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"Round Peg in a Square Hole": Lessons from Community Health Promotion Practice on Dynamics of Accountability, Reporting and Evaluation, and Governance

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This paper presents results from a small-scale institutional ethnography study of reporting requirements and evaluation practices in two urban community health centers (CHCs), as a sample of community-based nonprofit organizations that focus on social justice and health equity. The study illuminated complex relationships among accountability, reporting and evaluation, and governance. Among the CHCs, reporting and evaluation practices consistent with goals of obtaining social justice and health equity were undermined by an imbalance toward funder-oriented functional accountability. Analysis of accountability and reporting practices as systemic factors shaping knowledge production, decision-making, and action revealed notable consequences for CHCs' health promotion practice. This paper proposes a wholistic accountability model to encourage equitable power relations in evaluation, enable participatory methods, and better align CHC knowledge production and governance systems with their health promotion goals. This study further adds to the growing literature supporting critical attention to nonprofit accountability in the context of systems change work.

Keywords: accountability; evaluation; community health; governance; systems change.

Introduction

This paper illustrates the complex relationships among accountability, reporting and evaluation, and governance in a sample of community-based nonprofit organizations, which share an explicit focus on social justice and health equity. While seemingly devoid of action-based components directly related to organizational goals, reporting and evaluation are important sites of knowledge production, connected to and influenced by accountability systems that can inform influence decision-making and governance concerning an organization's shared vision, shared understandings, strategic directions, resource allocations, and program and service delivery approaches. The authors' experiences as health promotion practitioners within the Ontario system of community health centers provided the context and impetus for the inception of this research. We are thankful for the many practice-informed insights gained through critical

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practice conversations that took place during formal planning and evaluation processes within organizations, as well as informally with colleagues and community residents.

The study presented here examined reporting and evaluation practices of community health centers (CHCs) in the context of the reporting and accountability requirements of their core funder. Community-based, institutional ethnographic research was conducted in Toronto, in the province of Ontario (Canada) in partnership with the Alliance for Healthier Communities (a nonprofit organization which advocates for and supports CHC work at a provincial level), Health Nexus (a knowledge mobilization and capacity-building nonprofit with a community health promotion hub), and two neighborhood CHCs. The small-scale, institutional ethnography study examined reporting requirements for CHCs as a sample of midsize, community-based nonprofit organizations with shared goals of advancing social justice and health equity. Against this backdrop of reporting requirements, further research examined challenges faced by the health centers' staff and volunteers in the evaluation of CHC health promotion programs and the impact of these challenges for funding, resourcing, and other governance-related decisions. Accountability and reporting were analyzed as important parts of institutional discourse that influences health promotion[1] practice.

Examining accountability and reporting requirements of the core funding agency for CHCs in the province of Ontario, this paper argues that a narrow interpretation of accountability as predominantly funder-driven, "functional accountability" in a hierarchical funder–grantee relationship, undermines the resourcing and practice of evaluation approaches consistent with principles of health promotion—such as participatory decision-making, interdisciplinarity, and responsiveness to complexity (Rootman et al., 2001)—and this in turn has direct implications for decision-making and governance concerning CHC programs and services. Highlighting the limitation of functional accountability in the context of CHCs' health promotion activities and connecting the dots among accountability, reporting and evaluation, and governance, the paper proposes participatory evaluation as a pathway to knowledge production, governance, and accountability systems consistent with key principles of health promotion. With a distinct focus on reporting and evaluation as significant contributors to these system foundations within the sector, this paper adds to the growing body of literature supporting nonprofit accountability in the context of systems change work for social justice and health equity.

Context: Role and Scope of the Community Health Centers

As the COVID-19 pandemic demonstrated, illness is not a simple equation of individual predispositions plus lifestyle; it also results from modifiable "upstream" factors[2] that create conditions for ill health and the spread of disease and/or mount barriers to clinical care access. Among these modifiable factors 40% include social and economic factors, 10% include physical environment and 20% account for clinical care, whereas health behaviors account for 30% (Bipartisan Policy Centre, 2012; Remington, Catlin & Gennuso, 2015). Combined, these factors are also known as social determinants of health (SDH), i.e., the living and working conditions that shape individual health. The SDH concept accounts for specific mechanisms and pathways by

[1]Health promotion is defined as a process of enabling individuals to increase control over and improve their health (WHO, 2022); health promotion reaches beyond health education and communication and includes advocacy for improved social, economic and environmental conditions that impact individual health (ibid., 2022).

[2] The notion of "upstream factors" refers to socially constructed and modifiable factors for ill-health, which are also called "social determinants of health," such as socio-economic context, policy, environmental factors, and physical and built environments. For more reference, see *Focusing on Upstream Factors* by Alexis Koskan, PhD (2018).

which members of different socio-economic groups experience varying degrees of health and illness (Raphael, 2006; Raphael et al., 2020). Despite Canada's leadership in developing the social determinants of health concept, the country's domestic health policy remains dominated by the biomedical and behavioral models of health (Raphael, 2019).

