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Using the evaluation process as a lever for improving health and healthcare accessibility: The case of HCV services organization in Quebec

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ARTICLE INFO

Article history:

Received 8 May 2015

Received in revised form 7 December 2015

Accepted 10 January 2016

Available online 21 January 2016

Keywords:

Evaluation

Empowerment evaluation

Use

Hepatitis C

Access to care

ABSTRACT

Background: The evaluation process can be a lever to improve pathways of access to healthcare. The objective of this article is to show how an evaluation strategy can both contribute to knowledge development and have direct impacts on health services provision. We use the case of hepatitis C (HCV) services organization to illustrate the use and the value of this evaluative approach.

Method: Inspired by empowerment evaluation, the transformative-participatory approach involved overlapping phases of knowledge development and discussion with stakeholders. We conducted several knowledge development activities to discern the needs of people with HCV, the resources available, and the facilitators and impediments along the care pathway, starting from prevention and screening, all the way through to treatment. Using an overlapping approach allowed us to regularly transfer acquired knowledge back to the participants in the study settings and also to gather their impressions, interpretations, and suggestions during periods of deliberation.

Results: The knowledge development activities made it possible to document the needs, resources, and experiences of people affected by HCV. In the discussion sessions, viable solutions were identified to improve health and healthcare access for people with HCV and to prioritize certain actions. This project demonstrated that using the evaluation process can enable an instrumental, conceptual use of results and, in fact, can have a transformative impact on services organization.

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1. Introduction

The field of evaluative research in health is where several trends intersect. The first of these is funding agencies' intention to ensure research is useful and to promote its use by the various settings involved. This intention finds expression in the requirement to transfer research-based knowledge into practice settings, with key actors' participation being targeted as a prerequisite for achieving this objective (CHSRF, 2003, 2005; Denis & Lomas, 2003; Lavis,

Roberston, Woodside, McLeod, & Abelson, 2003; Lomas, 2005). The second is the recent trend of interventional research in health, which aims to increase the impact of research results on population health by no longer focusing on the analysis of determinants of health, but rather on public health interventions (Hawe & Potvin, 2009; Morabia & Costanza, 2012). The third is the demonstrated synergy between the contextual characteristics of the evaluation environment and the participatory approaches adopted, which explains the use of evaluation results (Contandriopoulos & Brousselle, 2012).

These three trends, in complementary but different settings, have led us to rethink the evaluative process, not—as has traditionally been the case—to reach a judgment on the worth and value of an intervention (Scriven, 1991), but rather to use the

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evaluative process as a lever to improve a problematic situation. The objective of this article is to illustrate how a transformative-participatory evaluation based on an empowerment evaluation approach (Fetterman & Wandersman, 2005, 2007; Mertens, 2009; Weaver & Cousins, 2004) can contribute to knowledge development while, at the same time, having direct impacts on service provision. Here we present the case of hepatitis C (HCV) services organization to illustrate the use and the value of this evaluative approach.

Hepatitis C, also known as the silent epidemic, is an infection transmitted through blood-to-blood contact. Physicians have access to treatments that can cure 50–80% of cases (MSSS, 2009), including recently introduced treatments that are even more effective with fewer undesirable effects (Leclerc, Morissette, Alary, Parent, & Blouin, 2014). However, even though Quebec has a universal health insurance system, only 10% of persons diagnosed with HCV received treatment in the period 1990–2004 (Allard & Noël, 2006). Those most at risk of contracting HCV are intravenous drug users (IDU). Even though the prevalence of infection is low in the general population (1% in Quebec) (MSSS, 2009), 63% of IDUs are infected (Leclerc et al., 2014; Noël et al., 2006), and more than 25% of IDUs contract HCV every year (MSSS, 2009). These persons often present multiple issues related to mental health, the criminal justice system, and co-occurring infections such as HIV, leading to even greater social stigmatization (Chayer, Vieux, Bruneau, & Jutras-Aswad, 2011; McCoy, Metsch, Chitwood, & Miles, 2001; MSSS, 2009; Noel, Gagnon, & Cloutier, 2012; Popova, Rehm, & Fisher, 2006). As such, they encounter significant barriers to access to healthcare (Butt, McGuinness, Buller-Taylor, & Mitchell, 2013; Patten, 2006) and to HCV treatment in particular (Leclerc et al., 2014). Those barriers to access to treatment for persons diagnosed with HCV provided the impetus for this evaluative research project.

First we describe the evaluative research approach we used. We then present our findings and their impacts on knowledge development, the results from stakeholder discussions, and the

evaluation's impacts on conceptual and instrumental use of results.

2. Evaluation strategy and methodology

In this study we had two objectives: (1) to contribute to the development of knowledge, and (2) to have an impact on the organization of healthcare services for persons with HCV. Our aim was to cover the complete care pathway, from prevention and screening through to treatment. We designed a transformative-participatory evaluation strategy (Weaver & Cousins, 2004) inspired by empowerment evaluation (Fetterman & Wandersman, 2005), in such a way that the evaluation process itself could be used as a lever to improve the situation being studied (Patton, 2012). The principle was to bring together stakeholders from different settings, all of whom were involved in the issue, in order to provide them with objective and credible information so that they might come to a shared understanding of the problem and develop solutions with as much consensus as possible. In that sense, we put into practice two primary uses of the evaluation process, as identified by Patton (2012, p. 144): enhancing shared understanding and increasing participants' engagement, sense of ownership, and self-determination. In this process, the evaluators' role involves not only developing knowledge, but also facilitating and organizing discussions and deliberations.

