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CHALLENGES OF PARTICIPATORY EVALUATION WITHIN A COMMUNITY-BASED HEALTH PROMOTION PARTNERSHIP: MUJER SANA, COMUNIDAD SANA—HEALTHY WOMEN, HEALTHY COMMUNITIES

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Abstract: Evaluating multiple-member partnerships is always a challenging task. This article is based on our experiences using a participatory approach to evaluating a community-based health promotion research project. "*Mujer Sana, Comunidad Sana*—Healthy Women, Healthy Communities" was partnership-based, multi-sector, multicultural, and participatory. We describe our experiences working with participatory methods to evaluate the partnership per se. Three evaluation frameworks were applied sequentially by the authors and provided insight into the functioning of the partnership in a complex and changing environment. Our experiences suggest that, through the process of participatory evaluation, the partnership itself also changed in ways that were not fully captured at the time of the original project evaluation. We reflect on the process with questions that might help other groups to consider ways to evaluate partnerships in community-based, participatory health research projects with minority and majority community partners.

Résumé: L'évaluation des partenariats multiples présente toujours plusieurs défis. Cet article présente nos expériences dans un projet

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communautaire de recherche participative en promotion de la santé basé sur un partenariat multi-secteurs et multiculturel : *Mujer Sana, Comunidad Sana* (Femmes en santé, collectivité en santé.) Nous décrivons nos experiences avec la méthode participative pour évaluer le partenariat en soi. Trois cadres d'évaluation furent utilisés en séquence et nous ont donné la possibilté de réfléchir sur le fonctionnement du partenariat dans une réalité complexe et dynamique. Nos expériences suggèrent que le partenariat lui-même a subi des changements qui n'étaient pas entièrement saisis au moment de l'évaluation originale du projet. Nous réfléchissons sur le processus en soulevant des questions qui pourraient aider d'autres groupes qui envisagent évaluer des partenariats dans des projets communautaires de recherche participative de santé avec des partenaires de communautés majoritaires et minoritaires.

In recent years formal partnerships among diverse entities have become common in community health promotion (Alexander & MacDonald, 2000; Best et al., 2003; Buckeridge et al., 2002; Naylor, Wharf-Higgins, Blair, Green, & O'Connor, 2002). Many funders require evidence of partnership prior to supporting new initiatives, and have high expectations about what partnerships will achieve. The nature of these partnerships varies along many dimensions: purpose and goals of the partnership; history of relations among partners; number of partners; the extent of participation, role, and responsibility of each member within the partnership; and the mandate, scope, size, and structure of different partner organizations. Few organizations assess the added value that working in partnership may offer to their projects, or evaluate the partnership dimension in and of itself (Bilodeau, Chamberland, & White, 2002; Naylor et al., 2002). Chiasson (1998) emphasizes that partnerships are fundamentally participatory experiences, and therefore any evaluation of a partnership must inherently include at least an implicit definition, and evaluation, of the participatory process among the partners.

This article stems from the authors' experiences as partners in a multi-sector, multicultural, participatory health promotion research project: Mujer Sana, Comunidad Sana (MSCS)—Healthy Women, Healthy Communities. Our experiences suggest that applying a participatory evaluation framework to a participatory health promotion research project had a direct impact on the project's processes and outcome, and on the partnership itself, that was not fully captured in the original evaluation findings. This observation inspired the authors to review and assess their application of participatory methods to evaluate the partnership throughout the course of the project.

We begin with an overview of the MSCS project and the participatory research approaches that guided the partners, including some of the challenges that the literature led us to anticipate in participatory research and evaluation. We describe the sequential application of three frameworks to evaluate the partnership itself, during and after the project. In a final section, we reflect on the process, with questions that might be useful to other groups who are considering ways to evaluate partnership in similar multicultural, community-based, participatory research projects.

OVERVIEW OF THE MSCS PROJECT AND PARTNERSHIP

Mujer Sana/Comunidad Sana (MSCS)—Healthy Women/Healthy Communities was born from a combination of community need, good ideas, organizational experience, motivated individuals, and available funding. MSCS aimed to increase the capacity of women in the Hispanic community to participate in their own preventive health care, and also the capacity of majority "mainstream" organizations to provide cancer screening for ethno-racial minority women. The project involved training 11 lay members from a minority Hispanic immigrant population in a large eastern Canadian city (Ottawa) to work with Spanish-speaking women in their own homes and communities. As lay health promoters (LHP), they addressed cultural and linguistic barriers in the context of preventive health care education. The LHPs also became participatory researchers and assisted in the design and implementation of the research component of the project.

For three and a half years, MSCS lived the complex process of establishing and maintaining multiple partnerships (MacLean, Plotnikoff, & Moyer, 1998). Four core partners had equal responsibilities for the success of the project. Other community partners were included in a number of ways, especially through active participation in an advisory committee.

The four core partners had different mandates, structures, sizes, linguistic capacities, working relationships, community locations, resources, and skills. The lead partner was LAZO, a Latin American women's group focused on community development, with a 12-year history of small projects bridging gaps between isolated women and health service providers. This group was the key link to the target population for this project: marginalized women from a minority (Hispanic) ethno-racial community in Ottawa. Operating in Spanish, LAZO had a strong network within the community, a practice of

mutual support among members, and a desire to maximize opportunities to work for change. It was also committed to continuing as a volunteer-based collective community action group.

A second partner, Centretown Community Health Centre (CCHC), provides primary care and health promotion in a downtown Ottawa neighbourhood. Although primarily staffed by and serving the ethnoracial majority population, CCHC had a history of positive working relationships with LAZO, and a mandate for local community development. Recognizing the need to focus on underserved and minority communities, this partner was willing to be the official home of the lay health promotion activities. The health centre provided another key element—access to preventive primary care for women—and administrative supports to the project.

A third partner was a small multi-lingual and multi-ethnic community-based consulting group, Gentium Consulting, experienced in participatory research with women, immigrant groups, and marginalized populations, as well as health promotion research with majority populations. Taking a lead role in participatory research methods, this partner provided a capacity development approach to health promotion research and to evaluation. Gentium was also committed to facilitating participatory approaches to help organizations increase their ability to serve the community and work for change.