Among healthcare agencies, community health centers (CHCs) are attempting to influence social determinants at community and population levels. In North America, CHCs have existed for over 50 years; while each CHC is distinct, reflecting the area and communities it serves, all recognize the influence of upstream social determinants of health (Collins, Resendes, & Dunn, 2014). The Canadian Association of Community Health Centres (CACHC) describes five main areas of action for CHCs: provision of customized care; illness prevention; breaking down barriers to health; responding to local needs; and championing health for all (CACHC 2023). The latter area specifically addresses measures aimed at reducing social inequities leading to poorer health outcomes. In the province of Ontario, Canada, a Health Equity Charter, a Model of Health and Wellbeing, and a Model of Wholistic Health and Wellbeing for Indigenous organizations articulate CHC commitments to "mitigating the impact of the many nonmedical determinants of health" and advocating "for healthier public policies that enable people to access a healthy environment and afford other basic necessities of life" (Alliance for Healthier Communities, 2020).

Ontario CHCs are classified as healthcare service agencies and are regulated federally under the jurisdiction of Health Canada and the Canadian Institute for Health Information; and provincially under the Ministry of Health and Long-Term Care (MOHLTC) and Local Health Integration Networks (LHINs). The latter, LHINs, are regional planning, funding, and coordinating bodies for services delivered through hospitals, community support services, long-term care homes, mental health and addiction services, and community health centers (Toronto Central Local Health Integration Network, 2014). LHINs provide core funding for the interdisciplinary clinical and community health services of CHCs across the province. To supplement LHIN funding, CHCs also seek resources from other government bodies and from charitable foundations (e.g., the Ontario Trillium Foundation, local United Way organizations). This additional funding supports community development and capacity building projects, as well as other community-based initiatives addressing social determinants of health. For such projects, CHCs often partner with other nonprofits and grassroots groups who share social justice values and health equity goals.

When reporting to their core funder (the local LHIN), CHCs must categorize such health promotion partnerships and projects as either personal development groups (which target individual knowledge, behavior, and attitudes) or community initiatives (which are broader and complex). Community initiatives are defined as a set of activities aimed at strengthening the capacity of a community to address factors affecting its collective health, through active involvement of community members and grassroots groups in identifying and changing conditions that shape their lives and health prospects (AOHC, 2019). Community initiatives facilitate network development and strengthen grassroots activism toward social justice and health equity. In many respects, they are a distinguishing characteristic of CHCs, as integrated, interdisciplinary, and comprehensive health care organizations with a focus on social justice and health equity (CACHC, 2023). Yet, CHC health promotion efforts to influence social determinants of health through community partnerships and upstream systems change remain nested within the economic, political, and social contexts of particular neighborhood, municipal, provincial, and national systems (Mendly-Zambo et al., 2021).

This paper examines the resulting dynamics when reporting, evaluation, and accountability within CHCs are influenced by overarching discourses of neoliberalization and marketization of

program and service delivery. Informed by health justice (Benfer, 2015) and social determinants of health theories (Brassolotto, Raphael, & Baldeo, 2014) this paper addresses the following questions:

- What institutional discourses and organizational practices enable or impede the application of methods and tools that are consistent with key principles of health promotion?
- What methodological principles in evaluation support equitable power relations?

Neoliberal Restructuring of the Nonprofit Sector and Its Implications for CHC Practice

Like other public and nonprofit organizations, CHCs were impacted by marketization and austerity measures driven by neoliberal and new public management discourses of the late twentieth and early twenty-first centuries (Albrecht, 1998; Loyd, 2014). Neoliberal restructuring downsized the welfare state and shifted responsibility for the provision of many social services to the nonprofit sector (Wolch, 1990; Phillips, 2003; Fyfe, 2005; Gibson, O'Donnell, & Rideout, 2007; McBride & Whiteside, 2011). This shift, often described in the literature as "off-loading," was accompanied by changing relations between nonprofits and the state, which become increasingly contract-based (ibid.). Within such contract-based relations, the role of nonprofits constricted toward service delivery with an emphasis on individual effort and responsibility that ignored systemic inequalities. Neoliberal restructuring emphasized efficiency, professional credentialization, and accountability towards funders as unquestionable virtues for nonprofit sector governance.

It is widely noted that marketization, expressed as the pressure to extract more value for money, impacted organizational culture and routine management practices in the nonprofit sector, limiting sector capacity to support vibrant civil society and equitable citizen participation (Brown, 2003; Eikenberry & Kluver, 2004; Phillips & Levasseur, 2004; Gibson, O'Donnel, & Rideout, 2007; McBride & Whiteside, 2011, Darby, 2016; Rudman et al., 2017; Malenfant, Nicols, & Schwan, 2019). Consequences of the shift toward contract-based relations extend to accountability and reporting practices. For example, results-based, funder-driven accountability measures favor upward-oriented "functional accountability" and stifle innovation (Phillips & Levasseur, 2004; Gibson, O'Donnel, & Rideout, 2007). Funding is increasingly tied to the demonstration of specific predetermined outcomes structuring how the work of nonprofits is organized and valued (Malenfant, Nicols, & Schwan, 2019). Together, such dynamics have significant downstream implications for organizations and communities where "non-profits fear negative consequences from reporting poor results under regimes of hierarchical accountability" (Phillips & Carlan, 2018, p. 2).

The prevalence of a neoliberal environment affected widespread structural change, weakening, and diminishing health policies addressing social determinants of health (Gore & Kothari, 2012; Raphael & Bryant, 2019). Despite contextual pressures, CHCs continued engaging in community initiatives and other partnerships beyond the health sector. To this day, their efforts offer the greatest potential for reducing health inequities at a community level by addressing upstream social determinants of health (Collins, Resendes, & Dunn, 2014).

