting for evaluation, as well as selecting criteria and evidence is especially concerning as it signals the lack of “early involvement of grassroots actors” in the process designed to judge the value of programs and services that directly impact them. In other words, community members become excluded from participating in developing options for action but are invited to participate in implementing an action that has been decided upon by others, usually more powerful institutional actors (Bilodeau et al., 2017). Such structuring of participation in evaluation process affirms that the process is largely controlled by the convener and as such limits the range of potential options for action and consequently the range of potential outcomes (Katz, Cheff and O’Campo, 2015; Bilodeau et al., 2019). As discussed previously, reporting requirements from CHCs’ core funder are structured in a way that makes community health initiatives outcomes invisible within an institutional framework based on the biomedical model of health. The actions of health promotion practitioners are most exclusively linked and facilitated through ‘paperwork’ at the organizational and institutional levels, but such ‘paperwork’ is designed in a way that distances practitioners from the communities they serve. As such it limits the types of input into information gathering and sharing (Katz, Cheff and O’Campo, 2015). Procedures for information gathering driven by funders present a significant point where community voices and stories may get lost (Wilson and Pence, 2006). Such procedures

often reflect priorities for data collection that preclude context-appropriate evaluation design prioritizing rigid criteria informed by a rationale that, according to Springett (2001: 147), "[r]arely has anything to do with increasing knowledge of what works and why, or contributing to learning within the community or project on which these (often) number-crunching exercises are imposed. Rarely do they generate indicators related to the true or local purpose of the programme." Evaluation and reporting processes that demand proof of results against pre-set criteria undermine learning for organizational development and capacity building (Guijt, 2010).

The following excerpts from individual interviews with health promotion practitioners illustrate how funders' priorities for data collection may further marginalise vulnerable community members and create distance between non-profit sector's practice and community priorities in relation to program delivery and program evaluation.

> If it is for funders [evaluation], the focus is very quantitative. We are accountable to our funders and cost-effectiveness is most important for our funders, but if you are using this equity lens, it's not only numbers... So that's why we put lots of stories. Using qualitative approach really helps, because you put lots of narratives, who are you clients and what their needs are. It's not only 1 plus 1 equals 2, it's not only about numbers (Health Promoter CHC B, 2017).

> Six years ago, we were so focused on the number of clients served, which is the main determinant of funding from the LHIN. There was also a note saying we can't serve those at high-risk, only those with pre-diabetes, but then in my mind based on the definition of high-risk, all seniors are at high risk of diabetes because they have co-morbidities… [a]nd our demographics are mostly seniors (Diabetes Education Program Manager CHC A, 2017).

Activities that do not produce easily quantifiable outcomes do not get funded. The refrain "What does not produce numbers is simply not getting funded" permeates the non-profit sector. The rift between the requirements of the funder in relation to data and community priorities is even described as a 'disconnect' by a community engagement project manager in CHC B (2018):

> [t]he disconnect is in how they [funders] are viewing stuff, and how it's played out on the ground. The admin support for programs gets pulled away because of the importance of numbers. The stress of the numbers can affect the work you do. It's a hard place to be a front-line worker because numbers, numbers, numbers – but it's not all about that, you also need the time to make the community connections that lay the foundation to keep and increase those numbers and support the community to keep coming out – it's not where money is really put in, organizations have to steal from another place to put that in, and it's very stressful.

Yet the fact that frontline workers and managers exercise considerable decision-making power over knowledge mobilisation and participation in evaluation gives organizations a leverage to share power over other aspects of evaluation and perhaps even the re/design of evaluation as participatory evaluation. It may involve expanding the range of actors who are invited to participate in the evaluation design, and/or building capacity for participatory evaluation among community members and staff, and/or facilitating collaborative decision-making processes concerning knowledge mobilisation.

These findings illuminate the need for capacity building and knowledge co-creation in collaboration with community members in relation to evaluation in the context of community-based health promotion initiatives. There is a need for producing local knowledge that is useful to health promotion practitioners, knowledge that addresses concerns of community volunteers and frontline staff and that ultimately contributes to improving community wellbeing and to a more equitable and sustainable relationship among various actors involved in community health promotion (Bradbury and Reason, 2008; Minkler and Baden, 2008). This is particularly the case for initiatives aimed at social determinants of health and delivered collaboratively between community members and non-profit organization. To reverse the hierarchical process where evaluation is designed and implemented as a top-down process and to build capacity for evaluation design among community activists, I involved community members in designing evaluation frameworks for the respective community projects they participate in. The following sections describe participatory evaluation design process with members from two community initiatives: The Neighbourhood Table and Residents in

Action.[21] Both community initiatives have been taking place in the Lawrence Heights neighbourhood in Toronto. I start with describing the history of the neighbourhood where both initiatives take place, followed by a brief profile of each initiative.

A Story of the Neighbourhood

The Lawrence Heights neighbourhood was planned in 1950s and its construction was completed in 1962. It was one of the first large scale social housing projects located then outside of the Toronto core boundaries, intended to house new immigrants/racialized minorities but effectively isolating them from the then predominantly white city core. The construction of Allen Expressway in 1964 bisected the area into communities of 'Lawrence Heights' and 'Neptune' further intensifying a sense of isolation from the rest of the city and entrenching fragmentation within the neighbourhood (City of Toronto, 2012). The community of Lawrence Heights also includes a small area of townhouses and high-rise buildings known as Lotherton and set apart from the larger neighborhood (Neubauer, 2012). Notwithstanding such geographical demarcation and the character of each of the three communities, they are often united under the general name of Lawrence Heights.

Historically, Lawrence Heights had a higher than average concentration of low-income residents, social housing, unemployment and social assistance rates. The neighborhood has long had a culturally diverse population, including residents who migrated to Toronto from the Caribbean region, East Africa, Latin America, and Asia. Half of the population of Lawrence Heights and Neptune is currently born outside of Canada (Be Part Steering Committee, 2010; City of Toronto, 2015). Until 2014 Lawrence Heights was designated as one of thirteen 'priority neighbourhoods.' Such status denoted higher than average unemployment levels and travel distance affecting residents' ability to access services such as social and employment services.[22]

[21] Both 'Residents in Action' and 'The Neighbourhood Table' are fictional name to preserve the confidentiality of the organizations and research participants.

[22] In March 2014, the thirteen priority neighbourhoods were replaced by the 31 newer 'neighbourhood improvement areas' under the Toronto Strong Neighbourhoods Strategy 2020 (City of Toronto website, 2018). However, Lawrence Height neighbourhood was not designated as one of the new neighbourhood

Lawrence Heights has long been subjected to negative stereotyping, racial profiling, social and economic discrimination. The geographical isolation of the social housing sector intended to house non-white immigrants did not happen by accident but was a direct consequence of colonial planning policies intended to segregate them from then predominantly white Toronto. Speaking about the spatial layout of Lawrence Heights, CBC (2019: np) states that Lawrence Heights' "streets were purposely designed not to connect to existing streets from established surrounding neighbourhoods." The neighbourhood is pejoratively referred to as the "Jungle." Some believe that this term indicates tangled cul-de-sacs characterising the residential streets of local social housing, others say that the name was used to denote the prevalence of immigrants from the formerly colonized countries of East Africa and Caribbean region. Either way, it denotes the inherent racism and discrimination of the 'mainstream' white Toronto towards racialized low-income communities. Moreover, the construction of Allen Road in the mid-1960s through the neighbourhood is an example of environmental racism inherent in post-war urban redevelopment. While intended to connect middle-class suburban neighbourhoods with downtown Toronto, the highway cut through the middle of Lawrence Heights neighbourhood dividing the community in two parts with unequal access to resources. The Lawrence Heights neighbourhood is just one example of Toronto's "geographies of exclusion" or spatially structured connections and disconnections between groups divided on the basis of race and income (Levine-Rasky, 2013: 62).

Kipfer and Petrunia (2009) note that racialization and racism is intrinsic to the formation of post-war public housing built to house immigrants of non-European descent. In addition to stigmatization, poverty, economic and social inequality, Lawrence Heights was also subjected to a chronic lack of services and programs that negatively affected the health and wellbeing of residents. The lack of services and programs for seniors and youth, the lack of affordable housing, community safety and gun violence, and social exclusion and isolation have been systematically and

improvement areas due to a major urban redevelopment project dubbed by the City and Toronto Community Housing (TCH) as 'revitalization' of Lawrence Heights.

consistently identified by residents at numerous consultation processes (Raphael et al., 2000; BePart Steering Committee, 2010; City of Toronto, 2012).

In July 2010 the Lawrence Heights Allen Revitalization Plan was endorsed by Toronto City Council and the Toronto Community Housing Corporation to redevelop the neighbourhood (City of Toronto, 2019). Both agencies presented revitalisation as means to improve existing housing stock and to transform the area that has been predominantly social housing and low-income into a mixed-income community with enhanced community programs and services. However, local residents repeatedly raised concerns about housing affordability and the potential displacement of local residents due to the higher costs of rental and home ownership that the redevelopment may bring (BePart Steering Committee, 2010). Such concerns are well warranted as critical urban development scholars have confirmed the risks of displacement and disconnection for community members (and especially racialized communities) who inhabit social housing areas targeted for redevelopment (August, 2008, 2016; Kipfer and Petrunia, 2009). Mixed-income redevelopment has become a popular approach for restructuring post-war public housing in advanced capitalist nations that housed racialized immigrants coming from the former colonies, as it is the case in Lawrence Heights (August, 2016). Kipfer and Petrunia (2009) describe such redevelopment model as re-colonisation, a process that essentially intends to reshape social housing neighbourhoods deemed ‘problematic’ on white middle-class terms where property, class and race are re-articulated by strategies of recommodification achieved through privatising land ownership and socializing the risks of private investments. A somewhat lengthy citation from Kipfer and Petrunia (2009: 121) is well justified here to describe the colonial roots of urban revitalisation projects:

> [t]hree-fold economic, social, and cultural recolonization strategy to recommodify public housing lands, recompose the resident population by reintroducing private ownership housing, and reengineer the sociocultural dynamics on the site with physical design measures and “place-based” social planning. Recolonization is meant to turn a segregated public housing site into a “normal,” “successful” neighbourhood with “diversity of building types, designs, and heights; diversity of tenures; diversity and mix of incomes; diversity and mix of uses; diversity of builders; and diversity of activities.” Rearticulating a seemingly progressive, but highly ambiguous

> discourse borrowed from reform planning in the 1970s, diversity, and particularly the notion of social mixing, now operate as code words to incorporate and submerge racialized public housing tenants under a cohesive form of normalcy defined by private property and the (middle-class and typically white) sensibilities of the “new normal”: gentrified Victorian neighbourhoods and neo-modernist condominium districts in central Toronto.

Social mixing deployed to extract higher land value often facilitate new processes of social exclusion by the removal of ‘undesirable’ others in order to achieve a social composition that is better aligned with the neoliberal ideal of self-sufficient, productive and profit-maximising individuals (August, 2008). While until now ignored by white middle-class, inner-city areas located relatively close to the downtown core have turned into coveted pockets of property (Levine-Rasky, 2013). As race intersects with class impacting the chances for certain groups to get established in an area while displacing less affluent racialized groups, redevelopment projects do not segregate explicitly but hide and submerge the differences under the ‘normalcy’ of property ownership and consumption practices consistent with white middle-classness (Kipfer and Petrunia, 2009; Levine-Rasky, 2013). However, gentrification does not necessarily unfold smoothly given resistance from local communities and their allies.

Learning from Regent Park redevelopment, described extensively by James (2010), Horak (2010) and August (2016), Lawrence Heights community, including but not limited to the tenants of Toronto Community Housing Corporation’s housing, successfully fought for their increased participation in negotiating the terms of revitalisation. As a result of community-driven advocacy supported to some extent by local community-based non-profit organizations, the residents of Lawrence Heights participated in the selection of the developer and the review of the redevelopment proposal, and actually won a commitment to “zero displacement” during the revitalisation and to the building of a new park in the area (August, 2016). Such an outcome was achieved, according to August (2016: 7), due to “well-organised network of agencies in place to support grassroots tenant organising.” However, the sustainability of the gains achieved by community members has been continuously threatened by the developers and municipal administrators and therefore require

constant negotiation and action on behalf of resident and grassroot groups. While the details of the mobilization of Toronto Community Housing Corporation's tenants and wider community advocacy for a more democratic redevelopment process is beyond the scope of my dissertation, this broad context of urban redevelopment and gentrification serves as a vantage point for examining the roles community-based non-profit organizations may play when addressing community action. I focus on the experiences of community members in two community initiatives: The Neighbourhood Table and Residents in Action.

Introducing 'Neighbourhood Table' and 'Residents in Action'

The Neighbourhood Table is a network of neighbourhood-based non-profit organizations, public agencies (e.g., Toronto Public Health, Employment and Social Services to name a few) and community and resident groups. Historically, The Neighbourhood Table came together as a group of community-based non-profit organizations and public agencies[23] to address increasing gun and gang violence in Lawrence Heights. The City of Toronto initiated a Neighbourhood Action Planning Committee, which quickly expanded to involve neighborhood-based agencies referred to as The Neighbourhood Table. This group never had independent funding and has been supported through voluntary and in-kind contributions from its agency-members, community residents volunteering their time and skills, and through securing project-based funding through community development grants.

During its twelve-year history, The Neighbourhood Table went through periods of increased funding for community engagement projects that accompanied revitalisation and gentrification processes, as well as periods of austerity marked by budget cuts to public services and community-based non-profits. The level of resident engagement with The Neighbourhood Table and its capacity to support community engagement fluctuated over the years. Reflecting on the history of The Neighbourhood

[23] Throughout the document the terms 'organizations' and 'agencies' are used interchangeably following their usage in the community. It is assumed that both 'organizations' and 'agencies' have non-profit status, receive public funding, and provide public programs and services.

Table, the group Residents in Action (2018) recall the peak period between 2008 and 2010 when “it was a vibrant mix of residents and agencies, and the Table was on a roll.” This was followed by an austerity period around 2012 during which many public agencies and non-profit organizations suffered severe budget cuts. Around that time, a local CHC, once actively involved with The Neighbourhood Table, went through a merger and withdrew some of its support.

Participation in The Neighbourhood Table was always associated with increased responsibilities and administrative commitments for participating organizations. When faced with reduced funding, organizations struggled to respond to the increased administrative and frontline workload as they were forced to adapt to diminished capacity. This limitation affected the ability of organizations to stay involved with The Neighbourhood Table and to support community engagement projects as many organizations’ priorities were shifting towards service delivery. Thus, the ability of The Neighbourhood Table to support collaborative action in partnership with community members has not been consistent and has been organised around short-term project-based funding. In short, the history of The Neighbourhood Table mirrors neoliberal restructuring of the non-profit sector that took place over the course of the last fifteen years.

Envisioned as a venue to bring residents, community groups, non-profit organizations and public agencies to work together and to create a platform for community members to voice their concerns, The Neighbourhood Table was not necessarily equipped in terms of resources and internal structure to respond to concerns raised. Depending on the respective capacity, scale, and internal policies and procedures of participating agencies, the opportunity for a dialogue with residents led to different outcomes. Occasionally, instead of working towards collaborative solutions, an organization withdrew from The Neighbourhood Table when frustrated by community demands. Community residents also started expressing their disappointment and frustration over the cumbersome or unclear decision-making process, the lack of cohesion in collective actions and the lack of clarity regarding roles and responsibilities of the members. Understandably, such frustrations resulted in a diminished participation of community residents in The Neighbourhood Table. The divide and tensions between

agency-members and resident-members deepened and the level of community engagement with The Neighbourhood Table dropped. In response, The Neighbourhood Table held an extensive community consultation process and reorganized its structure to offer resident-members more opportunities to access decision making roles. At the time of the research, The Neighbourhood Table was organised into several action committees according to areas of action prioritised by each committee, e.g., community safety, youth development and leadership, healthy living, seniors, civic participation, and economic opportunities. Each committee is co-chaired by an elected resident-member and agency-member, who also serve on the Steering Committee, the main decision-making body of The Neighbourhood Table. The Steering Committee is also co-chaired by an agency-member and resident-member.