The Community Health Research Unit (CHRU), a Government of Ontario-funded Health System-Linked Research Unit joining the University of Ottawa and Ottawa Public Health, was the fourth partner. The CHRU contributed to the project through staff with experience in health promotion capacity-building models and health services research directed at both majority and minority populations. This partner was also able to provide an ethical review of the project, access to literature and databases, and support for the transfer of knowledge and dissemination strategies.

CHALLENGES OF MSCS

Multiple Partner Project

Evaluating multi-sector initiatives, community coalitions, networks, and similar collaborative partnerships can be challenging on many levels (Nasser, 2003). Public health efforts often "assume that programs designed, implemented, and owned by community coalitions

will be far more effective than those developed by a single public or private group" (Butterfoss & Francisco, 2004, p. 108), despite limited availability of systematic research evaluating their effectiveness (Granner & Sharpe, 2004).

However, the work of multiple partner initiatives is often "complex and messy and does not easily fit the criteria for an experimental design evaluation" (Wallerstein, Polascek, & Maltrud, 2002, p. 361). Different sectors tend to use different criteria to understand what is meant by success; delays between initiating activities and detecting results are frequent; activities and goals purposefully shift over time as membership and conditions evolve.

Even with apparent agreement on the overall goals of an initiative, organizations and individuals may have different visions of the desired changes and of the strategies needed to improve social and health conditions of the target populations (Lawrenz, 2003). When multiple sector initiatives are couched in terms of "partnership," additional issues may emerge (Chiasson, 1998) that can evoke emotive responses around mutual trust, responsiveness, and flexibility. Evaluating the work of community-based partnerships also calls for understanding power relationships between community and evaluators (McHardy, 2002; Wallerstein, 1999). When the evaluators are part of the community, as with MSCS, these dynamics can become more complex and involve challenges different to those experienced by "outsiders" in community-based participatory research (Minkler, 2004).

Partnership among Minority and Majority Organizations

Additional challenges arise in multicultural or cross-cultural settings, when partners from different sectors (such as research institutes, community organizations, or primary care practices) also come from diverse ethno-racial backgrounds and countries of origin, speak different languages, and experience different levels of economic security (Strachan Lindenberg, Solorzano, Munet Vilaro, & Westbrook, 2001). These partnerships often require work across minority-majority dimensions of gender, class, and cultural and linguistic differences to overcome institutional and social racism (Johnson, 1996; Thomas, 2002). For evaluations of multicultural initiatives to be sensitive, accurate, and practical, evaluators are challenged to maintain ownership within the minority community, build trust and respect, and increase cultural competency (Edberg, Wong, Woo, & Doong, 2003; House, 1992; Maciak, Guzman, Santiago, Villalobos, & Israel, 1999; Pisano, 1993; Tortu, Goldsamt, & Hamid, 2002).

A high level of participation from minority communities is important in meeting the above challenges. The evaluation literature describes a few health promotion multiple-partner initiatives with active participation from ethnic minority communities. For example, in the LA VIDA partnership case study, Maciak et al. (1999) report on a process evaluation of a multi-level health promotion coalition in which Hispanic women and community organizations were equitably involved. Overall, however, few studies have examined a participatory research project across minority/majority communities while at the same time addressing both the effectiveness of a multiple-partner coalition and the project outcomes (Edberg et al., 2003; Stone, 1992).

Participatory Research Project

Introducing a participatory research framework into the evaluation of a multi-sector, multicultural partnership inevitably adds a further layer of complexity. This was the case with the participatory partnership evaluation discussed in this article. Participatory research is not only a methodological alternative; it is situated within a particular political and ideological context. It can generate intense feelings among practitioners (Potvin, Cargo, McComber, Delormier, & Macaulay, 2003), many of whom explicitly value relationships that are inclusive, equal, harmonious, accepting, cooperative, sensitive, supportive, and that emphasize truthful, accepting, sincere, and comprehensible communication (Stringer, 1996). Others also value empowerment, community self-determination, activism, and the struggle for social justice (Barnsley & Ellis, 1992; Freire, 1983, 1997; Gutierrez, 1986; Meyer, Torres, Cermeño, MacLean, & Monzón, 2003; Park, Brydon-Miller, Hall, & Jackson, 1993).

Some evaluators have suggested that participatory research projects do not always succeed in achieving the type and extent of participation they seek in practice. McHardy conceptualizes the negotiation of participation in evaluation as a "dance of collaboration" across exclusions, inequities, and "isms" that divide participants and evaluators (McHardy, 2003). VanderPlaat, Samson, and Raven (2001) describe a Canadian trend toward egalitarian strategies and empowerment-oriented evaluation in which participants' research skills and capacity to take action increase, although these do not always result in emancipatory social action. The literature also includes examples of projects where community participation is limited or restricted, collaboration is eroded, and power dynamics impede egalitarian relations. The amount of grassroots participation, in particular, varies

considerably in process evaluations of participatory community-based health promotion work (Chrisman, Senturia, Tang, & Gheisar, 2002). There is relatively little literature evaluating the process of collaborative research itself, as noted by Buckeridge et al. (2002).

Butterfoss and Francisco (2004) emphasize that evaluation can play a key role in the development and maintenance of coalitions and working alliances, despite these difficulties. There are few models, however, on which to base participatory evaluation of multiple partner initiatives, or participatory evaluation of a (relatively small) partnership per se. For example, in a national study of 63 partnerships, Weiss, Andersen, and Lasker (2002) identify an important relationship between partnership synergy and the leadership dimension of partnership functioning, but do not address whether "leadership" is expressed in fundamentally different ways when a partnership is based on a framework of participatory action research. Fawcett et al. (1997) describe a case study of a 100-member coalition, using a comprehensive system for evaluating community coalitions. They report on dimensions of coalition function, which could represent partnership, but focus on these more as process than outcomes. Dimensions of coalition function among 100 members may not automatically be applicable to smaller and more intimate partnerships with fewer members, as was MSCS.