Accountability and Governance in the Nonprofit Sector

Despite its frequent presence in nonprofit sector discussions, theoretical studies of accountability in relation to the nonprofit sector are relatively recent (Ospina, Diaz, & O'Sullivan, 2002; Williams & Taylor, 2013). As a concept, accountability is noted for its complexity and multidimensional nature, especially in the non-profit sector (Cutt & Murray, 2000). Candler and Dumont (2010) illustrate the complexity and ambiguities of the nonprofit accountability environment with a framework that focuses on its multiple stakeholders,

directions, and outputs while emphasizing that "the most intuitive stakeholders are those directly involved in or affected by the organization" and delineating fundamental distinctions between staff, members, clients, and constituents (p. 126).

In its essence, accountability is a relational concept and presumes the existence of two parties where one allocates responsibility and another becomes obligated to report on it (Cutt & Murray, 2000; Williams & Taylor, 2013). In nonprofit contexts, it most frequently references a process within a principal–agent relationship through which the agent is held accountable, against certain predetermined standards, by the principal[3] (Baez Camargo & Jacobs, 2013). This usage, known as "functional accountability," is often synonymous with fiscal and administrative accountability since it generally requires an agent to report to their principal on budget expenditures in relation to outputs. The direction of functional accountability is upward-oriented, and it is reinforced through legal contracts both within organizational hierarchies and externally toward the funder (Larkin & Reimpell, 2012). In nonprofit contexts, the contract is generally called a "funding agreement."

Specific to the nonprofit sector, O'Dwyer and Unerman (2008) describe the functional accountability framework between donors and grantees as hierarchical with the goals of controllability and performance measurement, and centralizing control by the principal over the agent. In relation to governance types, functional accountability is most closely aligned with fiduciary governance; it supports nonprofit boards to oversee technical operations and fiscal accountability (Chait, Ryan, & Taylor, 2011; Hodgson, 2015).

Apart from functional, other forms of accountability exist. Most notable is social accountability, or value-driven accountability, which refers to formal and informal mechanisms that enable community members to promote service providers' accountability to community priorities and that exist outside the hierarchical relationships (Cutt & Murray, 2000; Malena, Forster, & Singh, 2004; Baez Camargo & Jacobs, 2013). A distinguishing quality of social accountability is the direct participation of community members in activating and reinforcing accountability mechanisms (Malena, Forster, & Singh, 2004). In contrast with functional accountability, which is reinforced through formal institutional policies and legal contracts, social accountability represents a set of mechanisms and practices that reflect individual practitioner and organizational core values (Malena, Forster, & Singh, 2004). In contrast with upward-oriented functional accountability, social accountability is spread horizontally and is reinforced through the beliefs, convictions, and commitments of nonprofit teams and the communities they engage with (Murray & Tassie, 1994). It is value-driven and involves horizontal relationships to peer and organizational loci wherein the agent is accountable to a set of shared values. Social accountability is most closely aligned with strategic and generative governance approaches that place less importance on rules and operations (Hodgson, 2015).

In social justice and health equity contexts, value-driven accountabilities are noted as the most reliable forms of accountability since people are most accountable to what they believe in (Patton, 2006; Geer, Maher, & Cole, 2008). Value-driven accountability may challenge or even conflict with the external authority and/or funder focus of functional accountability creating tensions in nonprofit, social justice-oriented contexts (Phillips & Levasseur, 2004; Patton, 2006).

[3] Principal: a person or an entity who has controlling authority and is in a leading position (Merriam-Webster Dictionary, 2021)

Upward-oriented functional accountability to funders and donors frequently undermines accountability to communities served and to peer organizations[4]; in fact, several studies examining the state of accountability in the nonprofit sector reveal a significant bias toward functional accountability expressed as an overwhelming need to account to donors for financial resources and a much lesser need to account to the sector's constituents (Phillips & Levasseur, 2004; Candler & Dumont, 2010). This bias is noted as a growing tendency to interpret accountability as a predominantly technocratic concept focused on control, regulation, and compliance, rather than a democratic process intended to facilitate shared responsibility (Chouinard, 2013; Phillips & Carlan, 2018).

Reporting requirements and quality improvement protocols focused on functional targets and benchmarks established by funders and higher-level auditing institutions may sideline community priorities and values of nonprofits.

Several researchers highlight how subordination to functional accountability, characterized by a failure to counterbalance it via other forms and directions for accountability, undermines the organizational capacity for learning and innovation that are necessary to keep a nonprofit's practice aligned with its mission and core values (Philips & Levasseur, 2014; Ebrahim, 2005; Eikenberry, 2009; Guijt, 2014; Rudman et al., 2017). Funders, whether government or philanthropic, may themselves lack understanding and mechanisms to prevent such dynamics even when they allege to share parallel priorities and values.