In 2015 The Neighbourhood Table put together a grant application for community engagement project to support resident-led action groups and to increase levels of resident participation in the Neighbourhood Table. This is how the 'Residents in Action' initiative was formed. The 'Residents in Action' project was funded through an Ontario Trillium Foundation's 3-year grant and trusteed by the CHC B, an organization member of The Neighbourhood Table. At the time of this research, the implementation of the Residents in Action initiative was in its final project year and was already involved in a funder-driven evaluation process conducted by CHC B staff in collaboration with Resident in Action members. Over three years, the project engaged residents from the local communities in hands-on learning, workshops and grassroots events. The ultimate goal of the project was to build residents' capacity and it was hoped that residents would continue their engagement through The Neighbourhood Table after the Ontario Trillium Foundation grant ended. Upon the completion of the project, Residents in Action dissolved and some of its members stayed involved as resident-members of The Neighbourhood Table in a volunteer capacity and as activists in the neighbourhood.

Evaluating 'Labour of Love'

A participatory process for a 'bottom-up' evaluation

To understand residents' experiences of participation in collaborative action for health justice through the lens of participatory action research, participants of both

initiatives were invited to take part in designing evaluation frameworks for their respective groups. Three participatory workshops took place to build capacity for evaluation among community volunteers involved in various community development initiatives in the neighbourhood. A research-related goal was to discern what aspects of the evaluation process were important when supporting community action for health equity and justice while supporting and furthering community action (see Table 9 for each workshop's goals and objectives).

A total of twelve community members representing the 'Residents in Action' and 'The Neighbourhood Table' community initiatives took part in the workshop series and the accompanying community story mapping sessions. Data collection through participatory workshops was augmented by individual semi-structured interviews with community activists and the non-profit organization staff involved in order to further probe into the issues discussed during workshops.

Table 9: Participatory Workshops Goals and Objectives

Workshop	Goals	Objectives
Workshop 1	Define evaluation	▪ Understand evaluation as a process; ▪ Break down the process into smaller manageable steps/tasks;
Workshop 2	Frame evaluation	▪ Identify goals and priorities for the project evaluation; ▪ Develop key evaluative questions;
Workshop 3	Design evaluation	▪ Discuss and compare methods of data collection; ▪ Identify methods that are appropriate to the context; ▪ Design evaluation strategy/evaluative learning plan.

In the opening conversation about community action and motivations of people to participate, resident activists cited multiple reasons for their involvement that can be summarised in one word: *love*. Aware of the risks of appearing idealistic, I would like to

unpack the meaning of this word. Love is defined by bell hooks (2001: 5) as a mix of various ingredients, including “care, affection, recognition, respect, commitment and trust, as well as honest and open communication.” For Riane Eisler (2008), the notion of love encompasses the ethics of mutual care and partnership towards the goals of common health and wellbeing. Such themes related to various aspects of ‘love’ transpired in my conversations with community members.

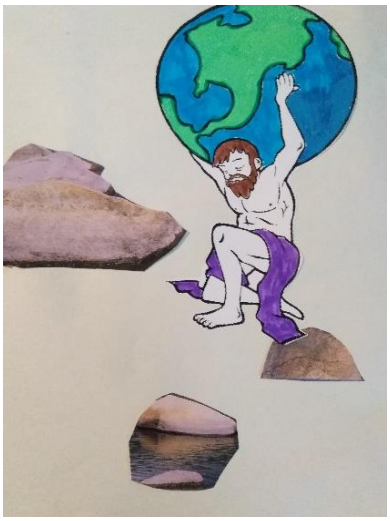
Most participating residents have been involved as community volunteers in different initiatives for the most part of their lives in the neighbourhood. There was a pragmatic aspect to this involvement as participants cited the benefits of getting access to various professional and personal networks as well as gaining work experience and earning references. Yet, the biggest motivating factor for their continuous involvement was care and love for their community. When people get involved in community action, they are generally guided by the vision to improve not just their individual lives and fortunes but the wellbeing of community as a whole. There are rarely references to exclusively personal gains in this process. Successes and gains, as well as challenges and obstacles, are usually framed in collective terms. Perhaps nothing illustrates and explains the theme of *labour of love* better than the images on the community story map that was created during one of the participatory sessions.

Figure 13: ‘Labour of Love’ Theme, Community Story Map, 2018

The community story map was used as an art-based participatory activity to capture the story of resident involvement in community action. Group members created a collage map using cut-outs from the local community reports, newsletters, as well as a wider range of printed materials. Participants first decided on the set of symbols to represent the group's major developmental milestones, challenges, obstacles, successes and moments of learning. They then approached creating a visual of their journey in a chronological order.

Among a plethora of images used, two symbols stood out to represent the continuous commitment of residents to their community. One is a picture of Atlas, a character from Greek mythology, who carries the world on his shoulders. The image was used to illustrate how community members do the work of keeping the community together. Members of Residents in Action clarified that instead of a single 'Atlas', it should have been "all Residents in Action members on the picture holding the world on their shoulders". They used this image to reflect the weight of their responsibility but also the pride in their efforts.

Figure 14: 'Holding the world on our shoulders', Community Story Map, 2018



Another image on the Residents in Action map is a red squiggly line going throughout the whole map representing community residents ongoing support for “all of these on the map happening”. The line is going back and forth, making loops, turning corners to show that the process is complex and far from being linear. The line goes through all the community initiative and development process bending, circling, meandering like a stream that feeds the meadow and makes it flourish. The community members also added ‘24/7’ sign and a picture of a clock to reflect that support is constant and ongoing, not something that can be done on a 9 am to 5 pm basis.

Figure 15: 'Caring is 24/7' work’, Community Story Map, 2018

Speaking about participation in community action, residents repeatedly mentioned the words ‘work’, ‘effort’ and ‘labour’ in connection with ‘passion’ and ‘love’. Such ‘labour of love’ theme is fundamental to community participation. The lack of acknowledgement, respect, and at times abuse of the ‘labour of love’ was cited as the cause of relationship breakdown between community members and local non-profit organizations and public agencies.

‘Labour of love’ gets caught in power dynamics in processes that involve multiple actors with significant power differentials among them. For non-profit and public

agencies convening participatory processes, an assumption that community members get involved as equal partners on a level playing field might not be correct. There is a significant power differential between non-profits and community members when both parties come together as partners at a collaborative table to make decisions concerning action in the community. Non-profit organizations and public agencies represent institutional partners, who bring programs and services to the community, as well as other resources such as small-scale funding. Community residents and/or grassroot groups represent non-institutional partners, who are on the receiving end of these resources as program users, service users, and sometimes applicants for the small grants distributed and managed by the non-profits. They enter participatory processes aware that they must maintain good relationships with the representatives of the non-profit and public organizations as they do not want to jeopardise their access to resources available in the community. Community residents want to advocate for their priorities in regard to programs, services, and community wellbeing. Yet, they are aware that in any attempt to challenge and contradict 'agencies', residents may come across as 'difficult' and risk losing support altogether especially in situations when organizations are not necessarily open to residents' opinions and voices. In the view of a community resident/volunteer (2018):

> Even though they are going to say we created this action groups for residents to have a voice, where does that voice go besides that? They are not ready to hear that voice and *to work* with that voice…

Resident-members when discussing their involvement and participation in The Neighbourhood Table noted that there is growing feeling that they are needed only to meet agencies' goals for community engagement. As one of the residents (2018) poignantly noted: "but with what money and whose time!" commenting that this is where 'participation' comes from - from community residents donating their time and energy but receiving little in return as they feel that their voice, perspectives, and ways of working are not being honored. Resident-members (2018) also cited meeting fatigue because "it's all they [agencies] do - meetings" and then "there is no energy left for action." And if there is action, planning and implementation processes may be carried

out in a top-down fashion, which may lead to cooptation of community ideas and participatory processes.

Participation fatigue leads to residents invoking their power of *non-participation* or self-exclusion. Residents refuse to participate in processes they do not trust as a pragmatic choice to avoid wasting their time and energy meeting other people's priorities (Cornwall, 2008). Clarity is expected and needed regarding what is meant by 'participation', otherwise much confusion and disappointment results from mismatched expectations regarding participation on behalf of the non-profit organizations and community members. Non-profit staff often bring up the rhetoric of 'managing expectations' applied to community members but expectations should be managed on both sides, and that includes clarifying what can be achieved within the participatory process and what is beyond the bounds of participation.

Oftentimes, residents are employed by non-profit or public agencies on short-term community engagement contracts as part of time-limited project-based funding as opposed to full-time permanent positions that decreased due to cuts to core funding. Such contract arrangements create 'in-between' roles for resident activists, where on one hand they have to advocate on behalf of their communities, and one another, comply with the terms of the employing agency regarding community participation and action. One of the research participants, who at the time of the interview was in such role, commented on the experience of going "above and beyond" her professional mandate and resources because of her long-time resident status in the community as well as personal values (individual interview, 2018). Even when they are no longer employed by an agency, such residents are still perceived within the community as 'agents of an agency' on whom community members may offload their frustration, disappointment or appeals for help and intervention: "When you live and work in the community the community demands ten times more from you than from someone random who lives outside the community" (individual interview, 2018).

Whether in paid or volunteer capacity, community residents approach their participation as a 'labour of love'. Yet, within current dynamics of power they may experience abuse and misuse of their labour of love in situations when non-profit and public agencies use resident participation to fulfil their own organizational needs in

regard to community engagement. Thus, residents largely see their participation as 'instrumental' and structured by non-profit organizations and public agencies in a top-down manner (White, 1996). The current and potential roles of non-profit organizations in supporting community participation in collaborative action, as well as factors influencing such roles, are discussed in more details in the following chapter.

In summary, the tensions in the relationships between institutional partners represented as 'agency-members' and non-institutional partners represented as 'resident-members' at The Neighbourhood Table occurred largely due to:

- The lack of a transparent and consistent decision-making process informed by evaluative learning that could enable a balanced accountability and mobilise knowledge for action in collaborative initiatives involving community activists and non-profit organizations;
- The attempts to implement an accountability structure and a decision-making process in a top-down manner and structured to satisfy funders' reporting requirements rather than support learning and developmental needs of community projects; and
- The loss of trust in participatory processes as participation of 'resident-members' was frequently used to fulfill the priority of 'agency-members', which did not necessarily reflect community priorities that motivated residents to participate in the first place.

In developing a 'bottom-up' evaluation in response to the issues described above, community groups identified specific criteria and indicators related to the quality of relationships between multiple-actors, as well as for the quality of resident participation. Both groups underscored the importance of *balanced accountability*, where accountability to community is as important as accountability to funders. Residents flagged relationship-building as integral to evaluation and accountability processes. In short, where there are no relationships and trust built with community members, there is no accountability in such process. In relation to indicators for participation, community members stipulated that it is of the utmost importance to capture *not only the quantity* of people participating but also *the quality of their participation*, and by extension the quality of the relationships among the two types of partners involved.

The need for *reflection on the process and experiences* was also identified as a priority in the evaluation process by both community groups. Such emphasis on process speaks to the importance of reflexive practice as one of the primary goals for evaluation in community development. In sum, residents from both groups created evaluative process frameworks that goes beyond funder-driven reporting requirements and that was designed to support a more balanced accountability system, relationships building, and reflexive practice development – i.e., evaluation that is developmental and participatory. Table 10 below presents a summary of criteria and indicators for evaluating the quality of community participation and relationships between multiple actors in a collaborative community action.

Table 10: Criteria and Indicators for Evaluating Quality of Participation

Criteria	Indicators
Resident Participation	▪ 50% of the members of Action Committees/Action Groups are residents; ▪ Number of programs delivered in partnership between agencies and resident-groups; ▪ Residents assessing the quality of their participation at the level of 'partnership' on the Arnstein's ladder of participation
Quality of the relationships	▪ Accessible information both in print and web-based is available and up to date; ▪ Conflict resolution policy is in place and is followed through; ▪ Resident input into a project/initiative is acknowledged in publications, announcement and grant applications with reference to the actual names of groups and individuals; ▪ Successes are shared and celebrated together
Agencies Commitment to Partnership Projects/Initiatives	▪ Agencies provide clear feedback in response to resident ideas for action, specifying if and how the idea can be supported and what are the necessary follow up actions; ▪ Contribution agreements for partnership projects involving residents are in place with reference to material and resource commitments on behalf of the participating agencies, such as: number of dollars contributed; number of staff hours; space; in-kind resources, e.g., printing, etc.; residents' contributions (skills, time, materials/supplies); ▪ Resident quorum is achieved consistently for the decision-making concerning projects/initiatives implemented in partnership with residents; ▪ Improved access to space for resident-members.

During participatory workshops, the two groups continuously exchanged feedback and input to inform the respective evaluation design. To minimise the risks of conflicts between members representing different groups, I grounded the process in community members' common values and goals. I used facilitation techniques that encouraged participants to acknowledge their respective strengths and contributions, and to clarify areas of potential or existing misunderstandings in relation to their roles, involvement and perceived 'positions' within their community. The evaluation frameworks developed resulted from collaborative reflection and learning, during which members from both groups had an opportunity to exchange ideas and perspectives and to reach a shared understanding. Such processes were grounded in the notion of 'labour of love' and aimed at sustaining mutual care, interdependence and relationality as guiding values in a partnership.

Participatory evaluation and community action for health justice

Participatory evaluation in community development initiatives that involve collaborative action for health justice creates a venue for community members to become implicated participants rather than passive consumers of initiatives convened by the non-profit organizations. Contributing to a transparent decision-making process, participatory evaluation minimises the risks of co-optation and tokenistic representation. Participatory evaluation invokes and reasserts the power of community to participate in the decision-making process according to which success will likely be assessed. It creates a framework that actively involves community members in the production of knowledge about programs and services in the community, and in the decision-making concerning actions informed by the knowledge that is co-produced and relies on a variety of perspectives, thus reflecting the values of many rather than a selected few (Guijt, 1998; Wagemakers, 2010; Springett, 2017).

There is a consensus in the field that best practices in health promotion necessarily involve engaging people in the process (Springett, 2001). Such consensus extends to evaluation. Evaluation in health promotion initiatives must continuously inform the nature of action taken, build relationships between multiple actors, and create

opportunities for collaborative learning and action. Measurements and metrics by themselves do not facilitate participation and empowerment. However, when the development of tools and metrics involves communities and draws upon a variety of perspectives among actors, such evaluation not only 'measures' but also *facilitates* participation and empowerment sought in health promotion initiatives (Wagemakers, 2010). Only a participatory approach to evaluation, regardless of its methodology (i.e., conventional or developmental) presents such an opportunity and makes participatory evaluation the most context-appropriate in health promotion.

Top-down approaches to evaluation are known to further reinforce marginalization and disempowerment of communities where health promotion initiatives take place as they tend to focus exclusively on individuals rather than the context within which initiatives unfold (Springett, 2001). A top-down approach is essentially disempowering and therefore undermines the key principles of health promotion. Participatory evaluation on the other hand facilitates a continuous iterative process of reflection and action, where action is informed by a deliberative democratic process (Springett, 2017). Thus, action is constantly informed by priorities identified by intended beneficiaries (i.e., community members) rather than by opinions of professionals and funders who are often removed and distanced from the everyday realities that communities experience first-hand.

It needs to be stated clearly, unequivocally, and repeatedly that participatory evaluation means much more than collecting qualitative data through open-ended surveys or focus groups. Interactive data collection methods by themselves do not constitute participatory evaluation. Participatory evaluation is about sharing and decentralising power in an evaluation process and it is about enabling participation through the following actions:

- Providing a space, both physical and intellectual, to discuss evaluation;
- Supporting community members in accessing such space;
- Building capacity among agencies staff to support equitable participation;
- Building capacity of community members and agencies staff in participatory evaluation design and implementation; and
- Designating sufficient amount of staff time and other resources to support all of the above.