Wallerstein et al. (2002) refer to a "third strand" of new literature on evaluating coalitions, focused on the development of "participatory, empowerment, or collaborative models of evaluation for community-based initiatives used to foster self-determination" (p. 363). From this strand, a new theory of community-based evaluation for coalition work is emerging that has led to the development of several tools, workbooks, checklists, and guides for use by community evaluators. The following sections of this article describe the authors' evolving experiences using several tools, identifying both strengths and limitations in their application to a participatory evaluation of the MSCS partnership.

DEVELOPING PARTICIPATORY EVALUATION FRAMEWORK FOR PARTNERSHIP

Original Plan for Evaluation

From the outset, the MSCS project was conceived within a participatory action research framework that integrates social investigation,

reciprocal education, and action toward social change (Green et al., 1995). The target populations for the health promotion and social change activities were Spanish-speaking community women, as well as organizations and health service providers. Women from the Hispanic community participated in all stages of the project: design, program implementation, administration, data collection, analysis, and dissemination. This participation is fully described in Estable, Meyer, Corsone, and Cermeño (2002) and in Meyer et al. (2003).

In this context, MSCS also used participatory methods for ongoing evaluative feedback about project implementation. There are many traditions within participatory evaluation (Cousins & Earl, 1995; Fetterman, 2000; Green et al., 1995; Kaiser, 2000; Upshur & Barreto-Cortez, 1995; VanderPlaat et al., 2001; Whitmore, 1998). The MSCS partners sought to apply a participatory approach to both the project and the partnership that links evaluation to social action, and fosters commitment to transfer knowledge to those with least power in the project and the community (Bosio de Ortecho, 1991; Morris, 2002; Stoecker, 1999). The MSCS participatory action research approach to the project and to its evaluation is described in detail in the final project report (Estable, Meyer, & Torres, 2003).

The original evaluation plan for MSCS involved both process and short-term outcomes. The evaluation was to be conducted by all members of the project team, including the Lay Health Promoters. The partners paid particular attention to ensuring that participation was not hindered by language differences, unequal economic resources, styles of working in meetings, organizational structures, and constraints or different understandings about bureaucracy and community (Meyer et al., 2003). The Community Capacity Building model (CCB) (Moyer, Coristine, MacLean, & Meyer, 1999), which describes integrated partnership among key players in health promotion, was used to provide a framework for evaluation.

In the case of MSCS, evaluation of the partnership per se was not a central focus at the design stage, but was implicitly included in some of the process measures (Chiasson, 1998). The original indicators included those frequently used to assess the success of a multiple-partner initiative, such as type of community groups involved, the number of meetings attended, and the diversity of organizations participating in discussions of results (Thorlby & Hutchinson, 2002). Other process measures included the degree of commitment felt toward the project from participating organizations, their readiness to work together

on joint programs, and the sustainability of working relationships among key organizations. Another set of success indicators covered the following issues: the empowerment of the minority participants, the acceptance and integration of the minority community within the service delivery system, the transferability of the Lay Health Promotion model to other ethnoracial minority communities, and the removal of barriers to service access (Estable et al., 2003).

At project end, all partners were pleased to find that the MSCS project had surpassed original outcome objectives (Estable et al., 2003) for health promotion activities. Could we say the same about the partnership? Had we captured the complex dynamics of multiple-partner, community-based participatory initiatives such as MSCS? These questions inspired the authors to review and assess what had been learned about applying participatory methods to evaluate the partnership itself during the course of the project.

Evaluating the MSCS Partnership Itself

From the outset, all partners periodically reviewed evaluation tasks and strategies for MSCS. As project activities intensified, ideas about indicators for the partnership began to extend beyond those originally anticipated using the Community Capacity Building model, to include more direct examination of how the partnership itself was working. For example: Eighteen months after the project began, the partners set in motion a participatory process for reflective self-evaluation that focused on the functioning of the partnership itself. The project partners generated many evaluation questions. Two types of questions emerged. One set was largely descriptive. The partners wanted to understand how we had been working together, including our level of participation, communication, and decision making. We wanted to know what changes had happened in our partnerships at this point, comparing these to our original expectations about each other. We wanted to examine whether or not alliances in the community were being strengthened. The other set of questions was more analytical and included an effort to understand the challenges in developing partnerships among four diverse organizations. Questions emerged about the extent to which different partners were in fact allies in the process of barrier removal. This led the partners to review the concepts, theories, and analytic frameworks that we were using to develop and understand the partnership. Other evaluative activities throughout the project generated further questions about the partnership itself and about the validity of indicators of successful participatory partnership.

Although the project formally finished in March 2003 and the official partnership was dissolved shortly thereafter, links among the partners continued for some time. New funding was (unsuccessfully) sought to maintain project activities. This gave the partners an opportunity to consider whether, and how, they wanted to continue to work together. In this context, one year after the MSCS project was completed, the authors undertook a post-hoc evaluation of the participatory partnership itself, applying three different frameworks to the partnership dimension of the project (see Figure 1). We began by reviewing the strengths and limitations of our application of the Community Capacity Building model (Framework I) to an evaluation of the success of *this* participatory partnership with multiple agents.

Using a Community Capacity Building model to evaluate the partnership (Framework I)