Figure 1. *Existing Directions of Accountability in the Nonprofit Sector and Their Funder Bias*

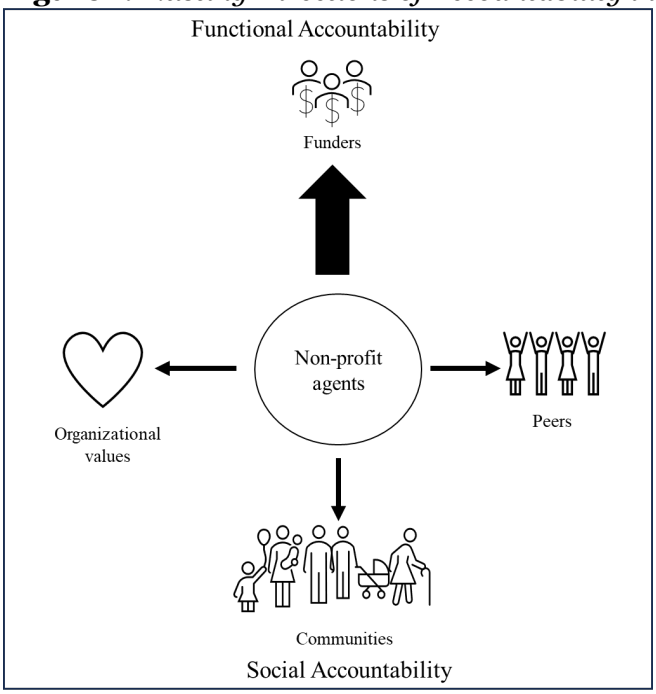


Figure 1 (p.12) illustrates the loci (focus) and directions of the various forms of nonprofit sector accountability discussed in this paper, including hierarchical (vertical) and lateral directions. The thick arrow depicts a heavy bias of functional accountability toward funders. Although

[4] Peer organizations include but are not limited to community partners, other CHCs, and professional associations.

functional accountability is not problematic, an imbalance favoring functional funder-driven accountability undermines community, organizational, and peer accountabilities.

Methodology

Situating Ourselves: What in Our Histories and Lived Experiences Positioned Us to Pursue This Research.

This study emerged from dialogue between an academic and practitioners involved in frontline health promotion work who experienced reporting, evaluation, and accountability systems in our day-to-day work. Given the intersectional feminist framing of the research, requiring attention to social location and positionalities (Pederson & Machado, 2019), it is relevant to situate the coauthors of this paper in relation to institutional and community contexts within which we undertook research and to note each co-author's positionalities and lived experiences. While Western epistemological traditions demand that researchers distance themselves from their individual social location, claiming this can minimize "potential bias", critical social theorists and Indigenous scholars have deconstructed this concept of alleged objectivity. Openly situating an individual's location and intentions, they argue, is a necessary step to ensure transparency and epistemological honesty in the research process (Absolon & Willet, 2005; Absolon, 2010; 2021; 2022).

Both coauthors have been involved in community health promotion and other systems change partnership work as practitioners, participatory evaluation facilitators, and community-based researchers. Julia Fursova, PhD, identifies as a community engaged scholar whose scholarship has been continuously informed by their experiences of and reflections on privilege and marginality produced by their many intersecting identities as a white Eastern-European immigrant navigating two immigration journeys, a settler in Canada, and a neuroqueer (Boren, 2022) individual. Gillian Kranias, MES, is a white queer settler of Greek-Irish heritage with significant unearned privileges, including class. Both authors encountered anti-oppression approaches within social justice movements from an early age and continually grow by "learning through action" and the power of reflection. We live and work on beautiful watershed lands that are traditional territories of Anishinaabe, Mississauga, Huron-Wendat, and Haudenosaunee peoples, as well as unsurrendered and unceded traditional Wolastoqey land.

This research project was informed by the coauthors' shared experiences as health promotion practitioners within the Ontario system of community health centres, navigating a divergence of institutional accountability and reporting requirements from community-based priorities and the organization's values and mission. The pursuit of this research aligned with its coauthors' commitment to use our privileged positions to question biases embedded in nonprofit sector systems, including reporting, evaluation, and accountability systems, with respect to social justice and health equity.

Theoretical Framing: What We Did and Why

To understand the impacts of the prevailing functional accountability discourse on nonprofits via their accountability-reporting/evaluation-governance-practice pathway, this research examined reporting and evaluation requirements for community health centres (CHCs), as a sample of community-based nonprofit organizations who share an explicit commitment to addressing social determinants of health to advance social justice and health equity. In this context, the research examined how evaluation practice is shaped within the current CHC reporting and accountability systems from the core funder and to what extent these systems support evaluation aligned with

the core health promotion principles of interdisciplinarity, participatory decision-making and responsiveness to community context.

Governmentality and intersectional feminist lenses were applied as analytical frameworks to examine the role of CHCs within a broader nonprofit ecosystem concerned with social justice and systems change yet unfolding within a dominant neoliberal discourse. Both theories provided important insights for understanding how the tensions between hegemonic and counterhegemonic claims arise and what role they play in the discourses and dynamics of accountability, governance, reporting and evaluation. In the context of our study, governmentality theory enabled understanding of how neoliberal discourse contributes to entrenching the biomedical model of health, individualizing responsibility, and neglecting social determinants of health. Both governmentality theory and intersectional feminist lens directed the research to consider complex relationships and interactions between positionalities and neoliberal policies, and how these together produce vulnerabilities (Crenshaw, 1991; Levine-Rasky, 2011; Hankivsky et al., 2014). Aligned with Foucauldian theorization of power, where power is a relational concept shaped by both relationships of communication and objective capacities, intersectional feminist lens afforded a focus on power relations among different actors in the reporting, evaluation, and accountability systems (Foucault, 1982; Choo & Ferree, 2010; Christensen & Jensen, 2012).