I noted earlier that participation itself does not necessarily results in more equitable power distribution among the participants. Indeed, ‘technologies of participation’ that manipulate participation of less powerful actors to meet the goals of those with more power may bring more harm than good, through a loss of trust, disengagement from civic participation, abuse of free labour provided by volunteers, entrenchment of existing status quo with inequitable power distribution and access to resources, and the loss of credibility for groups or individuals convening pseudo-participatory processes (Cornwall, 2008; Katz, Cheff and O’Campo, 2015).

The next chapter provides a closer look at the role of non-profit organizations in supporting participation in collaborative community action in the context of health equity and justice. I use participatory evaluation as a point of departure for further discussion about what meaningful participation means for community residents and how to define, measure, and most importantly nurture and sustain such participation.

The Intermission below serves as a bridge to the next chapter. It presents a poetic reflection in a form of a short play about the labour of love, where ‘labour of love’ is a notion that encompasses ethics of mutual care, partnership and a commitment to nurture one’s and another’s spiritual growth (hooks, 2001). It is a reflection on how the labour of love faces attacks of neoliberal capitalism and its market-driven rationale of domination, competition and profit making.

Intermission 5: Hearts, Arts and the Labour of Love

A non-accurate but true account of an ad-hoc committee meeting in defence of the Environmental Justice and Arts Curricular at the Faculty of Environmental Studies, May 2017, York University, a year before The Strike That Broke the Camel's Back
Dedicated to the Wild Garden Media Centre and the memory of dian marino

Setting: A large rectangular shape room with a long table in the middle. An administrative official is sitting in the centre of a long rectangular long table. Students and faculty of various ages and rank, from undergraduate student to long-standing faculty members are huddled around the table, some are occupying chairs, some are standing. There are more people than chairs available. Yet the presence of an administrative official is overbearing and strong.

Characters:
Administrative Official
Scholars – of various ages, ranks, creeds and identities.

A background humming noise against which the voices of scholars are growing:
Scholars:
Scholar 1: *How do you measure care?!*
Scholar 2: *Quantify outputs of the art?!*
Scholar 3: *Routinise, schedule, prepare*
a roster for the call of the heart?
Scholar 4: *How do you quantify love?*
Count outputs, measure impact and such?
Scholar 5 (sarcastically): *Oh, I know!*
1 = caring; 2 = caring enough;
3 = perhaps caring too much?

Scholar 1: *How do you measure care?*
Divide it into units of love?
No units assigned to despair,
when 0 is 'not caring enough'…

Administrator: *Oh, the labour of love… It's invaluable!*
Scholars in chorus: *Cost-effective when unpaid!*
Administrator: *Do more volunteer work!*

Scholar 5, muttering: *In the meantime, learn to budget better…*

Administrator: *We want you to stay…*
Administrator continues:

Get on with the program,
it is rolling out SHARP,
to cut the unquantifiable –
immeasurable matters of heart.
Accountable and transparent
to the logic threatened by arts,
by invaluable powers of care,
by transformative impact of hearts.
We encourage cooperation…

Scholar 5, interrupting: *But first, you make us compete!*
Administrator goes on: *Reward social innovation.*
Scholar 3 to Scholar 5, winking: *To serve the entrepreneurial need!*

Scholars in chorus:
This is how to manage
un-pragmatic, caring hearts.
Turning quantifiable units into
$$ signs in a world where art
Is good for beautification,
for making pretty things,
not for disturbing imagination,
unleashing radically critical dreams.
How?
How? HOW?

---------- s-i-l-e-n-c-e ----------

Scholar 6 (very quiet):
How do you quantify love?
Measure immeasurable impacts of heart
While keeping the fabric of life together,
without tearing it apart?
How do you quantify equity, justice, art?
Without severing connections,
without squeezing the life out of love
and love out of heart?

Thu humming noise resumes, one by one scholars leave the room. The Administrative Official is left alone in the middle of a large empty table.

Chapter 6: The Role of Non-Profit Organizations in Supporting Community Action

This chapter examines the factors and conditions influencing the capacity of non-profit organizations to support community participation in collaborative initiatives aimed at addressing social determinants of health – using the case study of The Neighbourhood Table, a local neighbourhood-based network of community-based non-profit organizations, public agencies and community residents. To understand power relations and relational dynamics that influence the experiences of participation for different partners, I adopted a dual research approach. First, I facilitated the implementation of a participatory evaluation framework designed by resident-members of The Neighbourhood Table as part of participatory action research. Second, I applied a self-evaluation tool for action in partnership as an analytical framework to discern what factors support or impede the capacity of non-profit organizations to support community action by focusing on how non-profit organizations as institutional partners approach participation of non-institutional partners such as community residents (Bilodeau et al., 2019).

Evaluating Quality of Participation

To evaluate the quality of participation for different types of partners in The Neighbourhood Table, Arnstein's (1969) ladder of citizens participation was chosen as a tool for participatory mapping and group discussion. Arnstein's (1969) model was selected for its relative simplicity and because it is a relatable and adaptable tool with a long history of use in the context of community work. The ladder was, however, adapted by participants to the context of the non-profit and community partnership. The adaptation of the ladder was an iterative collaborative process where I, as a researcher, presented drafts to The Neighbourhood Table evaluation working group for further work. The final version went through three editions before we ended with a product that was collectively satisfying and agreed upon to bring to the Neighbourhood Table meeting for participatory mapping activity.

'Fixing' the ladder

The proposed ladder of community participation does not offer citizen control as the highest rung for participation per the original Arnstein's model because control is not necessarily pursued in the context of non-profit community partnership. The highest level on the proposed ladder became that of *delegated power in partnership* and more accurately reflected community participation as both a goal and an intrinsic value inherent in community development activities supported by non-profit organizations. The rung of delegated power in Arnstein's original ladder was renamed *co-production* while the rung of partnership was renamed *co-design*, both levels reflecting indicators of meaningful participation as defined by resident-partners of The Neighbourhood Table. The primary difference between Arnstein's original rungs and our collective adaptation is the extent to which power is shared between partners. Co-design involves shared leadership and includes the sharing of knowledge, skills and expertise, while resources are still controlled individually by each partner involved. The level of co-production involves the sharing of power where skills, knowledge, expertise and resources are shared through equitable access to decision making. Changes are summarized below.

Table 11: Adapted Ladder of Community Participation

Arnstein's Rungs of Participation	**The Neighborhood Table's Adapted Levels of Participation**	**Quality of Participation for Resident Members of the Neighborhood Table**
Delegated power and partnership	Co-production (shared knowledge, skills, expertise, access to decision making AND resources)	Meaningful Participation
	Co-design (shared knowledge, skills and expertise)	
Placation	Accommodation (involvement with limitations)	Symbolic Participation
Consultation	Consultation	
Informing	Informing	
Decoration and manipulation	Decoration and manipulation	Non-Participation

The strength of the co-production concept resides in the inherent notion of partnership. Having its roots in civil rights and social justice work, co-production extends beyond consultation and involves collective development of service delivery models intended to transform wider social systems (Realpe and Wallace, 2010). Co-production is also one of the intended goals of The Neighbourhood Table envisioned as a venue for community members and non-profit organizations and public agencies to come together to discuss and tackle issues of concerns, including but not limited to service provision. As such, co-production is the rung of the ladder that is sought as a purpose of participation for The Neighbourhood Table members.

The rung labelled *placation* in the original Arnstein's model was changed to *accommodation*, for placation was perceived as a negative term in the context of a partnership between neighbourhood-based non-profits and community residents. These groups enter the relationship in good faith, with non-profits genuinely striving to support community participation. Yet, many organizations find themselves structurally constrained to the level where they are conflicted between efforts to respond to community needs and restrictions imposed by funding requirements and functional accountability systems. Such a level of participation was described on the ladder as *accommodation* to reflect participants' involvement with limitations imposed by structural constraints.[24] Participants of The Neighborhood Table summarised *participation quality* in terms of non-participation, symbolic participation and meaningful participation in the adapted model.

To assess the quality of participation of different groups of partners, members of The Neighbourhood Table were invited to identify the level of participation on the proposed ladder that was reflective of their experience of participation according to their respective roles. Resident-members and agency-members were given colour-coded dots according to their roles, i.e., resident members, agency-members who are frontline staff, and agency-members who are managers. This was done for the purpose of

[24] Such structural constraints are described in more details in the following section of this chapter. The analysis of data gathered during the evaluation design (Part II) of the research provided more insights into systemic factors structuring the role of the non-profits in relation to community participation.

differentiating between different members of the group who each exercise varying degrees of power over their own and other members' participation. Fourteen people took part in this activity. Participants were invited to place a colour-coded dot at the level on the ladder that best described their experience of participation in The Neighbourhood Table. Approached this way, evaluation of participation captured not only quantitative aspects of participation by tracking the number of members at each rung of the ladder but also captured differences in the quality of participation for different members of The Neighbourhood Table according to their institutional vs. non-institutional roles. Participants were also invited to share a story to illustrate the position of their dot on the ladder. The table below illustrates the results of the activity.

Table 12: Quality of Participation for Resident-Members and Agency-Members

Level	**Quality of Participation**	**Members' Experience of Participation** (n=16)
Co-production	Meaningful participation	○
		● ●
Co-design		○ ○ ● ●
	Symbolic participation	●
Accommodation		○ ○ ●
		○ ○ ○ ○ ○
Consultation		
Informing		○ ○
Decoration and Manipulation	Non-participation	

○ Resident-members at large (general membership) ● Agency-members, frontline staff

○ Resident-members, action committee chair ● Agency-members, managers

When responding to the mapping activity, some resident-members noted that their experience differed depending on their role as action committee chairs vs. their role as general members. Resident-members at large assessed their participation at the level between consultation and accommodation. However, when referring to their roles as committee co-chairs, one assessed their participation at the level of co-production and two at the level of co-design. When assessing their participation as general members, residents noted that it varied between accommodation and consultation depending on projects. To reflect this, five chose an in-between or intermediary level. Two resident-members assessed their participation at the informing level.

It is notable that eight resident-members (or community partners) described their experience of participation at the lower degrees of *symbolic participation* while four agency-members identified with institutional partners/agency-members described their experiences of participation at the degrees of *meaningful* participation. The three resident-members who were committee chairs described their experiences at the degrees of *meaningful participation*. Only two agency-members assessed their participation at the degree of symbolic, one frontline staff at the level of accommodation and one agency-member/manager at the in-between level of accommodation and co-design. Being in the position of the committee chair did not change the quality of participation for the agency-members. The following section examines what factors and conditions influence the quality of participation in collaborative action for different members of the Neighbourhood Table.

Partnership Assessment Wheel Model

To understand what factors and conditions influence participation in action, I adapted the self-evaluation tool for action in partnership tool developed by Bilodeau et al. (2017) as an analytical framework. Bilodeau et al.'s (2017) self-evaluation tool for action in partnership is based on a mid-range theory that defines six requirements for effective and equitable action in partnership from a series of case studies based on actor network theory (Bilodeau and Kranias, 2019). The World Health Organization identifies action in partnership as a strategy for addressing social determinants of complex issues at varying levels of public action (Bilodeau and Kranias, 2019).

Community action for health equity and justice addressing social determinants of health presents one of the examples of such public action. As it was discussed previously, community action is often carried out collaboratively between local non-profit organizations, public agencies and community residents. As such, it involves many actors with varying degrees of power distributed among different types of partners: *institutional partners* as represented by agency-members of The Neighbourhood Table, community, and non-institutional or *community partners* as represented by resident-members. Power differentials among actors influence quality and extent of their participation. For example, participation of the partners with less power such as grassroots groups may be compromised and their priorities for action diluted in the presence of more powerful partners – as exemplified by the complex relationships and participation dynamics among agency-members and resident-members of The Neighbourhood Table.

Bilodeau et al.'s (2017) describe six requirements for effective and equitable action in partnership in their self-evaluation tool for action in partnership. Four out of six requirements relate to participation dynamics and two address partnership arrangements for equalisation of power between partners and for collective rather than individual action (Bilodeau and Kranias, 2019). Each requirement comes with a set of indicators that help assess the overall strength of the requirement and identify possible enablers and barriers. A total of eighteen indicators are unevenly spread between the six requirements. Each indicator is assessed in the tool through a series of three options indicating three levels of achievement (weak, medium or strong) for each requirement.

The self-evaluation tool is centred on participation and each of the six requirements addresses an aspect of participation necessary for an effective and equitable action in partnership:

A. Who participates, reflecting on the *range of actors* involved in partnership;
B. What are the *options for participation*, including options for participating in developing options for action vs. options for implementation only;
C. What is the *extent of participation*, i.e. how partners with the least power are engaged in negotiating and influencing decisions;
D. How is *participation sustained*, reflecting on the commitment of strategic and pivotal partners;

E. Is *participation empowering*, reflecting on partnership arrangements that equalise power among partners; and
F. Is *participation collective* rather than individual, reflecting on partnership arrangements that help build collective rather than individual action (Bilodeau and Kranias, 2019: 3, Fursova et al., 2018: 1; my emphasis).

The strength of the indicators for each requirement is assessed using the qualitative data from individual interviews, participatory workshops and stories shared during group discussions, including but not limited to participatory mapping activity on the ladder of community participation. Qualitative data was analysed through NVivo 12 software where I set up self-evaluation tool for action in partnership (Bilodeau et al., 2017) as an analytical framework to analyse the data against the categories and indicators of strength outlined in the tool.

To illustrate the importance of each participation requirement for achieving effective and equitable action partnership, I arranged the six requirements and accompanying indicators in the shape of a wheel, where each segment represents a requirement. There is a symbolism in a wheel shape, where every segment needs to be present for the wheel to keep its shape and therefore its functionality, or in a partnership context, its effectiveness. When one or more segments are underdeveloped or missing, there will be a bumpy ride or the wheel (partnership) may fall apart. As the wheel travels across the terrain, it interacts with uneven surface, bumps, potholes and cracks, or what in the context of non-profit community partnerships is equivalent to changes in the socio-economic landscape within which partnerships work. The sturdier the wheel, the greater its ability to withstand the impacts of a changing landscape and so it is for partnerships.

All requirements of the tool were assessed at a medium level, except for requirement D on the capacity to sustained participation and requirement E on whether participation is empowering (see Figure 16), where indicators varied between ‘weak’ and ‘medium’. The indicators discussed are based on the assessment during a particular moment in time of The Neighbourhood Table as a living and developing initiative. There is a notable movement identified towards strengthening and enhancing certain requirements. Indicators for each requirement are discussed in detail in the section below.

Figure 16: Partnership Assessment Wheel

Requirement A: Range of Actors Involved in Partnership.

As per the indicators described in the self-assessment tool, some actors from agency-members and resident-members are mobilised while others are missing. The extent to which agency-members participate depends on each agency strategic priorities. The priorities may change in response to funding conditions and the political climate, and that may affect the participation of agencies. The decision regarding participation ultimately stays with higher management and depends on the resources (including staff time) that the agency can dedicate to support The Neighbourhood Table. In terms of representation, there are more agency-members than resident-members.

Community members with lived experiences of the issues related to The Neighbourhood Table wants to participate but their views are not necessarily considered when the decisions are made. For example, during the mapping activity with the ladder of community participation, a resident-member (2018) admitted that “overall as residents you are invited to the table, but your opinion does not matter to the agencies.”

Requirement B: Options for Participation, including Options for Participating in Developing Options for Action vs. Options for Implementation Only

Resident-members are sometimes involved in making decisions about options on issues defined by agency-members, and/or in implementing actions determined by agency-members. Action committee workplans are often developed without sufficient involvement of community members into options for action, for example in a one-to-one interview, one frontline staff and an agency-member of the Action Committee (2018) describes the initial workplan as “top-down”, and notes that although there was no funder requirement behind the deliverable of the workplan, “whoever created this workplan wanted to see it implemented.” From the resident-members’ perspective, “the residents had to come to the table to agree or disagree on things because they were not being involved with the decisions that were happening during the wrap up period [referring to a previous Neighbourhood Table structure]” (Group discussion, 2018).