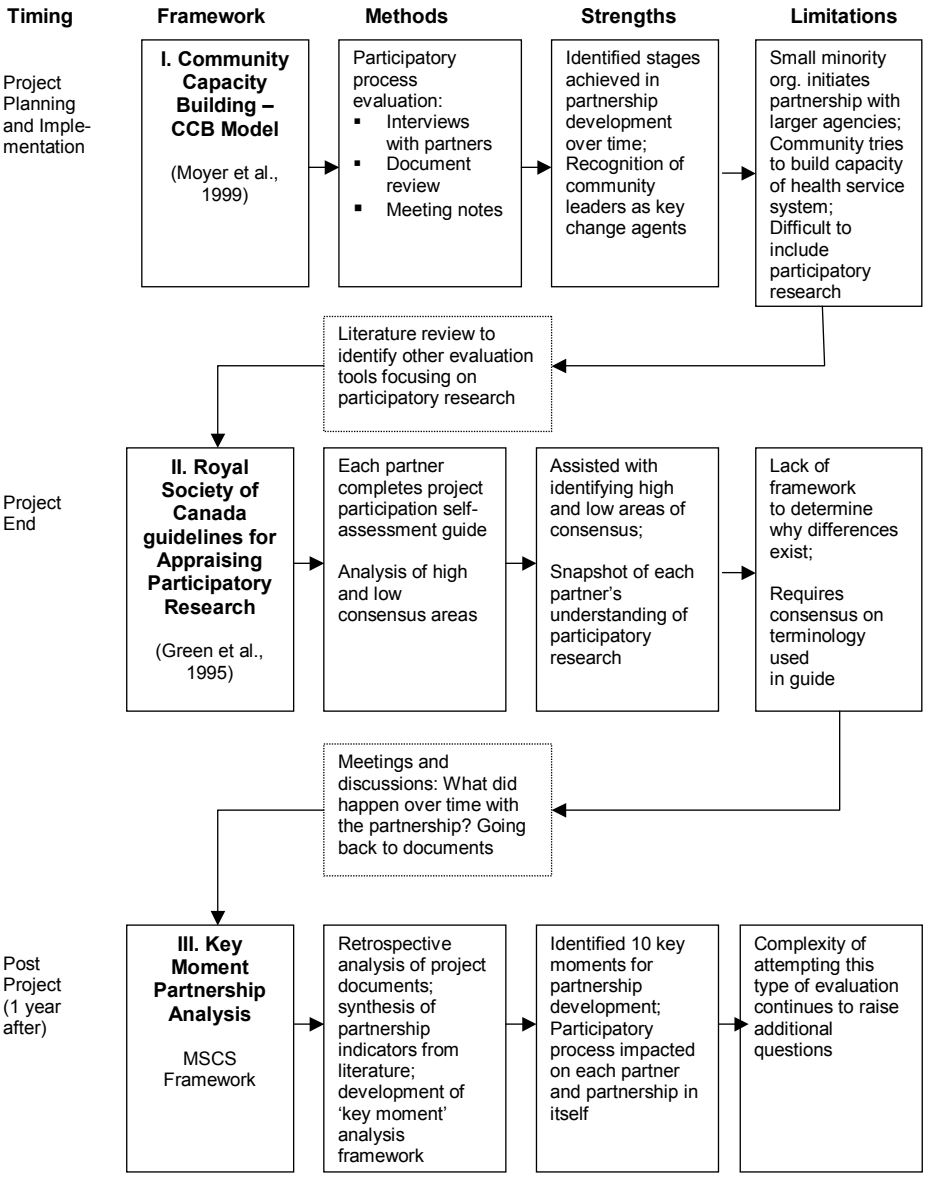
The partners chose the Community Capacity Building model because it appeared "directly applicable to the planning, implementation, and evaluation of community-based programs which have capacity-building objectives" (Moyer et al., 1999, p. 212). The model identifies four stages of building community capacity in establishing community-based health programs.

Stage 1: Identifying common ground, working cooperatively, and establishing self as a community player with an issue-based agenda.
Stage 2: Working in partnership on a common project.
Stage 3: Working across the community with multi-agency/ multi-sectoral partners.
Stage 4: Sustaining the project over time.

It is expected that organizations will progress through these four stages, with different goals, activities, and products, as they develop effective and sustainable working relationships and address health promotion issues in the community. Progress is influenced by practitioner and contextual factors, and by program goals as set by the lead agency (Moyer et al., 1999).

The Community Capacity Building model is constructed from the perspective of the initiator of a project, assuming that the practitioner who initiates the partnership is located within a well-resourced in-

Figure 1
Partnership Evaluation Frameworks—Chronology



stitution, typically a public health unit. The initiator is described as a health practitioner, with an agency mandate to develop partnerships with other community agencies or the community at large. Practitioners play a leading role and engage with community agents at each stage, building relationships and projects that lead to increased community capacity. Moyer et al. recognize that, despite the "expectation that the community will be a full partner in identifying and solving community problems. Experience suggests this may not happen" (1999, p. 211).

We found the Community Capacity Building framework very useful in a number of ways. It helped us to conceptualize partnership development as a process over time, and named a number of important dimensions that helped partners understand partnership work. Reviewing descriptions of initiators' tasks helped us to consider leadership functions and identify the characteristics of champions. The stages of partnership development were applicable to some of the partner dyads, and were useful to assess the stage at which new partners were becoming involved. The model also helped to identify some of the barriers to sustainability.

However, some unexpected limitations (see Figure 1) arose from the fact that MSCS was not initiated by a public health practitioner, but rather by agents within the minority community. These minority community champions, working as volunteers, had a mandate from their community organizations to approach a majority organization to develop a partnership. Their role was to sensitize the community health centre to the needs of their community, to identify organizational barriers that might hinder appropriate service delivery, and to try to overcome them. Without a public health practitioner as initiator, the actual processes of the MSCS project did not fit as neatly into the Community Capacity Building stages.

We found it difficult to include multiple entry points and account for the relationships among all the actors. Neither could we easily take into account differences in partners' working languages, mandates, resources, accountability, sense of commitment, and organizational structures; nor was there a way of addressing what happens inside organizations as a result of working together in a partnership. It was also difficult to incorporate participatory research as a central dimension. These considerations limited our ability to fully assess the MSCS partnership using our original framework.

Self-evaluation by partners using indicators of participatory research (Framework II)

Review of initial assumptions about building community capacity through the MSCS project brought out questions from all partners about the participatory nature of the project. If there were differences among partners about the purpose or extent of participation, this could influence both partnership development and project outcome. The authors proposed to examine how various partners had understood the participatory dimension. All partners agreed.

We found it useful to apply as Framework II (see Figure 1) the Royal Society of Canada (RSC) guidelines for appraising the extent to which research projects align with principles of participatory research (Green et al., 1995). The guidelines were originally developed "to appraise whether proposals for funding as participatory research [in health promotion] meet participatory research criteria" (p. 41), with a suggestion that they could also be used as a checklist by researchers planning participatory research projects. Green et al. (1995) emphasize that the guidelines leave considerable room for local adaptation according to the relative importance each combination of collaborators would attach to each dimension. We took the RSC guidelines one step further, and applied them to assess the extent to which an actual participatory research project had met participatory research criteria.