Methods and Ethics: How Did We Do It

This study combined institutional ethnography and participatory action research. Both methods belong under the umbrella of critical social research and share an explicit social justice and feminist agenda. Institutional ethnography is a form of qualitative research informed by feminist and critical social theories. It uses ethnographic data collection methods while making connections between individual everyday experiences and institutional processes that govern them (Townsend, 1996). Institutional ethnography untangles how everyday individual experiences are externally constructed through social relations of power (De Vault & McCoy, 2006).

Participatory action research involves research participants in shaping the whole research process, from the beginning, with an aim to mobilize co-produced knowledge for social change (Minkler & Wallerstein, 2008). Both institutional ethnography and participatory action research are consistent with critical social theory as well as health justice and social determinants of health theories. More broadly, these research methods align with explicit commitments to health equity and community empowerment practices in the field of health promotion.

Gathering a Research Advisory Team: Collaborative research governance is central to participatory action research, and community engagement is a cornerstone of health promotion practice. To codesign the research and its participant recruitment strategy, the principal investigator and representatives from the two research partner organizations (Health Nexus and the Alliance for Healthier Communities) formed an initial research advisory team. To enable a small-scale ethnographic study, we then recruited two urban community health centers to participate in the research and invited representatives from these to join the research advisory team. Led by our institutional ethnography approach to this study of how power relationships construct the practice of program evaluation in health promotion, we recruited CHC representatives from various health promotion stakeholder positions, including staff and volunteers.

The recruitment process sought CHCs operating in low-income neighborhoods of Toronto with higher percentages of racialized residents, immigrants, single parent families, and seniors. We also sought CHCs with an explicit commitment to community health promotion initiatives (CIs)

as well as existing relationship(s) to the initial research advisory team. These existing relationships facilitated quicker reciprocal trust and understanding and encouraged honest and clear communications (Bishop-Earle, 2018). In its full membership, the research advisory team included coordinators, managers, frontline staff, and community volunteers, with each engaged in health promotion practice from their unique interrelated positions.
Research advisory team members contributed to finalizing the research questions, the data collection tools, and the recruitment process. They later contributed to preliminary data analysis and knowledge mobilization. Ethics approval was granted by York University Research Ethics Board in April 2017.

Qualitative Research Methods: The qualitative multimethod research used document review, semi-structured individual interviews, and participatory group discussions. Data collection and preliminary findings were discussed and developed at monthly research advisory team meetings from April 2017 to January 2018. Detailed design of the methods was iterative. For example, the academic researcher first presented results from the documents review and the interviews with funder-level administrators. Then, collaborative data analysis discussions among research advisory members informed the subsequent interviews and group discussions for data collection with health promotion practitioners.

Through these mixed methods, the research analyzed how discourses of accountability shape reporting and evaluation and, in turn, influence governance decisions regarding community health promotion practice. This examination treated reporting and evaluation as a site of knowledge production influencing health promotion investments, activities, and their outcomes.

The following documents, guiding reporting and evaluation in health promotion at the provincial level, were reviewed: Ontario Healthcare Reporting Standards (OHRS); Multi-Sector Service Accountability Agreement (MSSA); Local Health Integration Network Provincial Strategic Framework and Logic Model. In addition, CHC-specific evaluation frameworks, plans, and program reports, related to the specific programs discussed by research participants, were reviewed.

In total, 14 individuals representing different organizational roles and location in relation to evaluation processes participated in the research. Among participants were four community volunteers, three frontline workers, three project coordinators, two managers, and two participants representing funding-level administrators. Both participatory group discussions and interviews were recorded and transcribed. To sketch institutional relations revealed in interviewees' speech, interview transcripts were analyzed with attention to institutional and organizational factors that enable or impede evaluation practices consistent with health promotion principles of community participation, interdisciplinarity, empowerment of individuals and communities, and appropriateness to context (Rootman et al., 2001). All transcripts were coded with participant role in the organization, e.g., manager, frontline health staff, volunteer/program user, and external funder/administrator and uploaded to NVivo 12 for analysis. The constant comparison method and member checking with research advisory team members constituted an important validity procedure (Lincoln & Guba, 1985; Creswell & Miller, 2000).

Collaborative Data Analysis: Via interviews and participatory discussions about the everyday experiences of health promotion practitioners in the implementation of reporting and evaluation processes, the principal investigator analyzed routine occurrences of reporting and evaluation in relation to the organizational and institutional texts guiding reporting and evaluation. A focus on discrete and interlocking activities of these managers, coordinators, frontline workers, and

community volunteers revealed how rules and guidelines generate a coordinated set of activities (Mykhalovskiy & McCoy, 2002).

To engage research advisory team members in collaborative data interpretation, the principal investigator presented preliminary themes on data placemats. Data placemats is a participatory technique to enhance stakeholders' understanding of data and promote cocreation of meaning (Pankaj & Emery, 2016; Gutierrez, Preskill, & Mack, 2017, Kranias, 2018). In this study, the placemats presented data highlights in relation to emerging themes, highlighting "tension" points between evaluation practices and key health promotion principles. The placemats also showed the flow of data through organizational and institutional hierarchies. The research advisory team enabled an integration of different stakeholders' perspectives to influence the research within a broader scope on contextual factors and institutional dynamics rather than on individuals or specific organizations. The combination of institutional ethnography and participatory action research informed the research process with the lived realities of frontline practitioners and validated findings through their diversely situated subjectivities.