Requirement C: Extent of Participation or Engagement of Partners with Least Power in Negotiating and Influencing Decisions

Resident-members are invited to express their views, but such views are given less considerations than those of agency-members. The participation of residents-members at large (i.e. those who are not in the position of action committee co-chairs) is limited to 'Informing', 'Consultation' and 'Accommodation' levels of the ladder of community participation.

As stated by a resident-member (2018) during the collective community story mapping session, "our voices are not being honored." This point is echoed by another resident-member (2018) remarking that "feedback is given [by resident-members] but what is being said is not being taken into consideration."

Requirement D: Participation Sustained or Commitment of Strategic and Pivotal Partners

Various factors and conditions affect the capacity of agency-partners to commit resources to support collaborative action. Some agency-members may not necessarily be in a position to make decisions or commit resources to projects on behalf of the partner agencies they represent. The capacity of some agency-partners to commit resources to The Neighbourhood Table is limited by their mandate that is focussed on service-provision for specific groups. As stated by participants:

> They [employment and settlement agencies] support only certain target populations, and if your group doesn't have that population how are you going to really get support? It is challenging (Community resident, 2018).

> Resources are always dependent upon decisions and resources beyond my personal control. Being able to get work done has been heavily dependent upon the relationships developed over years and other working relationships. Resident leaders' participation is limited by available financial resources and supports for co-chairs and members at large (Agency-member, Group discussion, 2018).

Only events or initiatives where agency-partners contributed dollars and staff time were described by resident-members as "true collaboration" (Resident-member, 2018).

The turnover in partner organizations weakens or slows progress on projects. Contributions from agency-partners are subject to each project, whether agency-partner can contribute depends on the strategic directions of their organizations. Strategic directions and capacity of organizations may change in response to funding and policy decisions, yet those changes are not necessarily communicated to The Neighbourhood Table in a timely and consistent manner. When there are staff transitions, the new staff joining The Neighbourhood Table as an agency-member may not be given a sufficient orientation:

> the relationship is built with the people present at the table, and people change... and those role change and it had a major impact on the community when people transition in new roles and there is no transition plan for [their involvement with The Neighbourhood Table]. Good practice - bring a new person to shadow (community resident, 2018).

Agency-members spoke about the importance of avoiding situations when people are "parachuted into the community" and where their participation in The Neighbourhood Table is used to fulfil functional accountability requirements or "organizational statistical purposes" (Agency-member, individual interview, 2018).

For agency-partners, some important resources are often missing but they still manage to make the projects work. For example, due to budget and reporting restrictions in their respective organizations, agency-members are not able to free up and contribute funds as quickly as it may be required in response to community driven action.

> Because I wanted to co-produce from the beginning but only got to co-design – example 2015 Federal elections… [w]e were not co-producing because agencies cannot move as quickly and commit funds in time (Agency-member, Participatory mapping activity with the Ladder of Community Participation, 2018).

Yet, for resident-partners some indispensable resources are missing, which may compromise the project implementation. Residents members (2018) reflect on the lack of some indispensable resources:

> There were no spaces for us to store information or places to meet for meetings – you want to have community engagement but there are no places for us to be engaged or try to do so. (Resident-member, group

> discussion, Participatory mapping activity with the Ladder of Community Participation, 2018).
>
> There are no resources that are reachable or tangible to be effective within the community, and we became resentful and started questioning why am I here? Why should I continue to come to meetings? What is really being done when I voice my opinions, but nothing is being taken into action?" (Resident-member, group discussion, Participatory mapping activity with the Ladder of Community Participation, 2018).

The Neighbourhood Table struggles to attract and retain new resident-members because of a certain level of distrust among community:

> You have your members of action committee and members at large – if members at large don't come out they don't have your back– you go out to do stuff for your community and fight for stuff for your community but there is no one to stand behind you and back you up. (Resident-member, group discussion, Participatory mapping activity with the Ladder of Community Participation, 2018).
>
> Residents were stopping coming to things. We had our own way of saying "well, I am not doing this anymore", so we had to recruit ourselves out from things - to say I am not doing this anymore because you are not hearing me, you are not supporting my needs (Resident-member, individual interview, 2017).

Requirement E: Empowering Participation or Partnership Arrangements that Favour Equalization of Power among Partners

In relation to the requirement concerning partnership arrangements for equalising power, data from resident-members and agency-members corresponded with weak indicators pertaining to this requirement. Resident-members expressed that they do not benefit from their involvement in partnership in the same way agency-members do. In some cases, community partners' contribution to carrying out activities are neither acknowledged nor compensated equitably. In relation to agency-partners and resident-partners, criteria and mechanisms for accountability are determined exclusively by funders, with no or little dialogue and negotiation taking place between funders and grantees.

Opinions coming from agency-members representing their respective organizations carry greater weight in decision-making. The voices of community partners at times become subjugated to the interests of institutional partners.

> Now that they are seeing us residents actually speaking out, instead of looking at it as positive thing, it is not considered as a positive thing, it's like "get on board, and go with a flow". Even though they say we created this action groups for residents to have a voice, well, where does that voice go besides that? (Resident-member, individual interview, 2018).

> As a co-chair resident – we are present at meetings to help make decisions, however when decisions are being made the agencies still have the final say on things that are being discussed (Resident-member, group discussion, Participatory mapping activity with the Ladder of Community Participation activity, 2018).

Community partners' contributions to carrying out activities are sometimes acknowledged but are not necessarily compensated equitably. Most often, resident-members volunteer their time. Resident-members would like to see their contributions acknowledged publicly by the agency-partners and not presented exclusively as the work of agencies. Resident-members feel shortchanged as they often are excluded from important communications, information exchange, job and networking opportunities. Resident-members often note that they do not see tangible outcomes of their participation, including programs and services being better tailored to community needs.

> For those who are active it increases time spent in meetings. Residents want to see meaningful participation and tangible outcomes of their participation. (Agency-member, individual interview, 2018).

Referring to their experience of not being informed about an important community forum facilitated by their local Member of Parliament, resident-members expressed feelings of betrayal and disappointment:

> [w]hen we did all show up, it was all agencies – we were not informed, but the agencies and the residents were supposed to be there, so now it was like what else we don't know, what else are they not telling us? Why are they withholding information from us when we are supposed to be a part of these type of things? (Resident-member, group discussion,

Participatory mapping activity with the Ladder of Community Participation activity, 2018).

Criteria and mechanisms for accountability for agency-partners are determined solely by funders. The Neighbourhood Table currently has no specific funding, so all project-related resources are accounted through community development or program budget of participating non-profit partners. This is done according to accountability mechanisms established by a specific funding body for each agency respectively.

Presently, The Neighbourhood Table strives to address inequitable power distribution in response to concerns raised by resident-members and agency members. In 2017 The Neighbourhood Table introduced a new leadership structure involving the co-chairing of the action committees and steering committee by a resident-member and an agency-member. Previously, only agency-members served as co-chairs. The results of the mapping activity about the ladder of community participation showed that proposed changes had a desired impact. Resident-members in the position of the action committee co-chairs assessed the quality of their participation at the degrees corresponding with *meaningful participation*.

The design and the subsequent implementation of the community driven evaluation process also presents one of the means for equalising power among partners. By implementing a bottom-up evaluation, The Neighbourhood Table is moving towards creating a more balanced accountability system. Resident-members and agency-members embarked on the evaluative process in a hope that such process will result in more equitable power distribution among members.

Requirement F: Collective Participation and Partnership arrangements that help build collective action

At the time of the research project implementation, members of The Neighbourhood Table frequently referred to the kinds of scenarios taking place where the exchange of diverse points of view was generally encouraged and supported by local data. For example, two community reports highlighting community priorities and directions for action were published in 2016 and 2017. Yet, in individual interviews and group discussions, resident-members frequently commented on the lack of action in

response to the exchange of information and opinions, and especially in regard to opinions expressed by community residents:

> These are issues, these are things we are highlighting that on a community level what residents have done, or planning on doing in the community, but it's not taken like that. It is more looking at the organizations aspects than it is looking at a [community aspect]" (resident-member, individual interview, 2018).

Nevertheless, a slow and incremental process to expand the possibilities for action has emerged. In one of the action committees of The Neighbourhood Table, the workplan discussed as 'top-down' by committee members was overturned. The committee co-chairs co-designed the new workplan with the committee members. This new workplan was grounded in resident-members' priorities and drew on support from the agency-partners. Resident-members noted that often this process was reversed i.e., workplans for action committees were grounded in agency-members' priorities while drawing on support from community members.

It is hoped that the implementation of a 'bottom-up' evaluation process will encourage collaborative learning to expand the possibilities for action. As observed in Bilodeau et al.'s (2017) self-evaluation tool, The Neighbourhood Table partners express points of view which may diverge but points of potential agreement generally remain the object of more discussion. The existing tensions between agency-partners and resident-partners are not dealt with productively. Conflict persists due to the lack of clarity and transparency in communication and decision-making. Resident-members frequently cited the need for outside conflict-mediation services to be brought in. There is no time and space created during meetings for collective reflection on those unresolved tensions:

> [i]n terms of actually sitting down and discussing as a group or reflecting on the impacts for the residents (how they felt, what still needs to be done, what was done), there was no time for this. It was just a "go, go, go" kind of thing (Resident-member, group discussion, Participatory mapping activity with the Ladder of Community Participation activity, 2018).

> [agency-partners] want resident capacity to build up but nothing is happening and therefore there is constant clashing – because there is nothing being done after all the conversations being held (Resident-member, group discussion, Participatory mapping activity with the Ladder of Community Participation activity, 2018).

Certain actors may dominate to the point of directing action to meet their own ends. The sentiment that the voices and priorities of agency-partners dominate The Neighbourhood Table has been repeatedly expressed by both types of members. For the agency-members, it is expressed as an awareness of their imperative to meet their organization's strategic priorities and needs.

A lack of support for the priorities coming from the 'Residents in Action' group was often cited in individual interviews and group discussion. The group was initiated as a resident engagement project by The Neighbourhood Table in response to the drop-in participation of community members. The initiative aimed to build community residents' leadership skills and integrate 'Residents in Action' participants as resident-members of The Neighbourhood Table. Many of the Residents in Action participants joined The Neighbourhood Table as members of various action committees and some were in committee co-chair roles. Yet, members of the Residents in Action often spoke about The Neighbourhood Table as an "agency dominated space" that imposes a top-down agenda for community participation, which often leads to co-optation of community ideas to fulfill organizations' mandate. Such dynamic is illustrated by the story of the food security action group initiated by Residents in Action. Residents in Action members started a food security initiative to address the lack of access to gardening spaces and fresh food. The Neighbourhood Table proposed to merge the food security action group under a broader focus of a Healthy Living Action Committee. Members of the food security group felt that this would dilute the systemic focus of their proposed action by shifting the conversation towards behaviour and lifestyle changes. This would prevent community action from targeting issues such as access to the land for gardening spaces, community purchasing ability, food sourcing and pricing. The attempt to integrate the food security action under the umbrella of 'healthy living' was cited by the resident-members as an example of agency-partners' attempt to shape community action to satisfy their needs rather than to respond to community priorities dictated by

people's lived experiences: "people are hungry, we need to feed them first, then maybe they will want to go to yoga classes" (community member, Residents in Action, story mapping session, 2018).

Some resident-members also expressed opinions that the Residents in Action initiative itself emerged to fulfill the non-profit organizations' community engagement strategy rather than to support meaningful community action. Residents noted that there was no collaborative process to develop the project proposal that involved residents, as well as no clear language around the goals and purpose of Residents in Action beyond capacity building and resident engagement (Residents in Action, participatory evaluation workshop, 2018).

Partnership Assessment Wheel Results Discussion

As per Bilodeau et al.'s (2017) self-evaluation tool, partners focus mostly on coordinating current action plans, programs and services. While some partners are able to modify their programs or services when innovative projects require it, others are not. As agency-partners focus mostly on coordinating their current action plans, they nevertheless recognise the value in being part of The Neighbourhood Table and work together to develop a new comprehensive option for collective action in response to community priorities. Yet, few agency-partners are able to modify their actions, programs or services to accommodate new innovative projects as part of community action. Often such limitations are due to constraints imposed by funding conditions, such as service delivery targets attached to particular target groups, limited community development budget and/or staff capacity. Grassroots groups and individuals approach non-profit organizations depending on the focus of their proposal or request for support. The extent of resulting collaboration depends on agency-partners' resource and capacity, as well as on the alignment of the proposed action with an agency's strategic priorities. Resource capacity of agency-partners to support participation of their agency-members in The Neighbourhood Table and participation of resident-members is impeded by their constrained ability to mobilize necessary resources, including budget and staff time. Frequent staff turnover in organizations representing agency-partners negatively affects collaborative action with resident-partners. Resident-members

engage primarily as individuals and their involvement is highly dependent on their individual circumstances, produced as a result of their positionality and social location - such as time availability, the need for child- or eldercare, and physical accessibility issues, to name only a few. Therefore, individuals who are positioned at the intersection of multiple vulnerabilities, for example gender, race, disability, single parenting, are most likely to be excluded from participation due to resource constraints.

The commitment of institutional partners or agency-members depends on strategic directions of the organizations they represent. Strategic directions may change in response to funding and policy decisions, and in some cases such changes affect the commitment of agency-partners to their participation in The Neighbourhood Table. Changes regarding the participation of agency-members are not necessarily communicated to The Neighbourhood Table in a timely and consistent manner. In terms of resource mobilisation, some indispensable resources such as access to meeting and supplies storage space for community members are missing. For institutional partners, budget and reporting requirements in their respective organizations restrict their ability to free up and contribute funds as quickly as it may be required in response to community priorities.

However, the implementation of a bottom-up evaluation framework developed by resident-members where criteria and mechanisms for accountability are informed by resident-members presents an effort towards equalisation of power among members. Yet, the capacity of The Neighbourhood Table members to implement such an evaluation and to act upon emerging recommendations is highly dependent on the commitment of members to their participation in The Neighbourhood Table. As discussed earlier in this section, such commitment is dependent on the resource capacity of agency-partners to support participation of their agency-members in The Neighbourhood Table, as well as participation of resident-members. This interdependency illustrates the relational nature of the requirements for effective and equitable participation and action in partnership. In order to achieve such levels of participation, an ongoing dedication is required to all six components of effective and equitable action in partnership. The requirements with their accompanying objectives should not be thought of as a linear ‘checklist’ but should be approached as a relational

model, where the fulfillment of one requirement, or the lack of such, creates a ripple effect for other requirements. The Partnership Assessment Wheel presents both a theoretical and practical model for enhancing effective and equitable action in non-profit-community partnership.

Only partnerships that have enough skills, capacities and resources to stay attentive to all six requirements for effective and equitable action in partnership identified in Bilodeau et al. (2017) will be well set for effective and equitable participation of all partners in a collaborative action.

An evaluative learning process that creates opportunities for collective reflection and deliberative dialogue among partners is essential for maintaining such attentiveness. Placed within such framing, evaluation of the outcomes of partnership work becomes more that a set of tools for tracking numbers of participating actors and measuring pre-defined outcomes but a process that enables collective learning and action.

A participatory bottom-up evaluation process that was initiated as part of participatory action research allowed to bring in focus power differentials between members of The Neighbourhood Table and facilitated the beginning of a dialogue about equitable participation in collaborative action in non-profit community partnership. A bottom-up participatory evaluation process contributed to strengthening the requirements for effective and equitable action in partnership in following ways.

With respect to partnership dynamics, a bottom-up participatory evaluation process expands the range of perspectives relevant to the evaluation of participation and its outcomes through the continuous inclusion of resident-members and drawing upon their lived experiences. It ensures the early engagement of actors, or participation of actors in analyzing issues and developing options for action. Such bottom-up process also involves resident-members in making decisions regarding evaluation design, such as developing indicators for meaningful participation and designing the tool for understanding the quality of participation.

With respect to partnership arrangements, such participatory evaluation process contributes to partnership arrangements that favour equalisation of power by allowing members with the least power to develop criteria and mechanisms for accountability

and by supporting dialogue among all members about existing power differentials. It also contributes to partnership arrangements that help build collective action by enabling time and space for collaborative learning and reflection, and deliberative dialogue focussed on identifying points of disagreements and resolution pathways.