The study was conducted over a two-year period (May 2011–June 2013) in the Estrie region of Quebec, where access to hepatitis C treatment for IDUs had been identified as problematic. We formed a round Table of stakeholders selected based on their roles in the care pathway of persons with HCV, along the continuum ranging from HCV vulnerability all the way to treatment. Our participants included street outreach workers, a person representing IDUs, community workers and professionals involved in prevention and support for persons with HIV and STIs, professionals from the addiction rehabilitation center, representatives from the soup kitchen, members of the local primary care center

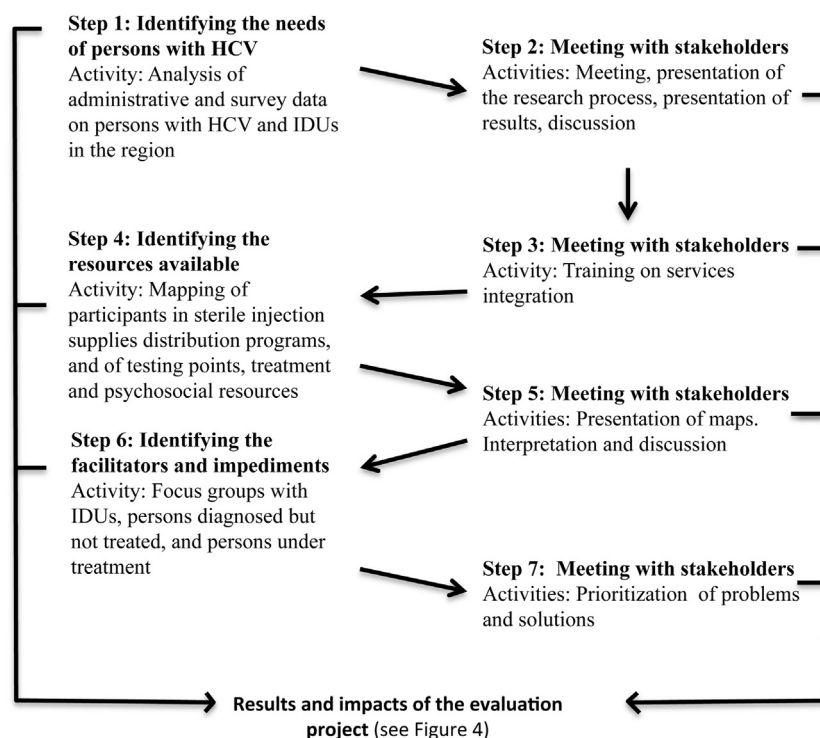


Fig. 1. Evaluation steps and activities.

team, and hospital physicians specialized in gastroenterology, infectious diseases, and psychiatry. Average attendance at the meetings was about 10 people, most of whom attended all the meetings, with others joining in only once or twice. This project received ethical approval from the various research committees involved.

Our process involved overlapping phases of knowledge construction and discussion with participants. Using an overlapping approach allowed us to regularly transfer acquired knowledge back to the participants in the study settings and to gather their impressions, interpretations, and suggestions during periods of deliberation. As such, this was a participatory and deliberative process in which objective and credible data were used as a key means of structuring the discussions. Fig. 1 illustrates the chronology and overlapping of the study phases.

We held five stakeholder meetings, each lasting two to three hours. These meetings were recorded and transcribed verbatim so that we could work from the transcripts. At the final meeting, the group developed a consensus on the most relevant and highest priority solutions to improve the prevention–screening–treatment pathway for people with HCV. First, going around the table, the participants each put forward one or two problems they considered high priority. Considering all the problems identified, the participants each voted for three they saw as highest priority. Then, for the two highest priority problems emerging from that process, the group identified actionable solutions.

We conducted several knowledge development activities to identify the needs of persons with HCV, the resources available, and the facilitators and impediments along the care pathway extending from prevention, through screening, all the way to treatment. To discern the needs, we used two sources: (1) an ongoing longitudinal survey of IDUs (SurvUDI) conducted by

Quebec's public health institute, which provides sociodemographic and epidemiological data, as well as data on injection and consumption practices, and (2) data from Quebec's notifiable diseases database (MADO) to develop a profile of IDUs and persons diagnosed as hepatitis C carriers in Estrie. To inventory the available resources, we developed maps of the region's resources. We produced four maps each for the Estrie region and the city of Sherbrooke, that region's largest urban center, for a total of eight maps, indicating: (1) locations where sterile injection supplies are distributed for free (prevention) and the volume of orders (see Figs. 2 and 3) (note that the maps do not show points of sale, such as private pharmacies, which are important distribution points and have extended opening hours); (2) hepatitis screening locations; (3) locations providing treatment; and (4) resources providing support services for IDUs and persons with HCV (lodging, psychosocial support, etc.). We used a variety of data sources. For syringe distribution locations, establishments designated as centers for access to sterile injection supplies for the period April 2008–March 2011 were classified by level of activity in terms of syringes distributed (low = 1–499 syringes, moderate = 500–999, high = 1000 and over). To develop a profile of the psychosocial resources available, we consulted the websites of public establishments and the directory of community organizations for the area. We identified HCV screening sites in collaboration with the regional Health and Social Services Agency, by means of the MADO registry. Lastly, we identified the resources providing medical treatment for HCV by looking at the missions of the region's various healthcare establishments and their admission criteria for this clientele. The resulting maps were presented to our participants, as well as to four focus groups of persons at different points along the HCV pathway; they were then refined based on that feedback.