The guidelines describe six dimensions of participatory research. Each dimension includes a set of questions and five possible reply categories. For example, to assess participation related to the origin of the research, the first question is: "Did the impetus for the research come from the defined community?" Respondents select from five possible reply categories, ranging from "issue posed by researchers or other external bodies," through "impetus shared about equally between researchers and community" at the mid-point, to "issue posed by the community." A single score is generated for each item.

The RSC guideline questions, with some very small modifications, were distributed to partners. All partner organizations participated in a self-assessment of the nature of their participation in the project, some developing more than one set of answers to reflect different perspectives within the organization. The results provided a snapshot of each partner's understanding of the participatory nature of the research component of the project.

Overall, the MSCS project met, in part, all six of the RSC criteria for participatory research. For example, indicators related to the nature of the involvement of the participants suggested that partners agreed that efforts were made to arrive at detailed and explicit definitions of the community, that the community was provided with many opportunities to participate, and that the project paid moderate to high degree of attention to removing barriers to participation for those who have been under-represented in research in the past.

However, there were noticeable differences in the way that partners scored many of the items. To help us interpret this variation, the authors looked for items with high consensus among partners, and for items where partners' perceptions about the participatory nature of the project strongly differed. Figure 2 illustrates the extent of the consensus among partners for each of the six dimensions.

Items related to action and empowerment appeared to have least consensus. For example, partners assessed the community's potential for action in very different ways. Two partners (LAZO, CHRU) indicated there was moderate to high alignment between the research process and the community's action potential; other partners saw the alignment as limited. There was also considerable variation among partners when asked whether the research process had reflected a commitment to actions arising from learnings. The Community Health Research Unit saw no commitment to action beyond data collection, analysis, and writing a report for the funding agencies. LAZO's assessment was closest to this: a low commitment. The community health centre respondents rated researchers and community participants as moderately committed to actions, while respondents from the community research firm, Gentium, assessed researcher and community commitment as moderate/high.

Questions related to the purpose of the research also indicated that partners had widely different views about the extent to which MSCS provided opportunities for community members to learn more about individual and collective resources that lead to more community empowerment, and whether empowerment was a priority objective of the project.

This exercise suggested there might be important differences in the way that partners interpreted the meaning and practice of the term "participatory," especially in relation to the dimensions of community action, community empowerment, and community leadership. Differ-

Figure 2
Partner Assessment of Participation

	Level of Partner Consensus		
Participatory health research indicators	Low	Moderate	High
1. Participant involvement			
Define community			X
Community experience with issue	X		
Community opportunities to participate in research			X
Remove barriers to participation			X
Community understands researchers' commitment		X	
Community participants enabled to contribute		X	
2. Origin of research question			
Impetus from community	X		
Issue supported by community			X
3. Research purpose			
Community opportunities to learn about empowerment	X		
Facilitate community/external resource collaboration			X
Empowerment objective priority	X		
Consider determinants of health		X	
4. Process, context, method			
Use community knowledge	X		
Community opportunity to learn research	X		
Researchers opportunity to learn community issue			X
Methods and focus flexible		X	
Opportunities to appraise experiences		X	
Community involved in analysis		X	
5. Address issue of interest			
Research reflects community potential to learn	X		
Research reflects community potential for action		X	
Commitment to action based on research learnings	X		
6. Research outcomes			
Community benefits from outcomes			X
Process to resolve differences interpreting results			X
Agreement about owning research data		X	
Agreement about disseminating results		X	

ences in partners' conceptual frameworks could account for different perceptions about the relative success of the partnership itself. For instance, partners who perceived participation as leading to actions for social justice at a community level may have been using a particular set of criteria to assess the success of partnership. In comparison, partners for whom the purpose of participation is primarily to broaden the information-gathering capability of the researchers/evaluators might have a quite different set of partnership successes criteria. As another example: differences in partners' understanding of who initiated the research project may have led to different senses of accountability to the community, echoing some of Minkler's ethical challenges in community-based participatory research in relation to developing a community-driven agenda and dealing with insider-outsider tensions, racism, limitations of participation, and use of findings for action (Minkler, 2004).

In summary, the RCS guidelines were a useful tool that provided a snapshot of partners' understanding of the participatory nature of the research component of MSCS, but did not explain why the different understandings existed.

Evaluating the partnership through "Key Moments" analysis (Framework III)

The Community Capacity Building model and the Royal Society of Canada's guidelines for participatory health promotion research provided some insights about evaluating the development of the partnership and the extent to which it was participatory. During those analyses, we realized that another step was necessary (Figure 1), because the partnership itself had been affected by the participatory evaluation process that we sought to apply in the MSCS project.

The authors used multiple methods (examined project documents; identified and synthesized partnership indicators from literature; interviewed other members of partner organizations) to review how the participatory evaluation activities had affected the development of the partnership. Working with a detailed project chronology, certain events and times stood out as crucial to the evaluation of the partnership; we called these "key moments."

The approach to key moments emerged spontaneously, as the authors sought a way to make sense of multiple data over time. Other authors,

however, have also worked with similar constructs. For example, Vanderplaat et al. (2001) describe awareness of a series of "critical moments" that led them to fuller understanding of participatory action research within the context of an empowerment evaluation. Fawcett et al. (1997) describe a similar method for overlaying "critical events" on monitoring data in an evaluation of a substance abuse coalition, during which process they acquired insights into the way that the partnership had evolved.