Yet, as any action in partnership, evaluation depends on skills, capacity, staff time and financial resources necessary to sustain an action. The concluding section outlines recommendations for sustaining effective and equitable action in non-profit community partnerships, addressing specific aspects related to funding and resourcing, capacity building and evaluation.

Managing, Maintaining, or Sustaining Participation?

The self-evaluation tool for action in partnership used as an analytical framework affords focus on power differentials between the two types of partners in non-profit-community partnership, i.e., institutional partners as represented by 'agency-members' and community partners as represented by 'resident-members'. When indicators for effective and equitable action in partnership are described as 'weak' or ranging between 'weak' and 'medium', power distribution in partnership is skewed towards partners with institutional power. With power distribution skewed towards institutional partners, the role of such partners becomes that of 'managers' of community partners, whose participation is used by institutional partners to fulfill their needs and priorities. As a result of such dynamics community members' participation is pushed down to the 'Informing,' 'Consultation' and 'Accommodation' rungs on the ladder of community participation.

Non-profit organizations who represent institutional partners also struggle with their internal and external limitations due to inadequate and inconsistent resources, the lack of internal policies, the lack of transparency in communication and decision-making processes. The funding conditions and accountability mechanisms that prioritise functional accountability are consistent with the values and rationale of the for-profit sector. As such they promote the values of competition rather than partnership among public and non-profit sector entities. Competitive behaviour promotes extractivist and exploitative strategies that undermine the capacity of non-profit organizations to be

reliable and dependable partners in the context of non-profit community partnership. Using the requirements and indicators proposed in Bilodeau et al.'s (2017) self-evaluation tool for action in partnership, I proposed three roles non-profits may perform when addressing community participation in collaborative action:

- *Managing participation*, when indicators for action in partnership gravitate towards 'weak';
- *Maintaining participation*, when the indicators gravitate towards 'medium' level;
- *Sustaining participation*, when the indicators gravitate towards 'strong'.

These roles influence the quality of participation for community partners, especially for those who are marginalized due to their specific social locations produced through combination of race, gender, disability, sexuality, immigration and economic status. Table 13 below describes each role of non-profit organizations as partners in relation to the degree of quality and levels of participation on the ladder of community participation.

Table 13: Three Roles of Non-Profit Organizations

Quality and levels of participation		**Roles of non-profit organizations as partners in non-profit-community partnership**
Meaningful participation	Co-production	Sustaining participation
	Co-design	
Symbolic participation	Accommodation	Maintaining participation
	Consultation	
	Informing	Managing participation
Non-participation	Decoration and Manipulation	

At the lower levels of the ladder, the role of institutional partners is clearly a dominant one where non-profit organizations perform the role of managers of non-institutional partners. Participation of community-members is structured in ways that assist institutional partners to fulfill their organizational needs, and participatory processes at this level have little potential to shift existing inequitable power relations. Such a role is characterised by minimal participation of community members who are connected to and have lived experiences of an issue an action in partnership aims to address. Both institutional and community partners are involved only in implementing actions determined by their funding bodies; community partners are not included in the decision-making concerning options for action. Commitment of strategic and pivotal partners is jeopardised through their limited ability to make decisions and commit resources. Inconsistent and interrupted funding affects staffing levels and access to other necessary resources to attract new and sustain existing partners. This role is also characterised by the absence of partnership arrangements aimed at equalising power among actors and supporting collective rather than individual action.

Moving up the rungs to the levels of consultation and accommodation corresponding with symbolic participation, the role of institutional partners changes to *maintaining participation* and reflects non-profit organizations' efforts to foster dialogue with and increase accountability to community members. This role is characterised by an expanded range of actors, including community members with lived experience, and greater involvement of partners in decision-making concerning options for action. At this stage both types of partners cope with various degrees of resource constraints undermining their continuous commitment as strategic and pivotal partners in the process. In this role, institutional partners take active steps toward introducing arrangements and structures to the partnership aimed at equalising power among partners and support collective action. On the community participation ladder, it is reflected as participation of community partners in consultation processes and efforts to meet in the middle at the level of accommodation. At this level, institutional partners also respond to community partners' priorities albeit with limited resources often by finding new efficiencies through various in-kind and volunteer support among both types of partners.

The levels of *co-design* and *co-production* imply collaborative decision-making and sharing of resources necessary for effective and equitable partnership. These levels of participation require non-profit organizations to be in the position where they are able to sustain their own participation and that of community members as equal partners by sharing access to decision-making and necessary resources in return for community members knowledge, skills, time and energy. This is the most difficult level to achieve within current funding conditions and accountability requirements in the non-profit sector. Yet, only at this level is community participation present in the form of effective and equitable partnership that strengthens the collective impact of non-profit agencies and community groups. Such role almost inevitably involves the risks of going 'against the grain' and requires advocating for funding conditions and reporting mechanisms that are responsive to community needs and are based on holistic, or balanced accountability models that prioritise social responsibility (Williams and Taylor, 2013).

Stepping Up the Ladder

To be able to move the participation of community partnership to the levels of *co-design* and *co-production* that correspond with *meaningful participation* as defined by community members, non-profit organizations as partners must be able to perform the role of *sustaining* participation. As the case of The Neighbourhood Table illustrates, non-profits often find themselves structurally locked between the roles of *maintaining* and *managing* participation, where they struggle to maintain community participation at the levels above the *consultation* on the ladder. Such role is structured at the institutional level through short-term project-based funding, reduced core funding, competition for scarce resources and pressures to find new efficiencies and leverage resources consistent with the roll-out of neoliberal policies of austerity.

In their role as *maintaining participation*, non-profits are quite literally between a rock and a hard place. On one hand, they genuinely attempt to support community action but, on the other, they perpetually struggle with insufficient and inconsistent resources and capacities in relation to their service-delivery targets and accountability mechanisms that tend to heavily biased toward funders and higher-level policy administrators. The funding and accountability mechanisms, the political nature of

strategic planning and turf wars between non-profit agencies striving to attract and retain service-users circumvent the capacity of non-profit organizations to be reliable and dependable partners in the context of non-profit-community partnership.

Funder-driven functional accountability models emphasising the quantitative aspect of community participation to meet short-term project needs structure non-profit organizations further down the ladder to the level of *managing* participation where top-down approaches dominate and rely on 'technologies of participation', i.e., using community engagement tools to shape community participation in response to the needs of the agencies. The emphasis on results-based funding and performance measurement concerning participation depoliticises partnerships and approaches participation as a technical process without attention to power differentials among actors in the process (Taylor, 2007).

Approached as a technical exercise community participation is sought in the form of consultation and/or feedback surveys to satisfy reporting requirements and quality improvement protocols. In such top-down processes, targets and benchmarks are established by funders and higher-level auditing institutions and do not necessarily reflect community priorities and needs. Community participation is pushed down to the levels of *consultation* and *informing*. At these levels of the ladder the line between *maintaining* and *managing* participation becomes increasingly blurry. Within such roles, the practices of non-profits become consistent with extractivist behaviour signified by dominance-based relationships where institutional partners extract labour and knowledge from community partners. Amidst the pressures to survive as an organization, adapting to political climate and funding priorities, the slip from *maintaining* to *managing* may happen inadvertently in a haste to meet targets and deliver results. It becomes tempting to use community participation in ways that mimic those of for-profit corporations, using community engagement as part of public relations strategy rather than a genuine act of solidarity, and relegating community participation at the level of *decoration and manipulation*.

Within the climate of performance measurement, practitioners are afforded little time and opportunity for reflection, as reflection does not deliver units of service or other measurable outcomes in the short term. Yet reflection, or the lack of thereof, almost

certainly produces impact, those intangible outcomes that accumulate over time and result in the observable *change*. In the context of community development, such change comes as a decline in community participation. In response to low engagement levels, non-profits bring yet another short-term community development initiative while not necessarily addressing the very issues that caused the engagement dip. What is interpreted as lack of engagement is often a lack of trust and disillusionment. On and off participatory projects, especially those focused on needs assessment without really addressing those needs, lead to "participation fatigue" when community members pragmatically refuse to participate in processes they do not trust as to avoid wasting their time and energy meeting other people's priorities (Cornwall, 2008).

Attempts to address participation by focusing exclusively on the numbers of people without considering the extent and scale of participation as well as the purpose and the bounds of participation, may lead to mismatched expectations among institutional and community partners. Stepping up the ladder in terms of moving community participation to the upper levels of participation corresponding with greater quality of participation requires non-profit organizations to step up the ladder in their role as institutional partners and to position themselves at the levels of *sustaining participation*. Moving to that level is perhaps the hardest task non-profits grapple with when they undertake participatory processes. Practitioners in the non-profit sector must be aware of the paradoxical nature of participation as, although it is enabled by performances that can facilitate empowerment, externally structured power relations curtail empowered participation (Kesby, 2005). This point is illustrated earlier through the example of Residents in Action initiative that was initiated to empower and build residents capacity to participate in The Neighbourhood Table. Yet, once agency-partners encountered *empowered* participation on behalf of the resident-partners, they were not able to respond to such level of participation as it often exceeded their capacity to accommodate the scale of actions proposed by residents. Rather than scaling up their role to support community action, institutional partners may scale community action down through *maintaining and managing* residents' engagement to fit the organizational goals. The very role of non-profit organizations is shaped to simultaneously create and curtail participatory processes they are mandated to initiate.

Even the work of non-profits that position themselves as agents of ‘systems change’ is structured in ways that may undermine the very change they claim to support. Immersed in such tensions and complexity, non-profits need to develop practice habits that do not detract them from the ethos of social justice and democracy (Pratt, 2019).

Moving to the position where non-profits are able to sustain community participation requires awareness about different roles the non-profit partners may perform when addressing community participation, it requires humility that is a necessary part of self-reflexivity, and it takes courage to challenge structurally imposed roles that position non-profits as subservient to extractivist policies of the hegemonic capitalist discourse. It calls for advocating with funders and policymakers for more flexible funding and reporting mechanisms that are responsive to community needs and are based on balanced accountability models that prioritise social responsibility (Williams and Taylor, 2013). As part of organizational reflection (and humility that comes with it), it may require the non-profit organizations to critically examine internal mechanisms of reporting, communication, and decision-making through the lens of equity. It also calls for building capacity not only among community partners who are defined as ‘marginalized’ but more importantly among partners with greater institutional power to foster arrangements that allow equalising power among partners to support collective action. Without addressing power differentials between institutional and community partners, as well as within those groups, non-profit sector practitioners may inadvertently support participation of already privileged groups and by doing so undermine the goals of equity and justice. Sharing of power involves sharing skills, knowledge, expertise and it must involve sharing access to decision-making and resources. Otherwise sharing of knowledge and skills in what is constructed as ‘participatory’ processes does not result in empowerment but rather abuse and misuse of power by those who have access to resources.

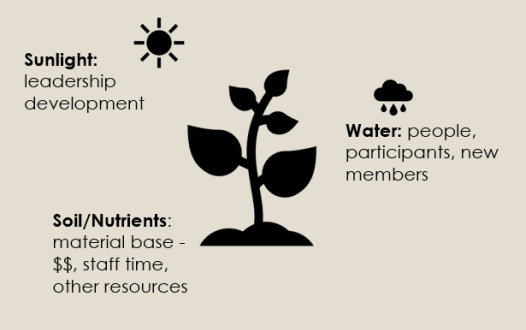
Without specific attention to the political economy of participation, participatory processes may become nothing but technologies of participation that co-opt community members’ time, energy and knowledge (English and Mayo, 2012) and that translate into community residents doing unpaid jobs that benefit agencies, i.e., volunteering with minimum of resources dedicated to support their participation. Such processes may

reinforce meaningful participation of a privileged few and the exploitation of those who are marginalized. To support meaningful participation that reflects and enables the whole spectrum of diversity, non-profits must approach participation intersectionally, not only with attention to various single characteristics of privilege and oppression but with attention to their interconnectedness, interdependence and complexity. An intersectional feminist lens applied to participation intends to redistribute power and resources across the lines of oppression to support participation of those who are most likely to be marginalized and therefore are least likely to be able to participate.

Another aspect of an intersectional lens in practice is capacity building for the actors with more privilege and power, including staff of non-profits and those community members who are more seasoned participants. Capacity building is often prioritised for the newly engaged community members, especially those who are positioned as 'marginalized' but from an intersectional feminist perspective it is of critical importance to build capacity of more powerful actors who must learn to recognise their privilege and channel it towards more equitable re-distribution in order to empower those with less privilege.

One of the long-standing community activists involved in this research compared community participation to a plant and commented that one cannot grow a healthy plant by adding water only. The resident-member (2018) summarized the challenges of participation relations quite succinctly in this metaphor: "It's like they keep watering the plant but do not add nutrients necessary for growth, with too much water and no nutrients the plant grows tall but it is weak, it lacks substance, it does not flourish." Indeed, any gardener knows that a healthy plant needs three key components: water, sunlight and nutritive soil (or nutrients). If we compare growing membership (expressed in numbers and diversity of members) to water, what is analogous to nutrients and sunlight? Sunlight might be *leadership development* for the participants that includes skills development, capacity building and opportunities to apply skills and capacities. Nutrients become *resources*, the necessary material base to support participation and development of a growing membership base – it is space, staff time, budget to cover transportation, childcare, food and other necessary elements of the infrastructure to support meaningful participation.

Figure 17: Growing Participation



Growing membership or increasing the number of people who are 'engaged' or 'participate' is often the first goal in health promotion and community development endeavours. It is also the one that is easier to measure, especially if participation is reduced to a 'head count' as often encouraged by reporting requirements from funders that prioritise quantitative information and measurements. Growing numbers of people who participate and expanding the range of voices involved in community initiatives is undoubtedly important but so are the resources necessary to support the participation in action at the degrees that are above symbolic. Too often, it appears that we, practitioners, in the non-profit sector are seduced by the relative simplicity of the first step, i.e., to recruit new participants and perhaps add some 'capacity building'. Unfortunately, too often we neglect long-term sustainability, partly due to how funding arrangements work and largely because it is a risky business to challenge the system that funds us. Yet, in the situation when the system makes us contribute, albeit inadvertently, to the inequities we aspire to tackle, we must confront it.

Attempting to address participation by focusing exclusively on the numbers of people without giving careful consideration to the other two ingredients is comparable to watering the plant without providing nutrients and sunlight. There is no one single important component, all three are essential for a plant to thrive. Yet, when non-profit organizations are not able to *sustain* participation, providing all three essential ingredients consistently, participation inevitably withers. In response to this challenge, non-profits may lament the lack of engagement and/or the need for capacity building --

and the cycle starts again, with some 'sunlight' or leadership development added to the 'water'. Yet, without the necessary nutrients, the material resources to support opportunities for practicing built capacities and leadership, and without equitable sharing of power, the 'participation plant' wilts again. What's worse, participation may drop for some groups of people only, usually those who need the two other ingredients the most – leadership development and resources, which then leads to sustained participation only for those who are privileged to access the aforementioned ingredients. This is how inadvertently non-profit organizations may reinforce the participation of a privileged few, instead of a participation that not only reflects and enables the whole spectrum of diversity but approaches it intersectionally by redistributing power across the lines of oppression that were used to contain it.

Sustaining participation takes courage and persistence, it requires the non-profit sector to courageously push back against rigid funding conditions and reporting requirements that do not support the flexibility and agility needed to *sustain* participation. It requires revisiting internal structures and policies at the organizational level that may reinforce the exclusive patterns of participation in their work with community, it calls for developing capacity building strategies that target those with more power to support those with less. Using the plant metaphor, it is not enough to provide only water for the participation. To reach the degree of 'meaningful participation', non-profits need to provide nutrients and sunlight necessary for the plant to grow and thrive. Yet, drawing on the language of Indigenous activism, past and present, 'water is life*'* [25] and for community participation, the number and diversity of participants, their skills, knowledge, inspiration and love is what keeps the community alive. As a sector, non-profit organizations are uniquely positioned to grow, nurture and amplify that energy to support collaborative action for health justice.