LOCATIONS WHERE STERILE INJECTION SUPPLIES ARE DISTRIBUTED IN ESTRIE

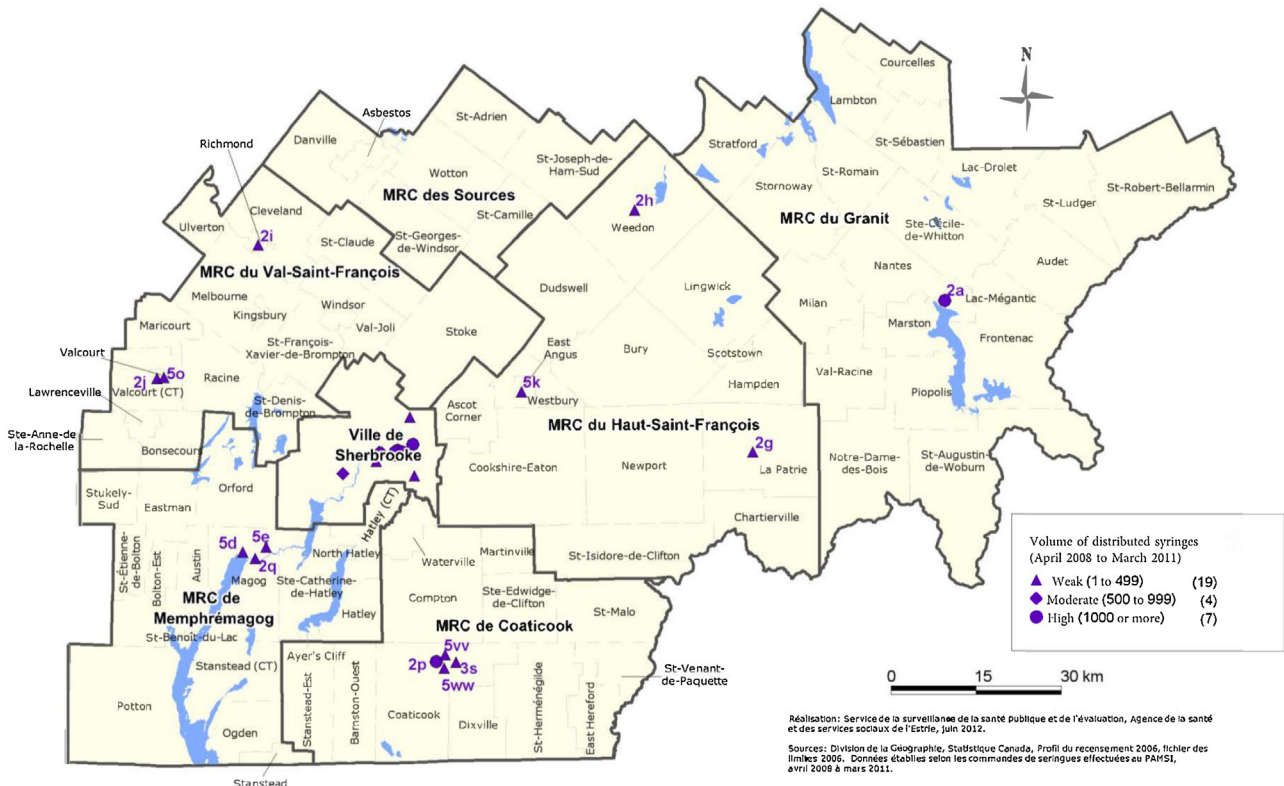


Fig 2. Locations where sterile injection supplies are distributed in Estrie.