Findings

The study revealed three interconnected phenomena:

i. a clinical model and biomedical view of health embedded in the structure of reporting requirements;
ii. methodological pressures and capacity constraints for health promotion evaluation; and
iii. weakened community participation in evaluation.

Layered together, these three phenomena hindered the use of evaluation practices consistent with health promotion principles.

A Clinical Model and Biomedical View of Health Embedded in the Structure of Reporting Requirements

This section presents results of the document reviews of reporting requirements from the CHCs' core funder, i.e., the Local Health Integration Network (LHIN).[5] The key documents reviewed were the Multi-Sector Service Accountability Agreement (MSAA) and the Ontario Healthcare Reporting Standards (OHRS). Both documents focus on financial accountability and performance measurements of health service agencies, including but not limited to CHCs. The MSAA also establishes the funding and service relationships between health service providers and the Local Health Integration Network (LHIN). Together, these documents comprise a reporting system reinforced and supervised by the province of Ontario's Ministry of Health and Long-Term Care, through regional LHINs.[6] CHCs and other health care organizations[7] submit OHRS-compliant financial, statistical, and balance sheet account information to a provincial database on a quarterly basis. The main purpose of OHRS is to ensure fiscal accountability to the province's Ministry of Health and Long-Term Care (hereafter the Ministry) and its reporting requirements focus on cost/benefit analysis.

[5] This is based on the data in 2016–2018 prior to any changes in the provincial healthcare system under the current Ontario Progressive Conservative government.

[6] At the time of this research, there were 14 regional LHINS; in 2019, the Ministry transitioned to six regions. https://www.ontariohealth.ca/about-us/our-programs/ontario-health-regions

[7] Among other health care organizations required to submit data through OHRS are public and private hospitals, community care access centers, children's treatment centers, community mental health and addictions organizations, community support services, and long-term care homes.

OHRS cost/benefit calculations apply to reporting categories named "functional centres." A functional centre is defined as a subdivision of an organization's revenues, expenses, and statistics pertaining to a specific function or activity. The category of functional centre is used to focus on and monitor the costs of labor, supplies, and equipment per function (MOHLTC, 2012). This concept of a functional centre was created for health service agencies that are clinical in nature (e.g., hospitals, children treatment centers, community care access centers) and where activities target individuals with identified pathologies or disabilities, whether permanent or temporary.

Four functional centres account for the diversity of health promotion activities within Ontario CHCs: community health; health promotion; health education; and community development. These intend to capture and track costs of CHC work that happens in group and community settings, i.e., that does not focus on individual clients (OHRS, 2017).

OHRS and MSAA are part of an institutional fiscal accountability and functional reporting system focused on "value for money." An administrative officer tasked with ensuring CHCs adherence to the provincial reporting system (2017), commented how the system presumes a "matching principle" structure, within which healthcare organizations report on activities and services delivered in relation to money spent. However, this "matching principle" structure only exists for clinical services and health education programs. The structure is mismatched regarding health promotion and community development activities targeting social determinants of health. The same administrative officer further elaborated:

> "[t]here is only one account on OHRS that has any relation to community initiatives, and it only asks for budget, so money spent on the community initiatives and no information about community initiatives whatsoever…" (Administrative Officer, Individual interview, 2017)

For the functional centre of structured health promotion initiatives, such as personal development groups, CHCs can also report the number of clients reached, and within that a breakdown of registered clients to non-registered clients; however, all costing analysis, if any, is based on the registered clients only.

Contrary to the CHC Model of Health and Wellbeing (Alliance for Healthier Communities, 2020) accepted across Ontario CHCs as their model of care, OHRS reporting requirements are rooted in a clinical model and biomedical view of health. Within the biomedical concept of health as an "absence of disease," being a client of a CHC means being a patient who presents a disease, illness, or any other form of pathology. As an administrative officer (2017) noted:

> … [t]his is where we don't fit in [their] box, we are the round peg in the square hole. They try to get us into the same system as them and we never fit, [w]hen they analyze our data, they are still analyzing them the way they analyze other [clinical] ones, [so] our costs look so high. Because we really don't fit in there. (Administrative Officer, Individual interview, 2017)

Within this clinical model, when a CHC spends resources to engage with populations that are difficult to register (e.g., people with precarious immigration status and homeless or near homeless people) and/or runs community initiatives targeting social determinants of health (e.g., community gardens, neighbourhood safety initiatives, youth development), the CHC looks "frivolous" in their expenses when compared with those that favor clinical activities and/or facilitate health promotion activities with registered clients only.

As a key feature of their reporting structure, functional centres generate several problems for CHCs. First, they influence CHCs to apply a pathologizing lens, as it becomes easier to fit clients and activities within a functional centre when the focus is on a pathology rather than a concept of wholistic wellbeing. Second, functional centres prioritize activities with registered clients over engagement with the broader community; this also frames community members as "clients" or "patients" rather than contributing participants in collaborative processes aiming to transform conditions that determine community and population health. Third, the concept of functional centres in reporting requirements structures CHC work along professional boundaries and hinders interdisciplinary work. Functional accountability frames a CHC clinician's involvement in interdisciplinary health promotion programs and health justice advocacy campaigns as "fiscally irresponsible" work. This narrow lens does not account, *by definition*, for the interdisciplinary nature of health promotion practice.