[25] 'Water is Life' is a slogan of Water is Life Movement (2018), a global protection action group that support communities worldwide to protect water for the benefit of present and future generations.

Intermission 6: Reporting and Evaluation Rap

Funders:
But we are your funders, funders
So, show us your numbers, numbers
If you don't give us numbers, numbers
then we are not your funders, funders

How much money did you spend?
How much money did you spend?!
How much money did you spend?!?!
How much!!!!????
How much money did you spend!

Non-profit agencies:
But these our funders, funders
All they want are numbers, numbers…
We have to guess those numbers, numbers
Just to keep the funders fund us, fund us.
'cause if we don't give them numbers,
they no longer fund us, fund us.

Community residents:
Funders, funders, all they want are numbers, numbers….
and the numbers numb us, numb us
to things that make us so much more
than numbers, numbers….

Where are our stories?
Where are our histories?
Where are our sorrows?
Where are our victories?
Where are our relationships
That weave together the unity
To make us a community?!

Community and non-profit agencies:
Stop asking us for numbers, funders,
Use something else to fund us, fund us.
Our stories, our voices,

our relationships, our choices.
Friendships we have built,
Youth we have raised,
Gardens we have planted,
Meals we have made.
They are more than numbers,
don’t you get it, funders?!

Chapter 7: Evaluation at the Nexus of Accountability, Learning and Democracy

My dissertation analyzes the roles performed and the challenges faced by non-profit organizations when supporting community action for health justice by applying institutional ethnography and participatory action research methods. I focus on the factors, conditions and power dynamics that enable or impede non-profits capacity to support community participation in collaborative action. I examine non-profit actors positioned as subordinate within an institutional hierarchical system due to inequitable access to and distribution of resources. I specifically discuss funding conditions and reporting requirements as factors that condition non-profit organization to reproduce the market-driven logic of competition and power differentials. Implicit capitalist values of competition and domination are present as top-down functional accountability systems that guide the relationships between non-profit organizations and their funders. Within a for-profit framework imposed on the non-profit sector, community participation is likely to be approached from a utilitarian perspective as a mechanism for control over stakeholders through managerial strategies, rather than a process driven by community needs (Suárez-Herrera, Springett and Kagan, 2009). Compromised participatory processes impede effective and equitable action for health justice in the context of non-profit community partnerships and may lead to a crisis of trust between non-profit actors and community members.

Drawing on the work of Riane Eisler (2008) on partnerism and partnership development, and applying it in the context of transformative learning, I discuss the ideas of competition and domination in hierarchical systems as epistemic assumptions[26] and frames of reference [27] (Mesirow, 2009) that are ingrained in conventional

[26] Epistemic assumptions are sets of assumptions about what can be known and how, they include assumptions about evidence, authority as well as definitions of what is problematic and interpretations of solutions to problems (Mesirow, 2009).

[27] Frames of reference are structures of assumptions and expectations on which our behaviours are based, they may include sets of rules, cultural codes, standards, worldviews, aesthetic values (Mesirow, 2009).

economies in general, and in capitalism in particular, as a dominant socio-economic system underpinning the hegemonic institutional discourse. Eisler (2008) discusses conventional economics of capitalism and socialism as having one commonality: the neglect of caring factor. Complicity with the interests of the market has been won by the habituation of a monetary discourse as an underlying logic informing all decisions and preserving economic interests above all others; such habits of thoughts have been normalized or 'naturalized' (Humphries and St Jane, 2011). All modern conventional economies, whether capitalism or socialism, have been based on the epistemic assumptions of domination and patriarchy, and conceived through the frames of reference that prioritize extraction and exploitation through the systems of top-down control. On the other hand, frames of reference that prioritize mutual care, interconnectedness and relationality and that stem from epistemic assumptions of partnership, have been consistently marginalized (Eisler and Eisler, 2008). Presently, neoliberal capitalism is centred entirely on the market and disregards any other units of economy, whether they be family, community, non-profit/public sectors or the natural environment, which together provide the very foundations for the market sector to exist and reproduce. Such relationship denies the obvious -- there would be no market if these other life-giving and supporting sectors did not exist. Nonetheless, the market accords no value to them. When it attempts to account for or measure outputs of the non-profit sector, it does so on market terms, subjugating the non-profit sector to market measures and logics. Functional accountability systems prevailing in the non-profit sector are aligned with neoclassical economics and consistently neglect caring aspects of the non-profit sector activities, both in terms of their inputs and outputs. Such structuring of the work in the non-profit sector promotes market-inspired competition rather than partnership and discourages caring. Therefore, the adoption of business-liked processes impedes rather than advances the core values of the non-profit sector related to care and social justice and affects the caring aspects of its work.

In this concluding chapter, I discuss accountability systems as important modes of objectification or vectors of discourse, and their impacts on shaping approaches to evaluation, organizational learning and practice in the non-profit sector. I discuss how marginalized epistemologies informing participatory approaches to evaluation and

organizational learning, contribute to balanced accountability systems by encouraging more equitable power distribution and fostering collective action in partnership that are necessary for achieving co-production and facilitating the required shift towards alternative economics of partnerism.

Co-production is integral for re/framing and maintaining public services as part of the urban commons. Expansion and protection of the urban commons is a vital part of urban resilience and the required shift towards caring rather than exploitative economics (Eisler and Eisler, 2008; Bauwens and Niaros, 2017). Urban commons, defined as resources collectively owned and managed by its members or users and valued by its members for their everyday use rather than potential monetary profits (Huron, 2015), will benefit urban communities by creating a pool of resources protected from private interests and a profit-seeking, extractivist behaviour. The commons, both ideologically and practically, are essential for promoting intersectional community cohesion that has been eroded by growing income inequalities produced by unregulated market forces that dangerously lead to populist rhetoric of suspicion or hate towards 'the other', driven by the hegemonic ideology of domination and competition for resources. The non-profit sector has an important role to play in this process as it is located in the civil society sphere and involves many diverse actors. Non-profit organizations are not static entities defined by the market and state actors, but rather active agents involved in the continuous process of negotiation between civil, state and economic powers (Corry, 2010; Darby, 2016). From this perspective, pedagogy and practice of non-profits play an important part in the development of a democratically engaged civil society, articulating "informal but powerful normative regimes" and influencing policies and practices at the institutional level (Brown and Moore, 2001: 569). The non-profit sector therefore plays a crucial role in the production of discourse, and drawing on the Foucauldian concept of governmentality, I studied the role of non-profit community-based organizations in the production of discourses related to evaluation and participation, i.e. what can be said and thought in relation to evaluation and community participation? How non-profits are regulated and regulate their own and their constituents' learning and participation?

To understand how to mobilize the collective energy of the non-profit sector for facilitating the transformative shift required towards practices that support and promote

partnerships and co-production in partnerships strengthening the urban commons, I analyze power relations in the non-profit sector through the antagonism of strategies associated with hegemonic and counter-hegemonic discourse (Foucault, 1982). Foucault's (1982) analysis of rationalization processes in relation to fundamental experiences such as madness, illness, death, or crime, is most relevant to the rationalities specific to the work of the non-profit sector. I study the experiences of community sector practitioners in relation to reporting and evaluating their activities (i.e., justifying their existence) and supporting community participation. To understand rationalization, Foucault (1982: 780) advocates for a way that is more empirical and is grounded in human experiences and "which implies more relations between theory and practice." Institutional ethnography afforded such analysis by focusing on the empirical puzzles grounded in practitioners' experiences and expanding from those empirical puzzles to theory (Campbell and Gregor, 2002). Overarching conceptual themes were discerned from those empirical puzzles and links were identified between these themes creating an overarching analytical map that explains how the empirical puzzles occurred in the first place (as summarized in Figure 19 below).

An intersectional feminist framework was also important for maintaining an ontological and epistemological shift from positivist reductionist approach (i.e., breaking the whole into parts) to an alternative, holistic systems thinking as it afforded the focus on the relationships between the parts. An intersectional lens allowed capturing power relations that produce experiences of privilege and oppression. It aided the elucidation of how power is re/produced by actors from multiple social locations defined by their positionalities that are shaped by various characteristics related to gender, race, immigration status, income levels, etc., conflating with their professional role and social status. Focusing on evaluation practice, I examined the mechanisms of subjection in knowledge production and its role in complex and circular relation with exploitation and domination:

> It is certain that the mechanisms of subjection cannot be studied outside their relation to the mechanisms of exploitation and domination. But they do not merely constitute the "terminal" of more fundamental mechanisms. They entertain complex and circular relations with other forms (Foucault, 1982: 784).

Within the current system of domination and extractivism, as well as reproduction and normalization of privilege in the form of ‘whiteness and middle-classness’ in the non-profit sector is hard to escape. Community participation and power relations in the non-profit sector that regulate discourses of knowledge production and participation (via reporting and evaluation) often result in the normative construction of whiteness and middle-classness through sidelining racialized and low-income perspectives. Through funding conditions and reporting requirements that drive evaluation processes, often those forms of community participation are supported that are consistent with white middleclass and market-oriented framing of participation and therefore we can point to a gentrification of participatory processes. An example shared in the previous chapter described how a resident-led action group’s goal of food security, framed from the perspective of food justice and advocacy for land access, were subsumed within the institutionally approved discourse of ‘health and wellbeing’ in a process led by a community health centre. At a first glance this may not be necessarily perceived as particularly linked to gentrification. Yet the community group had to make a strategic decision to hold onto their goals and aligned them with those of the supporting agency-partner to secure resources. This is an example of power relations, where the strategic priorities of an agency are influenced or to a certain degree co-opted by the larger institutional framing of health, consistent with the dominant biomedical model that prioritises individual behaviour and lifestyle choices, rather than collective action on social determinants of health. Such framing is enabled and engendered through accountability requirements imposed on the agency-partner and which were discussed extensively in Chapter 3. The institutionally approved discourse of ‘community health and wellbeing’ supports workshops on healthy nutrition and physical fitness classes -- which are also needed in the community -- but it stops short from framing ‘food security’ in terms of equitable access to resources, including the land, in low-income, racialized communities. What’s more, resident-activists who challenge such framing may subsequently be blamed for being difficult and uncooperative and therefore risk losing the support and resources from agency-partners. Thus, resident activists tailor their participation to fit the institutional discourse, which limits the effectiveness of participation to address the issues at hand. When ‘diversity’ of participation is invited as

is often the case in community-based initiatives, the participatory process is often moulded into a performance of 'white middle-class participation.' This process is evidenced in evaluation practices of community health centres, where those forms of evaluation that are non-conventional, i.e. often relying on marginalized epistemological frameworks rather than those deriving from quantitative, reductionist and colonial epistemologies, are often under-resourced and sidelined.

Participatory evaluation is still possible but is much harder to implement as its methods are more time consuming and resource intensive. This becomes even more of a deterrent in an environment of purported scarcity of resources, where efficiency is prioritized and praised as means of survival. Even though non-profits invite and encourage a diversity of participation, what may happen at the level of supporting participation is that the forms of participation consistent with the hegemonic institutional discourse reflecting the norms and values of whiteness/middle-classness become supported because they are easier, i.e. require less resources to support. Performances of whiteness and middle-classness are re/produced in the hegemonic capitalist discourse where performance of both is a form of representation within a set of material conditions, which enable and constrain what is understood as 'whiteness' and 'middle-classness' (McHoul and Grace, 1995; Levine-Rasky, 2013). Both categories are not simply derived from an individual but emerge from something that is interacting with others, and where privilege emerges by controlling the terms of engagement with 'others' or the less privileged (Levine-Rasky, 2013). The study of power relations is crucial to the understanding of re/production of privilege. The examination of community participation in the context of non-profit-community partnership through an intersectional feminist lens adds to the understanding of how even in processes convened to advance the goals of equity, inequitable practices may entrench and re/produce themselves through power relations embedded in the hegemonic discourse. Figure 19 in the section below presents a multi-level social systems analysis aiding to understand how power and privilege are re/produced in the hegemonic discourse at different levels of the system.

Mapping a Multilevel Social Systems Analysis

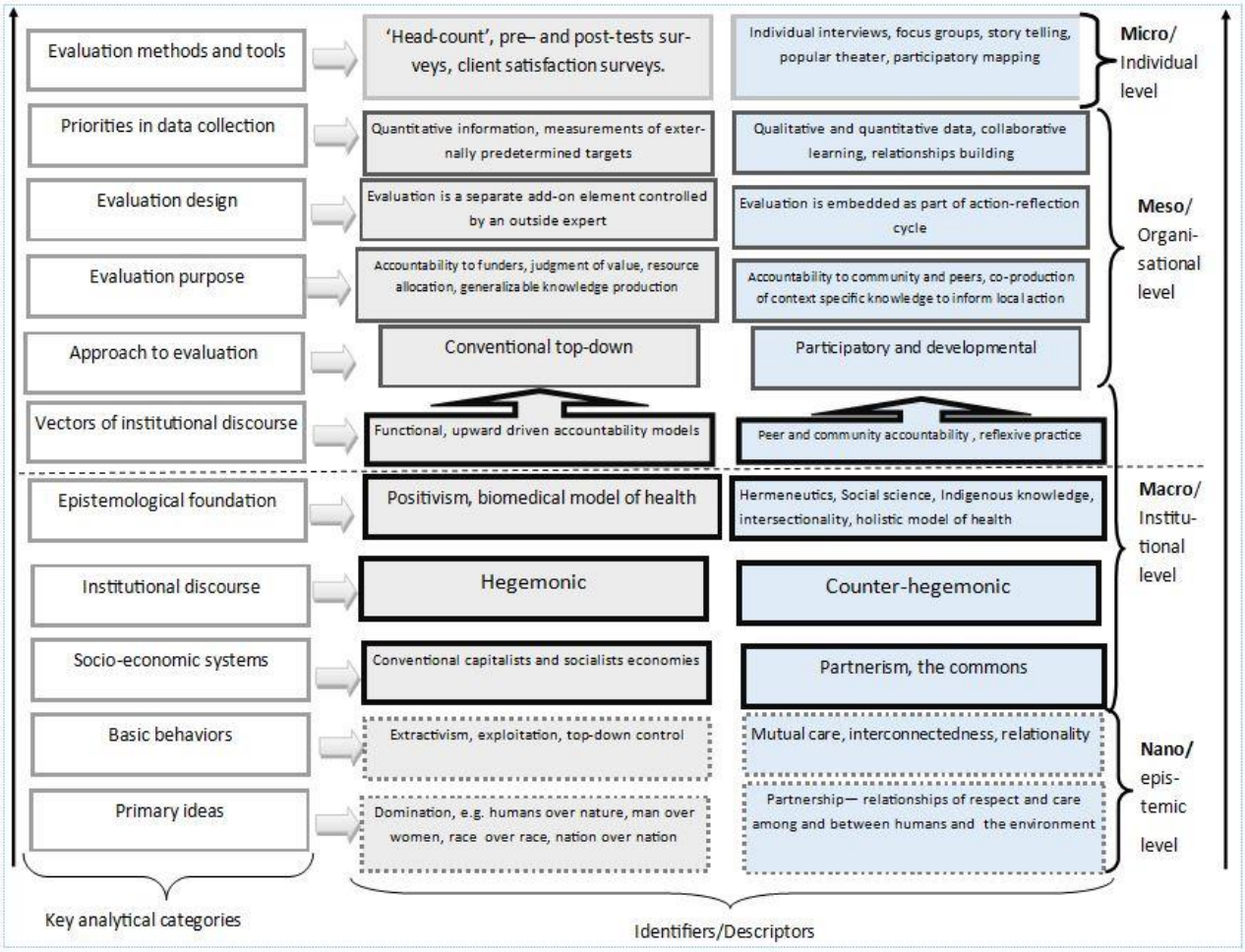
What's happening to us? (Kant in Foucault, 1982: 785).