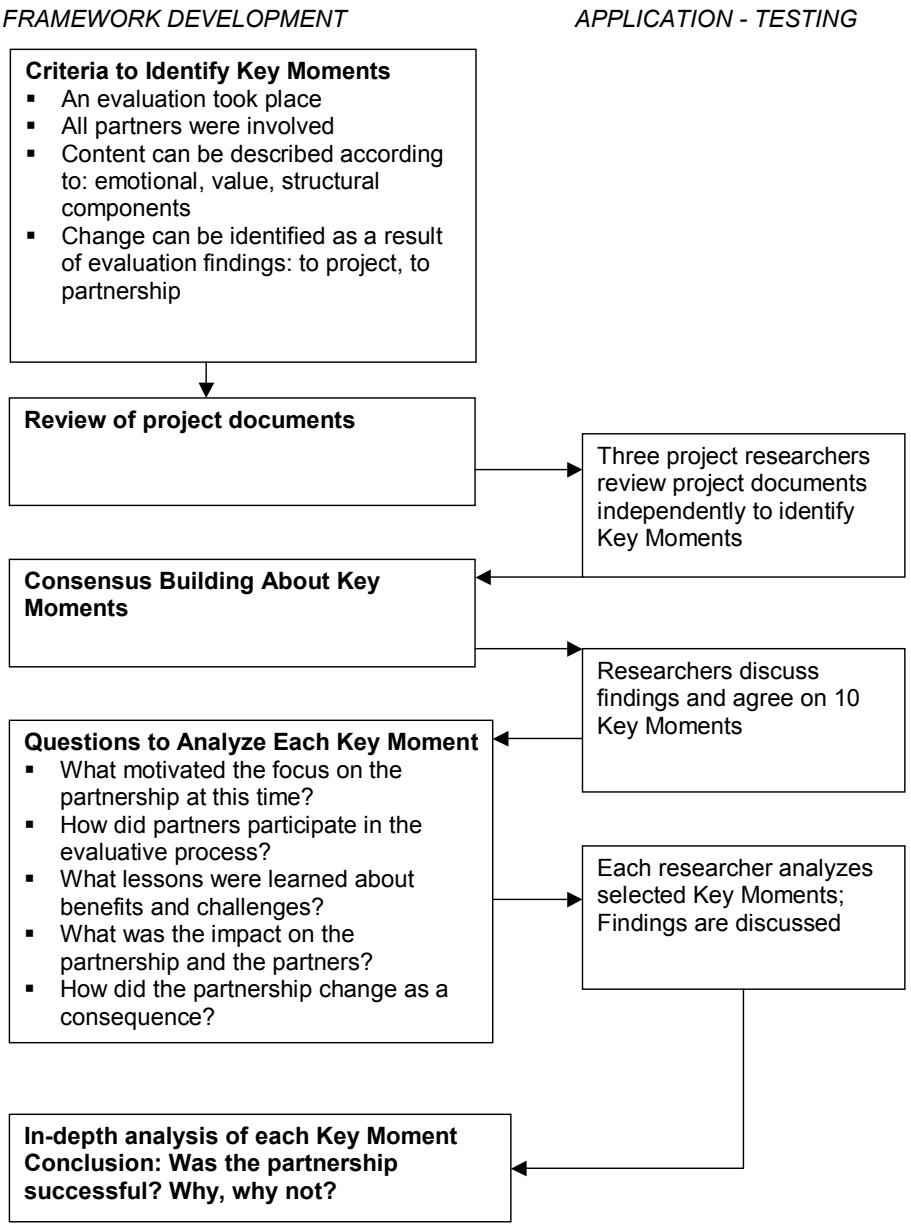
Similarly, the authors also returned to the MSCS data around selected key moments, to ask what impact the participatory evaluation process appeared to have had on the progress of the partnership per se. Figure 3 summarizes the development of the key moment partnership analysis framework, and its application to this project.

Key moments in the history of the partnership are those for which the authors could identify all seven criteria in Figure 3 through project documents. Through a process of group discussions and reviews of the timeline and documents**,** consensus was reached on 10 key moments in the partnership evaluation that occurred during and after the formal life of the MSCS project.

Some of these are similar to events in other descriptions of partnership development; others centred on unique challenges faced by an initiative with a relatively small number of partners. Some key moments were a product of the evolving and dynamic relationship between the community and the partners, and resulted in changes to the structure of the partnership, as well as the project. Some were a result of unexpected events, such as the moment in which the partnership reacted to the first research findings: the health survey revealed higher compliance rates for cancer screening among Hispanic women than originally anticipated, and also a number of other health and social needs, originally not included as a central focus, but to which the partnership attempted to respond.

Although the formal partnership consortium dissolved after three years, the authors identified key moments that occurred after this time. For example, engaging the community in a continuing change process included presenting findings to the community for validation, in a series of community forums after the funding had ended; this had unanticipated positive impact on the leadership role and internal functioning of one partner (the community group, LAZO), but also affected the sustainability of the partnership over time.

Figure 3
Key Moment Partnership Analysis Framework and Application



Key Moment Analysis Example

The following example illustrates the way in which we worked with one key moment, using the questions summarized in Figure 3 to reflect on the impact that the partners' commitment to participatory evaluation, and diverse understandings of participation, had on the partnership itself.

Key Moment: Responding to minority partner needs through changes to training course

1. What motivated the focus on the partnership at this time (e.g., key decisions, outside/inside pressures)? The training program was originally conceived as collectively developed, participatory, skills-based, hands-on training, based on egalitarian exchanges of knowledge and skills among adult learners. All partners were committed to respond to community needs in a participatory process. When LAZO members pointed out that that formal learning and accreditation opportunities for women from the minority community were highly valued and very scarce, the partners responded by deepening and expanding the training program into two university-level credit courses. This required re-allocation of resources among partners, which was successfully negotiated.

2. How did partners participate in the evaluative process? MSCS partners had to develop additional assessment criteria to evaluate the individual academic performances of Lay Health Promoters at the university level. (From the point of view of project outcomes, all LHPs passed the course successfully; 3 of the 11 are currently continuing post-secondary education in related areas.) For reasons of timing, skills, and linguistic capacity, two partners (LAZO and Gentium) became primarily responsible for this task. This foreshadowed increasingly asymmetrical involvement from core partners in the training. Adopting an academic evaluative process also introduced a hierarchical relation among people who had previously worked collectively in the same minority organization, with subsequent impact on the partnership itself. The LAZO co-investigator, who had been appointed by the group as its representative on the project coordination team, now also faced the task of formally evaluating other members of her group, using standards and methods that were to some extent external to the project needs. Because evaluating the academic performance of individual participants was not sufficient or pertinent to all the evaluation dimensions that were of interest to MSCS, a panoply

of additional training evaluation activities and methods (questions developed by learners and instructors, facilitated bilingual meetings of the whole group and sub-groups, taped interviews, anonymous questionnaires, standard learning outcome measures, discussion and review of data summaries, and analyses among all partners) were also used, yielding abundant data and telling a more complex and multiple-stranded story about the success of the training component than would otherwise have been visible to the partners.