By missing important "boxes" and failing to capture a significant portion of health promotion activities and outcomes, reporting tables informed by the clinical model and biomedical view of health contribute to the invisibility of community health promotion work and its impacts from the perspective of the core funder, the principal.

Stemming from these constraints of reporting from a biomedical viewpoint oblivious to social determinants of health, this study identified methodological pressures and capacity constraints for the effective evaluation of CHCs' health promotion practices.

Methodological Pressures and Capacity Constraints in Health Promotion Evaluation

Responding to reporting requirements underpinned by the clinical model and biomedical view of health, health promotion staff employ strategies and tools that attempt to quantify, to make evident, the outcomes and impacts of their activities. Examples of this include tracking numbers of program participants and the administration of pre- and post-program surveys. Such evaluation strategies produce reductionist assessments of the complex, synergistic, and long-term outcomes of health promotion initiatives.

Interviewed practitioners shared insights into barriers to the use of evaluation methods aligned with key health promotion principles, which are related to evaluation resourcing, staff capacity building, and pressures to favor quantitative, conventional evaluation methods.[8] CHC practitioners described conventional evaluation as less useful for community initiatives since it lacks in accountability to community priorities, and it is not supportive of collaborative learning and process improvement. The practitioners further noted how measurements against predetermined goals and objectives inherent in a conventional approach, i.e., in the linear framework of a logic model, are not necessarily appropriate for the complex structures and emergent (constantly evolving) nature of community health promotion initiatives. Practitioners expressed preference for a more responsive and continuous approach to evaluation, highlighting elements of what might be termed "wholistic, developmental, and/or participatory evaluation design." Such evaluation designs acknowledge the complexity of social contexts, accommodate interdisciplinarity, advance equity among partnership members, spark creativity and innovation, and promote wholistic accountability orientations towards the people who participate in programs and organizational values as well as their funding bodies (Guijt & Gaventa, 1998; Patton, 2006; Kranias, 2018; Absolon, 2022).

[8] Conventional evaluation derives from Western positivist thought. It aims to produce definitive judgments of success or failure, with accountability oriented to funders and other external authorities (Patton, 2006; Potvin & Richard, 2001). This contrasts with wholistic, Indigenous-informed approaches that focus on cyclical and relational activities and prioritize situated over generalized knowledge (Absolon, 2010).

The practitioners also reflected on institutional barriers to implementing evaluation designs consistent with key health promotion principles. Limited resources and capacities for evaluation in CHCs aggravate the tensions between the functional accountability demands from CHC funders and the priorities of a wholistic accountability system, since this latter would demand considerable reorientation toward community members and peers. An interviewed health promotion coordinator discussed accountability to program participants as highly desirable in community health promotion but noted how, in everyday work, their organization's accountability toward funders takes priority. With both CHCs' lack of resources to apply more complex evaluation methodologies to inform process improvements, strengthen relationships, and adopt wholistic accountability practices that include community priorities, evaluations often narrow down to a headcount:

> I think what would be really helpful is information, feedback around the process [of community engagement]… [learning] what has worked well in terms of support available to residents to get them to that discussion table, which is what I'd say most organisations are always aiming for. But there is often not enough infrastructure to facilitate that [kind of evaluation] But for the purposes of reporting, I think really at the end of the day that would be numbers. (Health Promotion Coordinator, CHC A, Individual Interview, 2017)

The emphasis on studying a CHC's "number of clients served" also favored engagement of community members with less complex engagement pathways from population groups facing fewer access and inclusion barriers. These dynamics generate negative implications for equity:

> Let's say you served 10 people. But those 10 people have lots of issues, and the amount of time and the amount of resource you put for those groups might be a lot … Or you might have 50 people with less underlying issues. When you look at it, you prefer 50 to show "Oh, I have 50 people." But … what does it mean? … The cost per participant or client [whatever] you name it … when you analyze, you prefer 50. But it is not only [about] cost effectiveness. You have to see who your clients are. If they are marginalized people, we talk about equity. Those 10 people may be with lots of complex health needs and issues. (Health Promoter, CHC B, Individual Interview, 2017)

The rift between funder requirements for easily quantified data and community priorities of sustained engagement and learning was described by one health promotion practitioner:

> [t]he disconnect is in how they [funders] are viewing stuff, and how it's played out on the ground. The stress of the numbers can affect the work you do. It is a hard place to be a front-line worker because numbers, numbers, numbers—but it's not all about that, you also need the time to make the community connections that lay the foundation to keep and increase those numbers and support the community to keep coming out … (Community Engagement Project Manager, CHC B, Individual Interview, 2017)

Additionally, pressures for client numbers and cost-efficiency exist alongside a notable gap in guidance and an absence of benchmarks from the core funder. A health promotion manager commented on the lack of clarity:

> [t]here is no guidance in relation to cost efficiency. So, when we evaluate (because you know we all face budget constraints), what's the reference point? I think it has to be realistic. We definitely have to talk about money as to how we make sure our resources are being spent on those who are most in need. I think addressing the financial piece is rather

> quite important. But at this point, we don't even know where the reference point [is]. What is considered to be cost efficient, and relative to what? (Health Promotion Manager, CHC B, Individual Interview, 2017)

This same health promotion manager also highlighted a lack of parallel pressure in relation to health promotion outputs/outcomes to match the pressure for cost efficiency.