The map for multi-level systems analysis (below) summarizing key findings of this research illustrates the interconnectedness between various components in the social system. The proposed mapping is informed by the Foucauldian concepts of discourse and governmentality, political economy theory, and an intersectional feminist framework. This mapping is the result of discerning how the work of non-profit sector is systemically structured and helps identify the leverage for change at the different levels of the system to empower the most marginalized actors in the system. This mapping emerges specifically within the context of the evaluation practice that shapes knowledge production, organizational learning and participatory processes within non-profit community-based organizations. I propose it as a flexible template for analyzing other social systems and identifying key elements at each level necessary for transition from domination to partnership. In the words of Foucault (1982: 785):

> Maybe the most certain of all philosophical problems is the problem of the present time and of what we are at this very moment. Maybe the target nowadays is not to discover what we are but to refuse what we are. We have to imagine and to build up what we could be to get rid of this kind of political "double bind", which is simultaneous individualization and totalization of modern power structures.

Specific to evaluation system in the context of community-based non-profit organizations, this mapping shows four levels constituting social systems – the most apparent and well-known being macro-, meso- and micro-levels and the less apparent being the nano-level of epistemic assumptions, which I also refer to as 'primary ideas' and frames of references that influence our 'basic behaviours'. Key analytical categories are presented at each level. The horizontal rows of the boxes in the middle at each level are identifiers or 'descriptors' at each level. The dotted line in the middle indicates the beginning of the content in the boxes that is specific to a particular system and context.

Figure 18: Multi-level Social System Analysis Mapping



At the nano-level, there are primary ideas and basic behaviours that influence what we understand and/or accept as 'common sense' or hegemonic discourses. These ideas and behaviours are not always easily identifiable as they become dispersed in the systems and institutions at the macro-level. I argue that they are often wrongly associated with the macro-, meso-, or micro-levels. This is understandable because ultimately what we see as 'the peak of an iceberg' at the micro-level of individual experiences is informed and shaped by these primary ideas and basic behaviours. However, I find it more useful to position primary ideas and basic behaviours as a separate *nano-level* because such ideas and behaviours both challenge and permeate dominant discourses and persist in our human consciousness as *taken for granted*

ideas. They both react to and crystallise as economic and other systems (of knowledge or epistemologies) at the macro-level and transpire as organizational practices and human experiences and behaviours at the meso- and micro-levels. For transformative systems change, it is necessary to work across all levels and learn how to recognise the *nano* elements permeating all subsequent levels. We need to be able to recognise how basic ideas and primary behaviours of the nano-level manifest at macro-, meso- and micro-levels within each system we focus on.

As I stated earlier, the suggested map for multi-level social systems analysis remains a *fluid* template. The key analytical categories and the identifiers or descriptors of nano- and macro-level below the dotted horizontal line form the stable foundation for analysis. They are relatively static, albeit open to change depending on what in the given system is described as 'hegemonic discourse' at a given point in time. The fluid and context dependent part of the map are the boxes above the dotted line starting at the 'Vectors of Institutional Discourse/Modes of Objectification'. For example, vectors of institutional discourse described in this map are specific to the non-profit sector in the context of evaluation practice. Other vectors of institutional discourse include, but are not limited to laws, guidelines, and/or operational rules and procedures. The following sections describe how key analytical categories in evaluation and reporting in the non-profit sector manifest at the macro-, meso- and micro-level in connection with basic idea and primary behaviours of the nano-level in more details.

Framed by the System: Functional Accountability as a Mode of Objectification

Prevalent institutional discourse is supported and disseminated through various vectors of discourse or modes of objectification (Foucault, 1982). I discuss functional accountability systems and reporting requirements as vectors of discourse in the non-profit sector as they are part of funding conditions to which the very existence of the sector and its activities are tied. They, therefore, contribute to a broader hegemonic discourse and define the parameters of what can be said and thought in relation to evaluation and reporting on the non-profit sector activities, including community participation (McHoul and Grace, 1995).

I studied individual practices, not individuals or 'individual subjects', within the context of evaluation and reporting in non-profit organizations that are immersed in relations of power. The object of my inquiry is on organizational practices and learning that occurs within relations of power produced by capitalist relations. I studied what Foucault (1982) refers to as 'banal facts' or aspects of everyday work activities in relation to community engagement and health promotion. But as Foucault (1982: 779) argues: "What we have to do with banal facts is to discover… which specific and perhaps original problem is connected with them." I therefore examined how such 'banal' activities that unfold at the individual level are structured at/by the organizational level, and how organizational preferences of some activities over others are structured institutionally through funding relations and accountability systems or reporting requirements.

I evidenced how funding conditions and reporting requirements that structure the work of non-profit organizations mirror the priorities and preferences of the for-profit sector, or in other words, are aligned with conventional capitalist economy and its extractivist behaviour. Such alignment is made particularly clear in accountability systems that are based on functional or fiscal models of accountability. Therefore, the work of non-profit organizations is structured in ways that rationalize and entrench the values of domination and competition. For those non-profits that are driven by goals of social justice and empowerment, the gap between their values and practice becomes increasingly harder to close. Caring in general, as well as equity-focused work or being attentive to the needs of the most vulnerable actors, is considered a liability within the for-profit accountability logic. Therefore, organizational and individual actors who are most committed to equity become disciplined according to the roles and modes of operations of the market sector precisely for their equity-oriented activities. In order words, non-profit actors are essentially 'framed' by functional accountability systems in both literal and figurative sense. The challenge is then to develop models and measures that recognise and value caring outputs of the sector on the sector's terms. In the words of Riane Eisler (2008: 15), "[t]his is foundational to a caring economic system where human needs and capacities are nurtured rather than exploited, our natural habitat is conserved rather than destroyed, and our great potential for caring and creativity is

supported rather than inhibited." Such transition requires an epistemological shift at the macro-level, which can be achieved through organizational learning and reflexive practice development occurring at the meso-level and supported through individual actions at the micro-level but everything is connected to a transformation of epistemic assumptions and frames of reference occurring at the nano-level.

Accountability presents an important strategic leverage for advancing the visions of the non-profit sector for a more just and equitable future and, thus transformations in the sector should start with transforming accountability systems so that they are better aligned with the sector's core values and principles (Brown and Moore, 2001; Guijt, 2010). Within functional accountability systems that are aligned with conventional neoclassical economics, non-profit organizations may be presented as agents of progressive social change, yet their work is structured in ways that undermine the very change that non-profits set out to pursue. While most non-profit organizations are poorly equipped by the system to change the system, systems change work inevitably relies on strategies and methods that originate on the margins of the system and are concerned with relational ethics and more responsible approaches to human activities and environmental stewardship (Humphries and St Jane, 2011). On the proposed mapping of multi-level systems analysis (presented above), I identified counter-hegemonic vectors of discourse that are consistent with epistemic assumptions of partnerism informed by frames of reference that include mutual care, interconnectedness and relationality and therefore consistent with the values of the non-profit sector. They are: community and peer accountability, reflexive practice, and principles of equity and justice. Such vectors of alternative discourse are rooted in marginal epistemologies of hermeneutics, social science, Indigenous knowledge, holism and intersectionality. Approaches stemming from such epistemological foundations are crucial for facilitating transformative learning at the organizational level necessary for transforming accountability systems and for achieving change at the institutional level.

Conscientization[28] and Transformative Organizational Learning for Systems Change

As vectors of the hegemonic discourse, functional accountability systems are in a mutually reinforcing relationships with institutionally recognised epistemologies (such as positivism) and clinical sciences and biomedical model of health. Such epistemological foundations promote conventional (market-inspired) approach to evaluation with the purpose of accountability to funders, judgment of success of failure, resource allocation and generalised knowledge production structured in a top-down manner to support upward oriented flow of information that is not shared among actors in the system.[29] Such an arrangement creates fragmentation between actors, interrupting the flow of information and dialogue among them. It marginalises participatory and relational ways of working, undermining holistic and intersectional approaches to knowledge creation that support balanced accountability and co-production of context specific and locally useful knowledge and critical reflection on action, as well as reflexive practice development among actors.

Uncritical acceptance of upward driven functional accountability systems and adaptation to the demands of the market-centred economics further drive non-profits organizations into behaviours that are competitive, extractivist and exploitative. Uncritical adaptation to the system that is exploitative and unjust -- especially under the pretense of 'systems change' -- co-opts social justice and equity driven non-profit organizations, hollowing out the non-profit sector from its very core.

As I write this concluding chapter, my mind is preoccupied by the most recent alarming headlines signifying the unfolding climate crisis and perhaps the end of the world as we know it. "Temperature leaps 40 degrees above normal as the Arctic Ocean and Greenland ice sheet see records" reads *Washington Post* headline (June 17, 2019). "Climate crisis: Alaska is melting and it's likely to accelerate global heating" claims *The*

[28] Conscientization is a social concept grounded in Marxist critical theory and developed by the Brazilian educational theorist and political activist Paulo Freire that focuses on achieving in-depth understanding of the links between one's individual conditions and broader socio-political-economic structures, enabling the exposure of social and political contradictions.

[29] By actors I mean participants in the system, both organizations as institutional actors at the meso-level and individual actors at the micro-level.

Guardian (Milman, June 14, 2019). In the meantime, far-right groups coalesce around the globe united by their rampant xenophobia, misogyny, intersectional hate and the denial of the current human-made ecological disaster (Anshelm and Hultman, 2014; Apperly, 2019; Beinart, 2019; Mirrlees, 2018; Oppeneheim, 2019). For far-right groups, accepting the origins of the climate crisis translates into accepting their defeat and relinquishing their perceived right to dominate and control the migrant's mobility or the woman's body, which in its ultimate form means ceasing extraction and exploitation of humanity and the Earth. Humanity stands at an existential crossroads, choosing over descending into a pit of the 'survival of the fittest' in the pre- and post-apocalyptic world or elevating itself to the choices that are caring, nurturing and therefore integral to the survival of many rather than a selected few. The former is the easiest choice to make and specifically for that very reason is the wrong one. The latter calls for transformation at the core starting from the nano-level of primary ideas or epistemic assumptions as well as basic behaviours or frames of reference.

Such transformation has already started in civil society, taking roots among individuals, families, and even some organizations and institutions. Most importantly, the seeds of such transformation are not new. They have been always present from the time immemorial, yet for centuries their growth has been stifled or brutally suppressed. The non-profit sector located in the civil society is strategically positioned to nurture or curb such transformative change. Such strategic position denotes a great responsibility and this sector too stands at its existential and moral crossroads.

To trigger and support true transformation from the inside, the non-profit sector itself must unlearn competitive behaviours. For that it should draw upon marginalized epistemologies that value holistic, relational ways of knowing and support partnering rather than competition. Transformative learning starts with a recognition how one's actions have been based unconsciously on beliefs, values, and ideas uncritically assimilated from others. Such reflection starts to reframe our deepest understanding of how things work or should work, personally and professionally, collectively, organizationally and institutionally (Humphries and St Jane, 2011).

Within conventional capitalist economy, non-profit organizations may be presented as agents of progressive change, yet their work is structured in ways that

undermine the very change they claim to support. In regard to community action for health justice, the role of the non-profit organizations is structured to simultaneously create and curtail the participatory processes they are mandated to initiate (Kesby, 2005). Through structuring the role of non-profits organizations as 'managers' or 'caretakers' of participation, as described in the previous chapter, neoliberal social and economic policies seek to integrate community action into the existing market-centered paradigm (Darby, 2016). Because non-profit organizations might never be well equipped by the market-centred system to change the system, systems change work must rely on strategies and methods that originate outside and on the margins of the system. Darby (2016) argues that transformation requires conscious creation of social relations and values-based practices as well as strategic engagement with state and for-profit actors.

Brown and Moore (2001) make an important connection between accountability and strategic engagement with the state and the market, arguing that approaching accountability critically and as a key strategic issue may help non-profit sector define and achieve their highest values. Through functional accountability systems, the sector has been shaped into the accessory of the market and the state. Yet, alternatively, through developing and embedding more socially responsible, balanced, or holistic forms of accountability, the sector may strengthen itself as an ally with progressive forces with and within civil society. Based on this premise, I argue for the value of participatory processes in the context of health justice work that is aimed at initiating change at a system level towards addressing social determinants of health and creating systems that minimise risks to health and wellbeing.

It is widely accepted that reflection and learning have no connection with accountability and yet nothing can be further from the truth. While many actors in the sector seem convinced at times that accountability and learning appear irreconcilable, such thinking largely comes from the narrow interpretation of the term 'accountability' (as functional and upward driven) and the uncritical acceptance of results-based management and rigidly set performance measurement metrics. Reflecting on the perils and challenges of accountability dogma for international aid agencies, Guijt (2010) identifies key factors driving simplistic accountability frameworks in the non-profit sector.

These factors mirror those that influence accountability requirements for smaller, community-based non-profits i.e., capacity constraints, economic and political trends, context constraints, organizational culture and philosophical simplicity (Guijt, 2010). Brown and Moore (2001) summarize these constraints under the triad of support and legitimacy, operational capacity and value. The challenge of navigating and negotiating multiple constraints and resource dependence of the non-profit sector on the funding bodies drives the predominance of functional accountability framework that control the flow of resources and through that all other aspects related to organizational practice. In the meantime, subordination to and emphasis on functional accountability unbalanced by other forms and directions for accountability undermines the organizational capacity for learning and innovation that are necessary for keeping organizational practice aligned with its mission and core values (Ebrahim, 2005; Eikenberry, 2009; Guijt, 2014).

Participatory evaluation is proposed here as a driver for an organizational learning praxis that can contribute to strengthening holistic accountability systems oriented to the needs of various actors in the process, and through that facilitate the development of a transformative and intentional organizational change (Suárez-Herrera, Springett and Kagan, 2009; Guijt, 2010; 2014; Springett, 2017). Embedding participatory evaluation in organizational practice for non-profit organizations is important for achieving co-production in partnerships they create with community members, including residents, grassroots groups, other non-profits and private actors. Considering the power differential between multiple actors involved in partnership (as previously discussed), the value of participatory processes is not only in the potential reconciliation of differences but “also in the development of an interactive learning environment that provides a common perspective for all the stakeholders involved in the evaluative process… [and] an opportunity to build sustainable networks of communicative actions and supportive partnerships” through which actors may become aware of their motivations for change (Suárez-Herrera, Springett and Kagan, 2009: 324).

Yet, as discussed extensively in the literature and in this research, participation can be easily co-opted and narrowed down to its instrumental role or utilitarian use, when participation of actors with less institutional power is mobilized by more powerful

actors to fulfill their own needs and priorities and to become a mechanism for control over ‘community action’ through managerial strategies (Cooke and Kothari, 2002; Taylor, 2005; Cornwall, 2008; Suárez-Herrera, Springett and Kagan, 2009).

Maintaining critical reflection on how organizations approach participatory processes, including but limited to participatory evaluation, is crucial for developing an organizational reflexive practice that enables an organization to regularly re/evaluate their position and purpose by critically interrogating its practices and whose interests they may serve (Brookfield, 2009; Darby, 2016). Darby (2016) describes reflexive practice as an important and necessary element in a holistic model of dynamic resistance that also includes rejection, resilience and resourcefulness. Darby (2016: 983) positions reflexive practice as a means to protect resistance to co-optation by market-centred forces, as reflexive practice “indicates a notion of reflexivity directly applicable to action: a questioning of practices to understand the social values underlying them, and an awareness of the sources and effects of those values” and where it generates empowering daily practices so that long-term action remains “values-based, feasible and grounded in conviction.” Resistance, instead of conformism to market-driven rationale and forces, is integral for the sector to preserve its progressive edge. It is integral to building the sector’s autonomy and creating alternatives around values that are not profit-driven (Darby, 2016). Reflexive practice supports conscientization within the sector, a process that develops in-depth understanding of the links between conditions imposed on individual organizations and the sector in general and broader socio-political-economic structures enabling the exposure of social and political contradictions. Such in-depth understanding for the sector’s conditions is necessary for developing alternatives to the life destructing logic of capitalism.