3. What lessons were learned about benefits and challenges? The active participation of all partners in this first attempt to apply reflective, participatory evaluation methods also had an impact on the partnership itself. It generated insights about barriers and strategies to facilitate participation of Hispanic community members in partnership activities, with the intention of equalizing power relations between minority and majority partners. Participation in the post-training evaluation activities increased all partners' understanding of training and evaluation, and generated innovative ways of assessing learning and measuring skills and knowledge, contributing to empowerment. The time devoted to this set of activities was considerable, however, and challenged resources of all partners.

4. What was the impact on the partnership and the partners? This moment set a precedent for the continuation of a participatory approach to evaluating both process and outcome, for working in both languages, and for allocating considerable resources to facilitate participation. This latter expectation created many tensions as the project progressed. The two bilingual partners were severely taxed by the expectation that all materials and meetings would be in English as well as Spanish. An unrealistic expectation was created that the community health centre could continue to provide the same level of support during the program implementation phase. Similarly, the health research unit partner, while committed to participatory processes, had limited resources allocated to this project: heavy participation in one aspect led to reduced activity in another, and to renegotiated tasks within the partnership. In contrast, the two partners with the fewest material resources (LAZO and Gentium) had the greatest flexibility in allocating them to the project, due in part to different accountabilities and relations to the Hispanic community, and in part to the number of actual participants in project activities, such as decision-making meetings. Some partners were more concerned than others when participatory processes and funded project deadlines did not coincide. Deeper conversations among partners followed, about perceived and

actual "sense of commitment" to the project and to the community. Unexpected power dynamics across language and organizational lines were made visible, and the debate about the meaning of participation within and among member organizations continued.

5. How did the partnership change as a consequence? Issues that surfaced during this key moment fed into a formative evaluation process, which took place at the transition point between training and implementation (another key moment). In the short term, implementation was delayed.

Despite a commitment of individual partners to continue with a participatory process for program development to ensure a greater sense of ownership by all partners in the program implementation, structural constraints and administrative requirements of the partnership as a whole tended toward a different and less fully participatory process. In retrospect, the evaluation processes linked to the university courses created tensions between competing understandings of the participatory ideal: between an egalitarian model of participatory partnership and an asymmetrical model.

DISCUSSION

Although participation is generally considered to be a good thing in evaluation, "the blanket use of the term 'participation' has masked the heterogeneity evident in its realization in practice" and there is often "a lack of transparency in participatory methods in evaluation" (Gregory, 2000, p. 179). In this article, we have tried to make our application of participatory methods transparent, including the evolution of our modifications to various approaches and tools. We found several tools to evaluate partnerships, and some to evaluate participation. All had limitations and were to some extent difficult to apply in practice to the unique conditions of this egalitarian, multicultural, participatory, health promotion research partnership. Their sequential application, however, helped us to focus discussion on the evaluation of a participatory partnership. Each of the three frameworks we describe in this article provided unique insights.

The Community Capacity Building (Moyer et al., 1999) model helped us to conceptualize the partnership as a process over time and encouraged us to pay attention to the dimension of leadership in building the capacity of the community. It did not fully describe the way that small minority community groups penetrate large majority institutions

seeking to make change through a participatory research process, using mutual empowerment or bi-directional championship, and left us asking: Where to fit in minority community members/partners from marginalized groups who empower themselves seeking partnerships with majority organizations? This first framework appeared better suited to describing situations where there is a single initiator from the majority organization, rather than several champions from the minority community initiating change.

The RCS guidelines for participatory research (Green et al., 1995) also had both benefits and limitations when applied to the MSCS partnership. This second framework helped us to describe succinctly many of the dimensions of partnership important to MSCS, especially in the context of Canadian health promotion initiatives. Individual partners were able to generate responses independently and quickly. The checklist format made it easy for us to identify areas where there were important differences and similarities in partners' assessments and interpretations, which led to a fuller discussion of the meaning of participation. There also were limitations. We found it difficult to maintain the distinction between "researcher" and "community" required by the guidelines, and found them problematic for use in participatory research with multiple partners. Unless used repeatedly, the guidelines miss the dimension of change over time. The quantitative appearance of the tool made some users question whether it could capture qualitative dimensions of participation. Finally, the abstract and complex language required considerable interpretation as well as translation with the participants in this project.

Analyzing key moments through a set of questions specific to the participatory partnership was our third framework. It is known that layers of complexity involved in multiple intervention programs such as MSCS can have impact on partnership processes (MacLean, Diem, Bouchard, Robertson-Palmer, & Edwards, in press). Collaborative processes can themselves engender considerable ambiguity, which in turn influences the collaboration (Buckeridge et al., 2002). The qualitative key moments approach yielded a very rich and multi-faceted chronology of the partnership's development and generated important insights, including that the partnership itself was changed in some important ways through participatory evaluation.

An evident limitation of this framework is the considerable time required for analysis, based as it is on detailed review of project documents, repeated iterations of both chronology and particular

"moments," and lengthy discussion among partners. One of the MSCS partners, the Centretown Community Health Centre, had insufficient time to fully participate in the key moments analysis: they nevertheless provided essential input to various drafts of this article.

CONCLUSIONS

Recognizing that increased understanding of community-based participatory evaluation is achieved through an ongoing and iterative process, we share a final set of questions that emerged from our evaluation of this partnership project. These questions might be useful to other groups who are considering ways to evaluate partnership in similar projects.

Can we conduct a participatory evaluation when partners have different understandings of what participation is for?