LOCATIONS WHERE STERILE INJECTION SUPPLIES ARE DISTRIBUTED IN SHERBROOKE

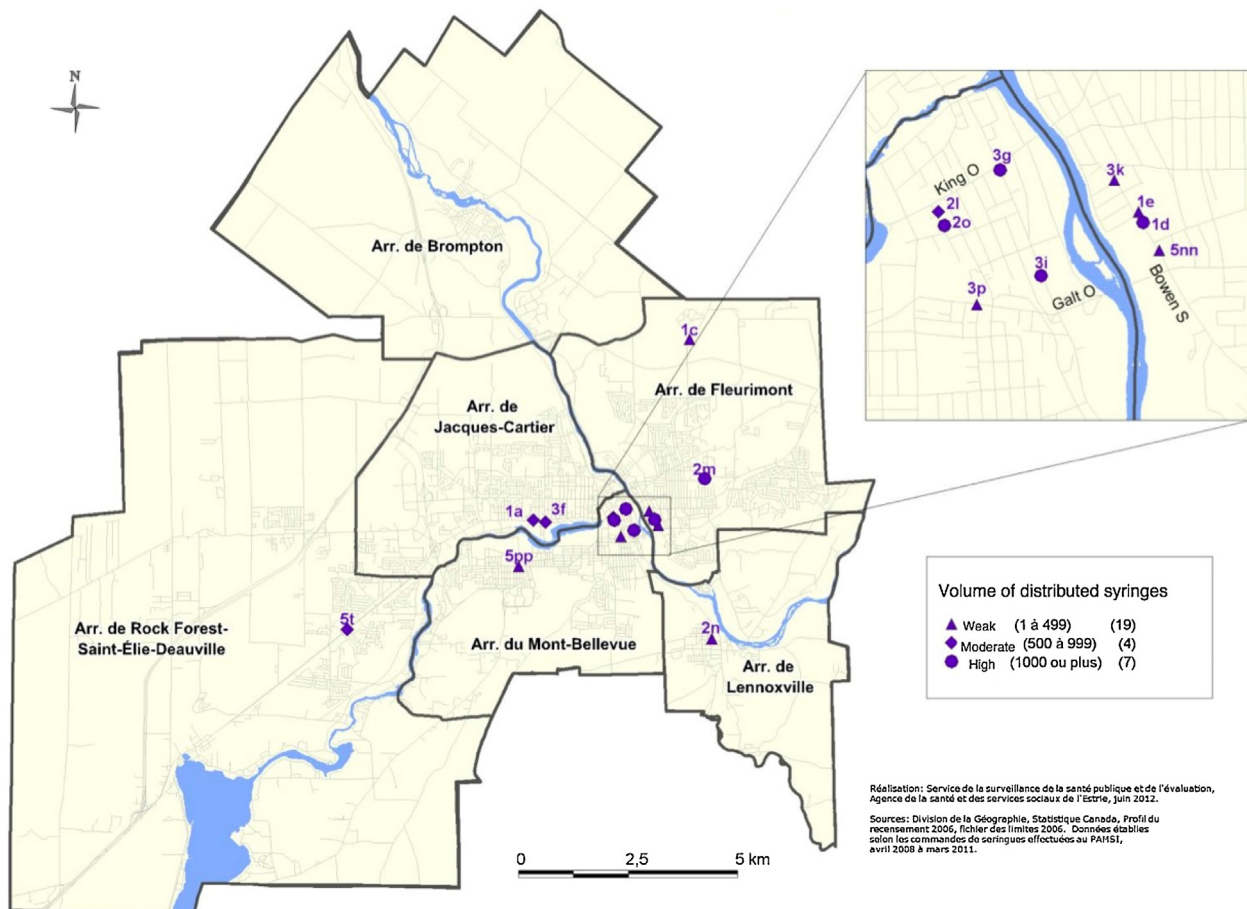


Fig. 3. Locations where sterile injection supplies are distributed in Sherbrooke.

To document the factors explaining the health and healthcare pathways, we conducted focus groups. These were made up of: (1) IDUs, to document their injection and syringe exchange practices and their perceptions and use of resources in the region (two focus groups); (2) persons diagnosed as HCV carriers but not in treatment, to learn about their history with this disease, their access to care and services, and barriers they encountered (one focus group); and (3) persons diagnosed and treated for HCV, to find out about the conditions surrounding their access to treatment and to document their care pathways (one focus group). These focus group sessions were recorded and transcribed. To determine whether we had reached saturation, we would have needed to organize at least one more series of focus groups, but it was not feasible to recruit participants for a second round (Krueger & Casey, 2014). It was difficult to recruit IDUs in the first place, as they were wary of exposure and mistrusted authority figures. In the end, those we interviewed were not young people, but rather people who had long experience with injection.

The project's impact was documented through careful monitoring of changes attributable to the evaluation project, which was accomplished by means of participant observations, by having a key actor/partner in the team of co-investigators, and by surveying the participants at the end of the project about their conceptual and instrumental use of the study's outputs.

3. Results

The results are presented in three sections. We begin with the empirical results of the project, after which we present the results from discussions with partners. Lastly, we discuss conceptual and instrumental uses of the findings of this evaluation project.

3.1. Development of knowledge

3.1.1. Needs

According to our data sources (SurvUDI and MADO), nearly 55% of IDUs in the region studied were infected with HCV; 10.5% were infected with both HCV and HIV. Men made up 83% of IDUs, yet the women were proportionally more infected than the men (73% vs. 52%). The data revealed that 39% of IDUs between the ages of 25 and 39 years and 60% of IDUs aged 40 and over were infected with HCV. Most lived in Sherbrooke, the regional capital, but the numbers suggested considerable mobility, as 52% of IDUs had moved within the previous six months. Also, 37% of those surveyed were in prison. This percentage almost certainly overestimates the real ratio of incarcerated to non-incarcerated IDUs, however, as identifying and surveying IDUs in the community presents a challenge for the SurvUDI survey recruitment process. Of all the drugs consumed by injection, cocaine was the most frequent. For 35% of the IDUs, their first injection occurred before the age of 20 years; 75% of IDUs injected in the presence of another person, 69% with someone they knew, and most often they injected in their

own apartment or a friend's home. Lastly, 80% reported that they never exchanged needles with another IDU, but 61% reported that they had occasionally used previously-used syringes.

With regard to IDUs' use of services related to HCV, the data showed that 97% had undergone at least one screening test in their lifetime. One-quarter of them had been screened in a hospital, and another quarter, in prison; 10% were screened by the clinical team following the homeless, and 6% were screened at the local community health center. Of the infected IDUs, 59.5% said they had not consulted a physician about HCV in the previous six months, and 82% said they had never taken any medication for this infection.

These data reveal the magnitude of HCV infection among IDUs, their great mobility, and the frequency of injection related to cocaine use. These results raise questions regarding the availability and accessibility of sufficiently large quantities of sterile injection supplies and their availability in detention centers and near the areas where IDUs reside. These data indicate good accessibility of HCV screening services, but infrequent medical care and treatment following diagnosis.

3.1.2. Resources

All the regional maps are presented in additional files (city maps not included) (online Supplemental material). Here we present only two of them, to illustrate the methodology used.

In Estrie, 150,000 free syringes are distributed annually. The main locations where sterile injection supplies are available are pharmacies and local community health centers (CLSCs). Of the 30 establishments listed, seven had a high distribution volume; these were mostly located in Sherbrooke. Differences in distribution

volume were due not only to prevalence of injection, but also to differences in accessibility. In fact, certain high-volume distribution centers were located near other centers with low distribution volumes, which underscores the importance of determinants of accessibility. Only five of the 30 centers were actively engaged in educating IDUs. Only two distribution points were open 24 h a day, seven days a week, one of which was the hospital emergency room (ER).