On the proposed mapping for multi-level social systems analysis, I identified reflexive practice as one of the counter-hegemonic vectors of institutional discourse, and participatory evaluation with its characteristics as an approach that fosters organizational practices conducive to developing holistic accountability systems aligned with organizational values of care, equity and justice. A participatory approach is essential for sharing and de/centering power as it reduces the power of ‘evaluators’ and ‘sponsors’ and increases transparency. In participatory evaluation, three elements work

synergistically: critical reflection, learning and participation – all of them being crucial in keeping the balance between different forms and orientations of accountability to ensure a balanced, or holistic accountability. Such an evaluation practice has been described as ‘progressive democratic evaluation’ that is morally engaged and focused on the promotion of democratic participation (Piccioto, 2015; Patton, 2018). Commitment to reflexive practice and conscientization is integral to the role of the non-profits as ‘gardeners’ or ‘growers’ of intersectional and equitable participation of actors in collaborative and co-productive action for health equity and justice. Progressive democratic evaluation ensures attention to three key components of healthy democracies: transparency, equitable participation and accountability to the most disadvantaged actors often excluded from democratic processes. Unfortunately, such evaluation practice is politically, economically and epistemologically marginalized and has been replaced by technocratic, positivist, utilisation-based evaluation models imposed by the corporate sector (Handberger, 2009; House, 2014; Piccioto, 2015). Such evaluation does not promote democratic ideals but rather monetary power and the interests of those aligned with it. Worse, conducted under the pretense of ‘empowerment’ and ‘democracy,’ evaluation processes might further undermine the value and integrity of democratic processes. The problem of liberal democracy is that by advancing the values of free market and profit accumulation above everything else, it discredits the word ‘democracy’ for many, hence the backlash of social conservatism and religious fundamentalism of all kinds (Harvey, 2005; Brown, 2003; Piccioto, 2015). Discussing ‘accountability myopia,’ Ebrahim (2005) argues that internal change in the non-profit sector is the main vehicle toward altering their interactions with external actors. To address the crisis of trust with grassroots constituents, non-profit organizations must examine their interactions with funders. For Ebrahim (2005), altering such interactions and achieving a transformation in relationships with the funders away from patronage and towards decentering power means expanding the narrow, vertical and upward model of accountability to a circular one in order to better account for/to community members, peers, and internal organizational values. Funders, who are committed to supporting processes intended to change the status quo by shifting the

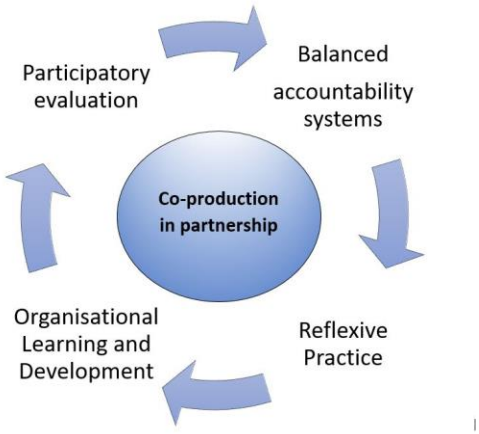
functions or structure of an identified system with purposeful interventions, would be willing to foster and drive such transformation.

Supporting Co-Production in Partnerships

Participatory and democratic approaches to accountability and evaluation are essential for supporting reflexive practice necessary for organizational learning, especially in the context of the non-profit organizations guided by values of care, equity and social justice. Developing more balanced accountability systems is vital for moving towards relations of co-production rather than domination in non-profit-community partnerships. Successful co-production for the expansion and protection of the commons requires support for the processes that are generative rather than extractive. To support *commonification* as opposed to commodification of the non-profit sector and non-profits as conveners of urban *commonification* processes, changes have to be made as to how non-profit organizations are funded and held accountable. It also may require non-profit organizations to change their rationale for organising around scarcities or vulnerabilities that leads many of them to operate based on a specific issue and/or 'target population' (Bauwens and Niaros, 2017). As I argued in the previous chapter, funding attached to 'target population' and the subsequent accountability requirements tied to 'target groups' curb opportunities for collective action. The logic of the commons is that of 'abundance' with the intention to mobilise people to direct their energy towards collective problem-solving. Such process requires partnership building with the attention to power dynamic between partners, especially because most actors in partnership have been schooled in the logic of scarcity, competition and dominance, which we now have to collectively unlearn.

Based on the experience of developing and implementing evaluative learning framework in co-production with The Neighbourhood Table (described in Chapter 4), I propose four key elements for non-profit practice intended to support co-production in partnerships, where all elements are connected and work in synergy (as shown on the Figure 20 below). Such elements are participatory evaluation, balanced accountability systems, reflexive practice and organizational learning and development.

Figure 19: Elements of Practice for Supporting Co-Production in Partnerships



Participatory evaluation forms a foundation for developing a balanced accountability system ensuring the inclusion of voices and perspectives of all actors in a given partnership. Participatory evaluation de-centres power in evaluation by critically interrogating who is included and how at each stage of the evaluation process. The framework for decentering power in evaluation (proposed in Chapter 3) rests upon accountability to all actors (especially those who are most likely to be marginalized in the process) and encourages reflexive practice for organizational learning and development aligned with organizational values of anti-oppression and ethics of care. Through a participatory approach to evaluation, the gap between accountability and learning is closed as evaluative learning becomes a part of a balanced accountability system. Functional accountability requirements become embedded as part of evaluative learning framework where evaluative process is centred in the organizational learning needs (Guijt, 2010). Strategies for achieving that accountability may involve aligning reporting schedules with the learning rhythms of organizations and/or partnerships, as well as scheduling evaluative activities around different requirements. For example, when creating an evaluative learning framework for The Neighbourhood Table, the proposed schedule of evaluative activities was synchronized with the schedule of The Neighbourhood Table's steering committee meetings and annual general meetings. Data collection included tracking numbers of resident-members participating in

meetings (fulfilling functional accountability requirements) as well as assessing quality of their participation using the co-produced tool ‘ladder of community participation’ (fulfilling accountability to resident-members). Participatory evaluation is also a key strategy for engaging with power dynamics that exist between actors in partnerships as decentring power in evaluation process itself contributes to realising a more transparent and holistic accountability process. Such process prompts actors to reflect on power dynamics and their role in promoting or curbing competition. Unlearning domination is a collective effort that requires critical reflection on behalf of all actors. Participatory evaluation when involving the participation of actors often excluded from decision-making in all stages of the evaluation process (with the aim to build capacity and to inform decision-making) allows for a reflexive practice (Springett, 2001; Guijt, 2014; Springett, 2017). Reflexive practice informs organizational learning and development that is aligned with the core mission and values, centered on the common vision shared by partners rather than on the pursuit of individual organizational gains.

The proposed theoretical model for co-production in partnership (Figure 20) outlines four key interconnected elements of practice necessary for supporting co-production in partnerships forming among non-profit and community actors. To be successfully fostered in practice, the model as a whole requires a strong organizational infrastructure capable of supporting organizational learning and development, investing additional resources in participatory evaluation, supporting reflexive practice and balanced accountability. The non-profit sector has been subjected to a debilitating trend of underinvestment in organizational infrastructure, (often referred to as ‘the non-profit starvation cycle’) largely fuelled by neoliberal discourses of efficiency and austerity and misleading donor expectations of low overhead costs (Lecy and Searing, 2015). To enable non-profit organizations for supporting co-production of programs and services in partnership with communities, funders’ expectations should be aligned with a commitment to supporting organizational infrastructure (e.g., frontline staff, administrative and capital expenses) that provides the necessary stable foundation for growth and sustainability for the non-profit sector (Lecy and Searing, 2015).

Assuming that when organizations and individuals/groups come together with an intention to achieve ‘co-production’ in partnership, they all bring some amount of

resources to the collective table, they may benefit from approaching co-production through the lens of Partnership Assessment Wheel proposed as an analytical framework in Chapter 4. Planning action in partnership with the attention to six requirements to maximize and sustain participation of all actors, as described in the self-evaluation tool of Bilodeau et al. (2017), may help partnerships foster those dynamics and arrangements that are conducive to sustaining co-production in partnerships.

Suggested tools and frameworks may support non-profits toward transforming their practice towards generative rather than extractivist, with the commons rather than markets at its centre, and with civil society as its institutional locus and responsibility. The market itself could even be transformed into a generative market that serves the accumulation of the commons. Finally, the transformation of the commons also requires state institutions to act as facilitating mechanisms for supporting commons-friendly infrastructures (Bauwens and Niaros, 2017). Such transition requires many actors working at different levels, but as stated earlier, the non-profit sector is strategically located in civil society and uniquely positioned to spearhead and promote such transformation.

Immersed in socio-economic and political tensions and complexity, and involved in governing non-commodified resources, the non-profit sector needs to develop ways of practice that do not detract from its commitment to promoting democratic values and afford critical interrogation of power in and outside the sector (Huron, 2015; Pratt, 2019). It is imperative that foundational values of care are not eroded in the process of adaptation to a capitalist economy rooted in domination and extractivism that continuously exacerbate competition for resources. The values of competition, individualism and profit-seeking have led us to the crisis point putting species, climate and ecosystems under threat. Surely, the same extractivist values are hardly suitable for overcoming such a crisis and can only cause more devastation. Rather the values of partnership and mutual care are integral to the survival and future evolution of humanity. As strategic actors positioned within civil society, non-profit organizations have a responsibility for upholding values that protect humanity from devolving into atomised

species driven by greed and domination purportedly embedded in human minds as if they are profit-driven algorithms of artificial intelligence.

Research Significance and Contributions

My dissertation examines the role of community-based non-profit organizations in supporting community action for health justice. I examine structures and mechanisms of accountability systems, funding conditions and reporting requirements as enabling or impeding capacity of non-profit organizations to support meaningful participation and actions of community members to address social determinants of health at a community level. I examine the non-profit sector within a systemic context cognizant of the fact that non-profit organizations are positioned within an institutional system where there is subordination between actors resulting from unequal access to and distribution of resources. I analyse how the role of non-profit agencies mandated to support community participation is shaped within such relations of power. Based on this analysis, I propose the key roles non-profit organizations may perform when they address community participation.

My research clearly exposes the gap between the community development and social justice mandate of community-based non-profits and their practice that is increasingly shaped toward direct service-delivery and where the capacity of the non-profits to support meaningful community participation is curbed. Such gap is largely facilitated through funding relations that prioritise fiscal accountability and results-based performance measurement. Both are the result of neoliberal policies applied to the non-profit sector that have restricted the sector's capacity to carry out advocacy and social justice work. At the same time, advocacy and community development aspects of non-profit work may directly contribute to the protection and expansion of urban commons necessary to protect public resources and advance health justice. The expansion and protection of the urban commons require collaborative processes conceived and implemented through co-production partnership. To advance co-production in the context of partnerships among non-profit and community actors, I propose mutually interacted processes of organizational learning and development, reflexive practice, balanced accountability systems, and participatory evaluation.

My research brings to the fore current funding conditions and reporting requirements as framing the sector as an ally to the logic of monetary accumulation that drives extractivist and exploitative processes the sector claims to oppose. Drawing on theoretical frameworks of governmentality, political economy and intersectional feminism, my research findings call for transformative practices in the sector that include resistance to rigid funding conditions and re/negotiation of the relationships of top-down patronage towards more relational and dialogical interactions. However, my research makes clear the fact that the sector cannot achieve the required levels of transformation if non-profit organizations continue to conform to the extractivist practices rooted in the logic of profit accumulation and domination. Key findings are summarised in the proposed mapping for multi-level social systems analysis that identifies elements of practice at different levels for transforming social systems towards those that are rooted in values of partnership and care (Eisler and Eisler, 2008).

As I examined the role of community-based non-profit organizations in supporting community action for health equity and justice in the urban context, my dissertation's main contribution was to examine accountability requirements in the non-profit sector using the specific example of community health centres and to confirm that existing accountability requirements from core funder undermine health promotion and equity-oriented aspects of the community health centres work. My dissertation also identifies challenges and promising practices in health promotion evaluation and proposes a set of recommendations aimed at funders/policy makers, senior management and frontline workers for strengthening the alignment of evaluation practice with key health promotion principles. My research critically analyses issues of power and participation in collaborative action in the context of non-profit community partnerships through the co-development of an evaluative tool for assessing the degree and quality of community participation in non-profit community partnerships. Based on a collaborative research, my dissertation presents a framework for analysing power distribution in evaluation process. Reflecting on the roles non-profit organizations may perform when addressing community participation in various processes convened and supported by the non-profit actors, I identified three key roles: managing participation, maintaining participation and sustaining participation.

Using specific case studies in Toronto drawn from the practice of two community health centres located in two low-income neighbourhoods, my dissertation analyses the particular factors and conditions that influence the capacity of these non-profit organizations to implement participatory evaluation and meaningfully support community participation in a collaborative action. A multi-level social systems analysis identifies ways and strategies towards generative practice rooted in co-production and partnerism.

Working on this dissertation further advanced my interest in and commitment to an engaged scholarship aimed at strengthening organizational learning and reflexive practice among non-profit organizations involved in systems change work. Future research avenues related to the urban commons abound and as this dissertation has focused mostly on a critical analysis of the social relations and discourses produced and reproduced in the processes and structures of the non-profit sector, I am particularly interested in re/searching emerging and promising practices connected to the expansion and protection of urban commons. More research is also needed on evaluating action and co-production practices supporting organizational learning and capacity for effective collaboration with non-profit and public sector organizations working on projects related to programs and/or service delivery in partnership with grassroots groups and community members.

Intermission 7: In Search of Verisimilitude

In the final leg of this intellectual journey, during the dissertation revisions stage, I found myself reflecting on truth, validity and integrity in my research process, and pondering whether my research is 'intersectional enough'.

During my fieldwork and while writing the dissertation, I continued reflecting on how I change as a researcher, as a practitioner of evaluation and a convener of participatory and collaborative processes - how the experiences I encounter change me, and how I contribute to the experiences of people I work with? How the knowledge co-produced with the communities has changed my understanding of participation, engagement, collaboration, partnership and co-production? How do I find ways to bring this co-developed knowledge back to the community? How do I make my social, theoretical and epistemological locations explicit and not obscured from the point where the research participants stand? How am I accountable not only to the academic community as represented by my dissertation committee and external reviewers, but also to community of practice?

The poem I am sharing in this final intermission presents a summary of my reflection. It was inspired by Creswell and Miller's (2000: 126) discussion of validity in qualitative research where the authors quote Richardson (1994), who used the metaphor of a crystal to illustrate the concept of validity: "Crystals are prisms that reflect externalities and refract within themselves. What we see depends on our angle of repose".

Richardson's metaphor and stumbling upon a not-so-well familiar word "verisimilitude" inspired the short poem below. The poem is meant to bring the attention of researchers to the importance of being cognizant and aware of their various and often changing locations in the research process and in relation to research participants. Truth is multifaceted, what we see depends on where we stand, or where we are located - theoretically, epistemologically, spiritually, socially and geographically. Thus, intersectional feminist researchers have multiple responsibilities when conducting research and conveying their findings, or their truth: a responsibility to practice self-reflexivity to maintain an acute awareness of the locations named above, which are not static but change as the research and life go on; a responsibility to maintain awareness of the research participants' locations, and how the research process involves and interacts with participants representing various locations; and a responsibility to explain the process of locating these multiple locales to the readers/audience when sharing the research findings.

Making multiple locations and interactions between them explicit, as well as explaining how such locations are produced in the system of power relations is what I believe makes the research valid from an intersectional feminist point of view.

In Search of Verisimilitude

"Crystals are prisms that reflect externalities and refract within themselves. … What we see depends on our angle of repose"
(Richardson 1994 in Creswell and Miller, 2000: 126).

Verisimilitude,
the word sounds like the name of a mineral,
A precious stone, perhaps a rare crystal?
She wore shiny verisimilitude earrings…
Or a vintage verisimilitude necklace…
It is a fitting name for a gemstone.
And I feel I was on a quest,
In search of verisimilitude -
A treasured stone, a hidden gem.
And the quest was perilous like
Any worthwhile quest should be,
It led me through some dark places,
At some point nearly killing me,
But in the end, all was well,
I found the precious gem,
a multi-sided prism.
And I was dazzled, almost blinded
By the shining truth of its many faces
That reflected everything around them,
And refracted everything within themselves.
What we see depends on where we stand.

September 09, 2019

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