We are not sure. Our experiences are similar to those of others involved in democratic and participatory evaluation activities. They raise issues of differing world views, paradigms, and the meaning of power (Chiasson, 1998; Murray, 2002; Patton, 2002). At times, our partnership seemed to stall as we spent time trying to understand each other's objectives and how to achieve them. We often were unable to incorporate results of ongoing evaluation that would have required us to invest resources in specific components. This was in part a result of different visions about the long-term outcomes of the participatory project. At some points, although we seemed to agree on the goals of the particular initiative, we had different ideas of what the specific changes to activities should be to achieve them. At other points, for some partners, the key objective was to complete the project and move on, hoping that enough change had been achieved so that others could take over and move it in new directions. For other partners, the desired change was ongoing involvement in the social and political empowerment of the community, a process that continues well after program funding ends.

Should we do participatory evaluation on an outcomes-based project?

Hughes and Traynor (2000) remind us that striking the balance between outcome and process when evaluating community-based activities and social interventions is not a new concern. We know that it can be done, but it takes a lot of time and effort. It may not be worth the investment unless there is careful negotiation and allocation of

resources to this component throughout. For instance, if a funding body approves a participatory research project, it should be advised that timelines and specific outcomes are likely to change considerably. In a participatory project, process measures may conflict with outcome measures. Process objectives may lead to different outcomes, but if outcome objectives are changed, the project may be perceived as a failure. Striving to meet outcome expectations will generally have primacy over achieving participation objectives, thus compromising the participatory evaluation.

If the project outcomes show success, need we also evaluate the partnership?

The partners have no consensus regarding this question. Some of us feel that achieving successful outcomes in a partnership project means that it worked. It may not have worked the way the partners originally expected, but the success of the project is a witness to the success of the partnership. Others think that it is important to evaluate partnership separately from project outcomes because it will help understand other dimensions of the project that might lead to ongoing or future work with those partners. It also will help explain why this partnership was successful, so that others can learn from it.

How much information needs to be collected to permit evaluation of the partnership?

Our partnership spent a lot of time generating and analyzing written documents. We chose this method to ensure that we would have a clear and fixed frame of reference for remembering and interpreting what we had decided to do. Reviewing our detailed, complex, and lengthy bilingual partnership agreements confirms that it was a useful but insufficient exercise. Writing down an agreement is only a first step. Such documents need to be revised and interpreted in practice. They need to be discussed, analyzed, and rewritten again, and again. We have also learned that to increase the chance of equal participation from all participants (minority and majority) in a bilingual project, all information has to be available in both languages and in multiple formats (oral, print, electronic), so it is equally accessible to all.

Can evaluation be participatory if partners have significantly different economic, organizational, and linguistic resources?

The requirement of participatory evaluation may place a heavy burden on the poorest and least secure partners if the evaluation is to

be truly participatory (El Ansari & Phillips, 2004), and may require them to negotiate participation in different ways than more powerful partners (McHardy, 2003). In the MSCS project, the burden of translation, interpretation (of language, bureaucratic rules, administrative procedures), explaining process, getting people to join up, arranging meeting times, obtaining community buy-in, trying out innovative strategies, resolving internal conflicts, increasing political awareness and analysis, responding to the public, and supporting learners was excessively felt by those partner organizations who had the least financial security and fewest resources. Individual members of the minority community with other part-time jobs and inflexible hours, as well as family commitments, also felt the burden of flexible availability and time resulting from their participation in the process. The project, and the evaluation, benefited enormously from this participation, but the cost was high.

Is participatory evaluation of a partnership worth the time and effort?

From the perspective of empowering the minority partner to be at the table as an equal partner with the majority partner(s) when assessing the partnership, the answer is yes. This model provided an opportunity for the minority partner to challenge and to be challenged by the majority partner(s) and vice-versa. However, the participatory approach takes time and effort away from other activities that the partners want to undertake, including participatory evaluation of the project itself. Differences in resources and time availability have been described as a challenge for the creation of equal, non-hierarchical research partnerships between universities and communities (Buckeridge et al., 2002; Suarez-Balcazar, Harper, & Lewis, 2005). The MSCS partnership was not primarily a university-community research partnership; nevertheless, there were considerable differences in the time available for participatory processes, including participatory evaluation.

We are not sure if the benefits of a participatory evaluation of the partnership outweigh the disadvantages. We think that partnership itself should be evaluated; however, there may be less participatory but equally useful ways. The process we followed to evaluate this particular multicultural, multiple-partner participatory health promotion research project was unique, to the extent that each participatory partnership is unique. Conceivably, all the frameworks, including the "key moments" approach, may be used in more or less participatory

ways, to guide community-based health promotion programs through transitions or key moments.

Did participatory evaluation of the partnership contribute to sustainability?

Sustainability (Stage Four of the CCB model) was an expectation for the MSCS partnership. Alexander et al. (2003) enumerate many threats to the long-term sustainability of community health partnerships; and there are numerous tools, manuals, and articles that describe how partnerships can be developed and strengthened. In reviewing our process, we realized that the MSCS partners did many of the things that the literature suggests partners should be doing, from developing detailed and explicit agreements about roles and responsibilities, to specifying ideological frameworks, to creating multiple and flexible opportunities for interpersonal contact to build trust. Despite this, the MSCS did not receive ongoing funding after the demonstration stage, and was unable to continue as a lay health promotion program.

The impact that participatory evaluation had on the partnership could not be assessed at the project's end. However, three years after the project formally shut down, the partners continue to support each other in various ways. All four core partners acknowledge that the participatory nature of the project strengthened their inter-relationships and commitment to supporting the minority partner to increase the Hispanic community's capacity to participate in their own preventive health care. The minority partner organization was enabled to review its internal structure, and has a renewed mandate from the Hispanic community for continuing health promotion and community development in the area. The majority partners acknowledge that their capacity to understand the barriers that marginalized minority communities face in accessing health services has increased, and continue to seek ways to remove those barriers in the work they do.

We conclude with the reflections of a minority community group participant, one year after the project had finished:

> From the point of view of the group, the achievements are also enormous. And that is because people look at what we achieved, from the outside, and they go: "Wow!" People on the outside see what we did, not the struggles and problems and fights inside the group. And maybe

> in the end that is what matters the most, to have that result. And only now are we seeing, now we are getting the fruits of our labour. All sorts of mainstream services and organizations now know of LAZO, they invite us to participate in community committees about things like violence and improving the services in the city for women. And this is what you only can see now, some time later, looking back. [Translated from Spanish by authors.]

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