There was good geographic coverage of screening sites. The urban centers carried out higher volumes of screening tests. HCV screening was often done concurrently with HIV screening. When the project started, HCV treatment was only available in the region's main urban center, at the hospital and the infectious diseases outpatient clinic. As for psychosocial support, the maps show good coverage regionally and considerable heterogeneity in the types of services offered.

3.1.3. Facilitators and impediments in the care pathway

The in-depth analysis of the interviews is presented in another article (Foley et al., submitted for publication). However, here we present, in a table (Table 1), the determinants in the care pathway of persons with HCV with regard to prevention, screening, and access to treatment. We did not assume an HCV diagnosis was routinely followed by treatment.

3.1.4. Cross-sectional analysis

In terms of prevention, cross-sectional analysis of these three types of data confirm the existence of a problem with regard to the availability of syringes as a means of preventing HCV infection. Most IDUs inject cocaine. During the period when they are using

Table 1
Determinants of the health pathway of persons with hepatitis C.

	Determinants	Quotes
Prevention	Availability of syringes	"100 syringes . . . That's not much, 100 syringes, because you have to change syringes each time."
	Reception at the distribution locations	"You're never welcome when you go to the ER to get syringes! Even the nurses look at you sideways, so, you know . . ."
	Poor knowledge about, or lack of interest in, hepatitis C	"I know it because . . . for me, in Estrie, hepatitis C, it was unknown to me. I took it lightly."
	Indifference toward the risk	"I knew enough about it [hepatitis C], I knew a little about what it was like as an illness. I new that the person had it: 'It's no big deal!' I was stoned, so I didn't care."
	Injection practices	"And if I talk in terms of 'me', when I injected myself, I didn't give a damn. I was in 10 feet over my head. It was like . . . To a certain point, we're chasing after our own death, bit by bit, you know? You know it, and . . . pfft, you don't care."
Prison environment		"Like . . . I was stoned, I was in a state of . . . a state of euphoria, in other words, of using cocaine. There was one that was contaminated with HIV, and sometimes you manage to inject and sometimes you have trouble with it, you become blind. You have trouble finding your veins . . . So he said to me, 'Do you want to . . . shoot up?' So I put out my arm."
		"We were 700 prisoners, and out of those there were, I don't know, 300–400 who were heroin addicts. So we probably used the same syringe to inject, I don't know, 100 of us!"
Screening	Wanting a complete physical exam	"And so around 20 years ago, because, after all, I was using drugs, I said, just to have an idea, to be sure, because I'm a very insecure person, I said, I'm going to be tested . . . I'd like to be tested for every disease."
	Getting tested for HIV	"What worried me the most, because I'm gay, was more HIV, which I wanted to check on because I'd had sex with a lot of partners, and that's when I found out that what I had was hepatitis C, and not HIV."
	Partner's insistence	"At 45 years, my girlfriend said: 'Okay, now it's the finger in the ass, the big test, go for the whole thing!'"
	Worrisome test results	"The nurse, when she gave me the results of my blood tests, she said my ATL enzymes were very high, and she didn't actually say it was hepatitis, but I could see there was something. So then, I went into treatment, and I was lucky, I actually had the test, and I found out right away that I was infected."
	Information distributed on STIs and HIV	"There were CLSC nurses who came and did a screening, talked with us about STIs and all that. So I took the initiative to have the blood tests."
Accompaniment	"Because I was homeless, I was really like a homeless person, with no connections, no health services, social services, whatever. They just brought me there to . . ."	
Access to treatment	Poor knowledge of the illness, feeling healthy because symptom-free	"No symptoms, I didn't feel sick, you know . . . I didn't know what I should do, and I wasn't planning on living to be 90, either, you know . . . I didn't have the best life in the world, intravenous drug injection, that's not very much fun."
	Physician attitude at diagnosis	"And that very same doctor even told me something once, he said: 'You'll die sooner from drinking than from hepatitis.'"
	Fear of treatment	"We used to hear people saying that it was like chemotherapy. And what we heard about chemo was that, well, you were flat on your back, your hair fell out, your teeth, your balls, the works, so! It was a huge battle."

cocaine, they inject many times and need a large number of syringes (sometimes several hundred in a week), whereas our data show a much more parsimonious distribution. Even though there were two distribution points open at night, the IDUs seemed to be aware only of one, the ER. Furthermore, the prison appeared, in our focus groups, to be a setting that placed IDUs at particularly high risk of reusing injection supplies. Nevertheless, the situation reported by our respondents may not be the same in regional prisons; this question needs further investigation.

The survey data, maps, and focus group results all confirmed good coverage in terms of hepatitis C screening.

Our empirical results confirmed the problem of access to treatment, which, from our data, appeared to be due to: (1) the fact that there was only one treatment center, (2) professionals' attitudes when announcing the diagnosis, and (3) the beliefs of those diagnosed regarding the treatment's side effects.

3.2. Results from stakeholder discussions

As our project advanced, we organized structured encounters with stakeholders to discuss the results and enrich our analyses, as well as to identify solutions for a more effective structuring of service provision. The results of these discussions are presented here, not meeting by meeting, but rather in thematic summaries of the observations, from prevention to treatment. We also present the results of the priority-setting exercises applied to the proposed solutions for improving the prevention–screening–treatment pathway for persons with HCV.

3.2.1. Prevention

The participants were surprised on several counts: the small number of locations distributing free sterile injection supplies; the number of syringes needed by the IDUs if they were to use new supplies for each injection; and, as such, the considerable gap between the number of syringes distributed and the actual needs of IDUs, which was not apparent to them before our discussions.

They put forward several structural suggestions to optimize preventive services, centered especially around the two key concerns of accessibility and education.

1) The importance of making sterile injection supplies more accessible, especially at night. Currently there are only two distribution points open at night, and only one of them—the ER—is widely known to IDUs. Participants said many distribution locations do not provide information on preventive injection practices, are close-fisted in terms of the number of syringes they will give out, and insist on syringe exchange, as opposed to simple distribution. However, since requiring the return of used syringes is perceived as an obstacle to accessibility, participants suggested that syringes be recuperated without making this a condition for access to sterile supplies. They stressed the importance of having a storefront distribution site open 24 h every day. One participant, a street worker, spoke about the effectiveness of multiplying agents: actors in the community distribute injection supplies that are then disseminated in large quantities by multiplying agents, such as dealers or others who are in relatively close contact with IDUs. However, such a system can only be set up if the worker is able to establish a relationship of trust with those multiplying agents, which is built up over time. Such a system also makes it possible to recover used syringes. Police dismantling of 'shooting galleries' is an impediment to this type of distribution strategy, however, as the sites where IDUs had been able to congregate are closed, generating more mistrust of authority and fears of getting caught.

2) The importance of providing education and not just distributing supplies. There appeared to be a consensus that distributing sterile injection supplies will not have much of an impact if IDUs are not also taught about safe injection practices. Yet many of the current distribution sites did not devote any time to education. The participants also insisted that, to be able to convey certain educational messages, it is necessary to establish human contact and a relationship of trust, and that this is unlikely to occur in impersonal distribution sites such as pharmacies and the ER, or if the IDU is in a state of withdrawal.

3.2.2. Screening

All the participants agreed it is not appropriate to suggest screening to IDUs when they come to obtain syringes. Before suggesting screening, workers need to establish a relationship of trust and find out about the person's injection practices, which is not easy to do while respecting the person's privacy. The participants also insisted on the need for post-screening intervention, stressing the importance, when communicating the results, of providing relevant information on the illness, means of prevention, and existing treatments.

3.2.3. Treatment

When the project began, there was only one center that offered treatment for HCV—the regional hospital. Our project contributed, as a catalyst, to the creation of a second treatment site, at the addiction rehabilitation center. This is a day center whose clinical team consists of professionals trained in gastroenterology, nursing, and psychoeducation. Within its first year of operation, 25 persons were seen in consultation and nine went into treatment. According to the gastroenterologist, who also provides treatment at the hospital, the rehabilitation center's organization is ideal for patients. The psychosocial support they receive is clearly advantageous for treatment continuity. Thanks to this organizational model, the physician was able to accept in treatment some less stable persons whom he would have hesitated to follow at the hospital.

The eligibility criteria for treatment are quite restrictive. The person must no longer be a regular user, and must be motivated and sufficiently stable. For the time being, persons with co-occurring HIV infection are not eligible, even though the gastroenterologist stressed the importance of treating them; otherwise these persons are at risk of dying of untreated hepatitis.

Organizing a multidisciplinary team appears to be one way of reducing certain problems of access to treatment. Such a team, made up of professionals in different organizations, could be helpful in maintaining contact with the more unstable persons who are not eligible for treatment, and might facilitate their access to treatment when their living conditions become stabilized. During treatment, a multidisciplinary team approach would lead to better supervision and follow-up and increased patient retention. The participants spoke about the need to establish links with various resources and to develop clear pathways for managing this clientele. They noted that the map of resources showed there was already a great variety of psychosocial resources in the region, and in large numbers, although some investigation would be needed to find out whether these resources were prepared to get involved in following this clientele, and if so, under what conditions. As such, there appears to be a need to identify and provide training to organizations that would be willing to invest in a continuum of services for persons with HVC.

3.2.4. Prioritizing solutions for improving the prevention–screening–treatment pathway

3.2.4.1. High-priority problems. The problems identified by the group are as follows, in order of priority based on voting: (1) no identification of available resources and lack of clarity about the care pathway (need for formalized links, multidisciplinary collaboration, support for persons affected, preparation for treatment); (2) lack of availability in terms of the distribution of sterile injection supplies (need for multiplying agents, distribution resources, 24/7 coverage, supervised injection sites); (3) lack of knowledge about HCV among IDUs and professionals; (4) difficulties in accessing medical treatment for HCV (retention in treatment, services performance, services organization, geographic coverage); (5) non-existence of any sterile injection supplies distribution program in the prison system (need for creation of a treatment site); (6) lack of awareness among youth (inadequate information on prevention, vulnerability of young persons); (7) no identification of measures to provide support before, during, and after treatment; and 8) lack of pre- and post-treatment counseling. The group identified actions to be implemented for the two problems considered most important.

3.2.4.2. Priority actions to identify available resources and clarify the patient pathway. Participants identified the need to build on healthcare establishments' and community resources' willingness to work together, in a complementary manner, to: (1) consolidate the services network and the prevention–screening–treatment pathway for HCV infection; (2) clarify the various participants' respective roles and responsibilities; (3) make this pathway known; and (4) obtain the support, including financial support, of the decision-making authorities to create and sustain the relevant partnerships.

3.2.4.3. Priority actions to make sterile injection equipment more available. Participants appraised the merits of setting up a shared site where different service partners could take turns providing coverage, not only to distribute sterile injection equipment, but also to offer healthcare services, counseling, health education, and psychosocial support, and to build on opportunities to establish relationships with the IDUs.

Participants also recommended distributing syringes by the box rather than singly and suggesting to IDUs that they pass them along to their friends and acquaintances. This would be an easy and inexpensive way to distribute a larger volume of syringes using multiplying agents who already have significant connections with other IDUs.

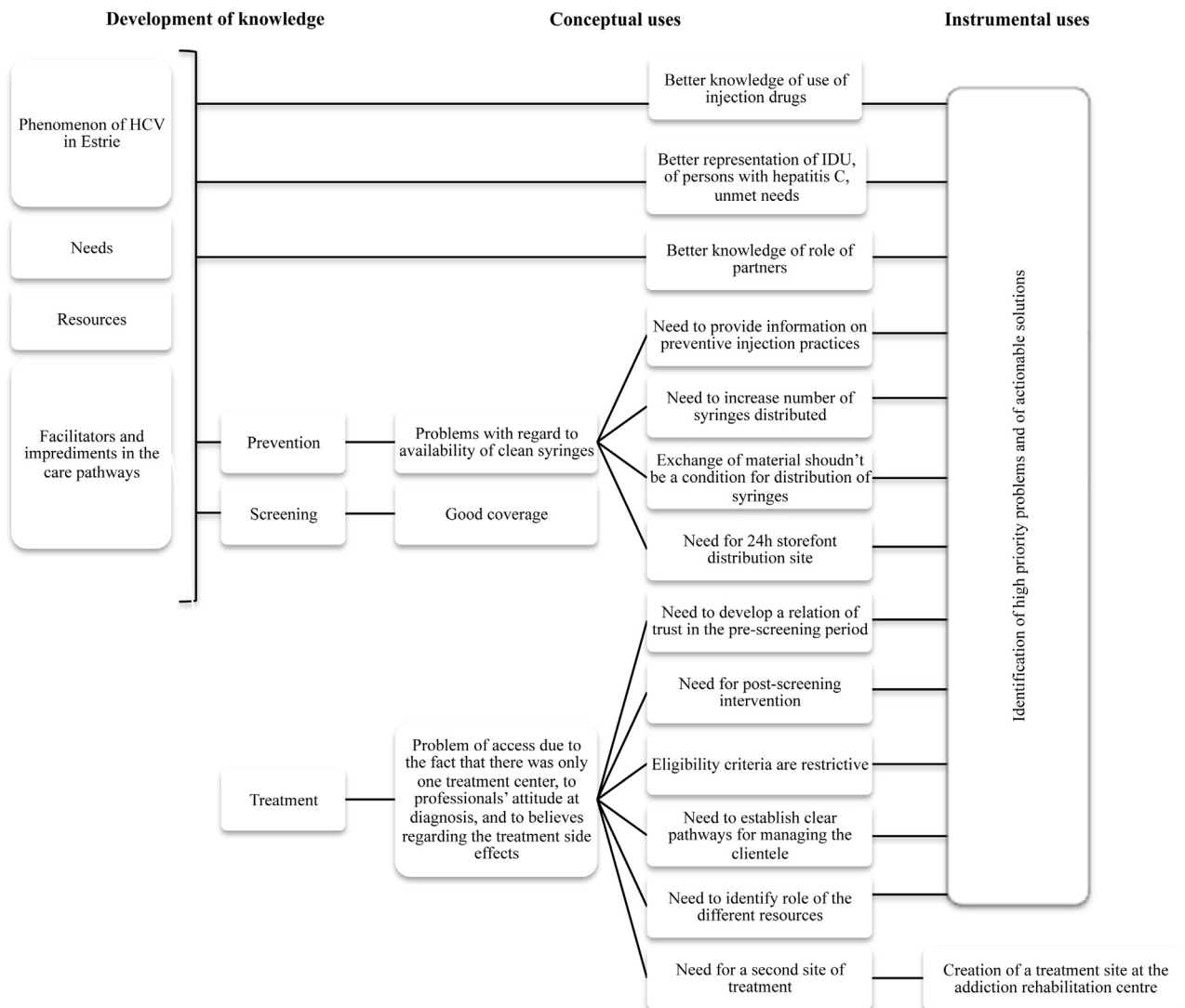


Fig. 4. Evaluation project findings and impact.

3.3. Conceptual and instrumental uses

The aim of this project was to provide relevant and objective information regarding the phenomenon of HCV in the Estrie region of Quebec, so that the participants could develop a shared understanding of the situation and might together identify some avenues for solutions to improve services for persons with HCV. This involved several types of research use: *instrumental*, when research results have a tangible and programmatic influence on the issue or program being studied; *conceptual*, when the study influences the actors' understanding of a phenomenon and their conceptualization of it (Contandriopoulos, Brousselle, & Kêdoté, 2008; Greene, 1988; Weiss, 1977); and *symbolic*, when the results serve to legitimize the pre-determined positions of certain groups of actors (Beyer & Trice, 1982; Champagne, Lemieux-Charles, & McGuire, 2004; Cousins & Whitmore, 1998; Greene, 1988; Preskill, Zuckerman, & Matthews, 2003; Shadish, Cook, & Leviton, 1991). Participatory evaluation has generally been seen as a means to increase these three types of evaluation use (Turnbull, 1999).

In the context of this project, we are unable to assess the symbolic use of the results. However, based on our observations and on the participants' perceptions of changes, we are able to assess, to a certain extent, the conceptual and instrumental uses of this project's results. In Fig. 4, we summarize the main empirical findings and link them with conceptual and instrumental uses.

3.3.1. Conceptual use

Conceptual use is a prerequisite to instrumental use. In a situation where change is needed, it will not occur until participants agree on the need for action, the solution to be implemented, and the means to be mobilized. Contrary to non-participative evaluation, in which findings are transmitted at a given moment in time, in this project we dedicated specific times to deliberation and exchange. The absence of disagreement, with, at the end of the project, the identification of priorities for action are themselves records of conceptual use. We conducted participant observation activities during which we kept track of changes in the various actors' representations, undertakings, and commitments. To supplement our observations, we developed a questionnaire that participants completed at their final meeting. According to the questionnaire, of the 10 attendees at that meeting, between 8 and 10 reported that, at the end of the project, they had more knowledge about: the phenomenon of HCV in Estrie; the use of injectable drugs; the realities for IDUs and persons with HCV; unmet needs; difficulties related to prevention, screening, and treatment; the roles of the different partners; and the solutions to be implemented to improve the care pathways for persons with HCV. Even though these results are self-reported, there appears to have been a strong consensus that the project had an impact on the participants' knowledge and representations. The fact that the discussions about solutions were not polarized is another indication that the participants shared a common understanding of the problems.

3.3.2. Instrumental use

In the field of evaluation, instrumental use appears to be relatively infrequent and most often occurs gradually and diffusely (Contandriopoulos et al., 2008; Patton, 1988). Yet we were able to observe modifications to the service offer that were directly attributable to the evaluation project—in particular, the creation of a day center for HCV treatment at the rehabilitation center. This was a key spin-off of this project on healthcare services accessibility. Other programmatic spin-offs might also be possible if efforts could be invested in raising awareness among key actors in the regional network. This latter dimension brings us to consideration of the limitations of our approach.

3.3.3. Limitations

The time frame of the evaluation project clearly limited the implementation of real changes that could improve access to health and healthcare for persons with HCV. The time frame created a break in the conceptual-to-instrumental uses continuum. The fact that this exercise was undertaken as part of a research project gave this process a temporal frame that both mobilized the actors and, at the same time, limited the time within which they were able to pursue the objectives identified during the project. In this respect, the main limitation of this project, the temporal limit, was also its strength.

4. Discussion

Recently Contandriopoulos and Brousselle (2012) proposed a new interpretation of the determinants of evaluation use. They showed that the primary determinant is the fit between the premises of the evaluative theories/approaches used and the study's implementation context. In contexts where actors are ready to invest resources, participative approaches are likely to lead to an appropriation of results. Here we designed a transformative-participatory approach inspired by empowerment evaluation principles and methods. Research on empowerment evaluation has shown that the empowerment evaluation approach is regularly adapted to the evaluation context (Miller & Campbell, 2006), which is considered normal and desirable according to the conceptions of this approach (Fetterman & Wandersman, 2007). The evaluation process, in this case, was organized to allow periods of discussion based on objective empirical data and to encourage the various actors to take action. The fact that this study was undertaken in a context that had been prepared and was receptive to carrying out this evaluation project, that the actors were ready to invest time and participate actively in the stakeholder meetings (cost-sharing), and that they shared the perception that the current situation of services for persons with HCV was inadequate (low issue polarization)—all combined to position this study in what Contandriopoulos and Brousselle have called "utilization paradise". The good fit between the evaluative approach adopted and the evaluation context meant we could expect to observe a use of the project's results, to the extent that the participatory process enabled actors to be mobilized and to integrate the knowledge produced. Indeed, if evaluation use is explained by the fit between the evaluative strategy and contextual characteristics, then it is contingent on the evaluation process that is designed and carried out, as this article makes clear. This project illustrates how a transformative evaluation project can be designed when the approach selected is congruent with the evaluation context characteristics. However, we consider that the participative qualities, on their own, are insufficient to explain the observed evaluation use. We believe that using a deliberative process structured around objective data is also a means of rallying the actors and getting past any differences in perceptions. The relative contribution of using objective data in deliberations, in relation to the process itself of actors' participation, warrants further exploration in the field of evaluation. This would help to identify more clearly the relative effectiveness of participatory processes and other components of the research strategy in contexts that are conducive to the use of research results.

5. Conclusion

This evaluative project, while small in scope in terms of both budget and time frame, perfectly illustrates the fact that strategic use of the research process can effectively influence conceptual and instrumental use of results. This article illustrates how a study or evaluation can be organized in such a way that it becomes in

itself interventional, as advocated by the PHIR movement (Hawe & Potvin, 2009; Morabia & Costanza, 2012) and thereby contributes not only to the development of knowledge, but also to improving the problem situation. However, this project also raises other fundamental questions: What determined the project's effectiveness in terms of results use? Was it the participatory processes used, the use of objective data in the deliberations, or the context that was conducive to using research results? Probably all three of these components played a role, but the relative importance of each remains to be explored. Various authors have analyzed the determinants of research results use (see the synthesis of Contandriopoulos, Lemire, Denis, & Tremblay, 2010) in relation to evaluative theories (Contandriopoulos & Brousselle, 2012) or have dissected participatory processes (Weaver & Cousins, 2004). However, we still know very little about the mechanisms that, in participatory processes and in use-conducive contexts, really determine the effectiveness of research processes (Henri & Mark, 2003; Shulha & Cousins, 1997), and there is certainly a research agenda to be found here on theories and practices in the field of evaluation.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.evalprogplan.2016.01.004>.

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