The focus on functional accountability combined with the CHCs' organizational capacity constraints narrowed the purpose and benefits of their evaluation practices:

> I think that, in a lot of time[s], evaluation is just something that we kind of tuck at the end of the program, just to say that we did it… I think that often it's because lack of resources, lack of time … thinking that … it is not actually going to change anything … (Frontline health promoter, CHC A, individual interview, 2017)

The study noted how this narrowing coalesced into a third phenomenon in practitioners' health promotion evaluation practice, identified as "weakened community participation in evaluation."

Weakened Community Participation in Evaluation

Within this study, health promotion practitioners, including managers, coordinators, community health workers, and volunteers, assessed the extent of their input into their CHC evaluation designs and implementation using a framework adapted from Furubo and Vestman (2011), which describes seven aspects of power in the evaluation process. These aspects of power are agenda setting, framework development, establishing values and criteria, evidence collection, knowledge sharing and knowledge mobilization, and defining parameters for participation in evaluation. Within the context of this study, each aspect was labelled as a step of the evaluation process and practitioners assessed their decision-making power at each step (aspect) on a scale of 1 to 3, where 3 indicated executive power with access to necessary resources.[9] The practitioners also shared examples illustrating how their decision-making power unfolded at the practical level of evaluation implementation.

Not surprisingly, the self-assessments showed that managers exercised the most decision-making power at each step of the evaluation process. In high contrast were community members, who noted having especially limited opportunities to influence design of CHC evaluations. At the same time, community members highlighted that, when they are invited to sit on advisory groups (i.e., to participate in evaluation design discussions), this contributes to a more inclusive and context-appropriate evaluation:

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

Yet within these group discussions, community volunteers often experienced unequal power dynamics, with the "agency" maintaining a dominant role in shaping evaluation design: "It's usually the agency that takes the stronghold in these things, so even as a steering committee we rubber-stamp what agencies push for." (Community Volunteer #1, CHC B, 2017)

[9] Practitioner input was conceptualized as the degree to which individuals participate in decision-making concerning each aspect of evaluation process, combined with recognized skills, expertise, and access to resources.

Frontline workers and managers confirmed these observations regarding structural constraints on community participation in evaluation design. A manager of a community engagement project shared that voices at the advisory tables may be valued differently: "If a resident brings something to the table, there's less buy-in than if an agency proposes it."

In the study, CHC workers and managers often misconstrued qualitative data collection (i.e., open-ended questions in feedback forms, interviews, and/or focus groups) as participatory evaluation. Within their CHCs, the involvement and influence of program participants in evaluation design itself, - the hallmark of a participatory evaluation approach, - ranged from limited to nonexistent. Those who did understand participatory evaluation methods cited lack of time and other resources to enable a higher degree of community participation in the evaluation process as one of the barriers to adopting this approach. A health promoter shared the following: "Yes, in theory, I agree. But in practice, I have never done that. In theory, even though I agree, time is a factor. It is really hard to bring people in[to] design of evaluation and design of the overall program."

When determining such scaffolding design structures as values, criteria, and evidence for an evaluation, managers and frontline health promoters often align evaluation processes with the priorities of their funders without determining to what extent such priorities reflect those of community members. This gap impacts both knowledge development about programs as well as subsequent decisions about implementing or scaling back health promotion activities in the community. As community volunteer 1 in CHC B (2017) asks:

> Why do funders fund things the way they do? It doesn't make sense. Instead of seeing what the community needs are, they [the funders] decide what the needs are. It's very top-down. You have to decide to put your round peg in their square box and in doing that a lot of things get lost."

Both money and expertise resources were described as instrumental for enabling greater participation of community members in health promotion evaluations. For example, a participatory Photovoice evaluation of a food security project was discussed as comprehensive and useful in helping to inform program development and enhance community engagement:

> [T]he more extensive and more creative kind of evaluation has happened with the project because there was an added resource and expertise to bring that lens forth. (Health Promotion Coordinator, CHC A, Individual Interview, 2017).

In another case, continuous evaluative learning[10] efforts were spearheaded by a program manager, who introduced an ongoing client feedback survey alongside a quarterly participatory team review of the survey results to inform program planning. This evaluation process led to new program developments that were responsive to community members' priorities.

In both cases, which illustrate community-oriented accountability, the CHCs exceeded their funder reporting requirements. In the first, participatory evaluation was enabled through additional external funding and a graduate student placement. In both, it resulted from a manager's determined commitment to quality improvement and CHC values. Yet, their work

[10] Evaluative learning denotes an ongoing, iterative process for continuous quality improvement (Kranias & Quinlan, 2013). Many collective reflection and continuous learning approaches, including those from Indigenous knowledge traditions as well as grassroots and activist organizing practices, parallel an evaluative learning approach (Brown, 2017; Absolon, 2022). Most recently, this approach is described as developmental evaluation and evaluative thinking (Patton, 2018).

remained a "supplementary" evaluation activity that dwelled on the margins of institutionalized discourses and practices of the CHCs.

In summary, evaluative efforts that contribute to a wholistic accountability (i.e., are participatory and aligned with goals of social justice and health equity) occur on the margins. They are rarely supported and resourced via formal accountability structures. Further, high turnover of frontline staff, increased service delivery targets, and overreliance on unpaid community volunteer labour erode existing elements of participatory evaluation design (Fursova et al., 2022). In the absence of wholistic accountability systems that would center, support, and resource community participation, evaluation practices struggle to stay aligned with key health promotion principles.

Discussion of Findings

This study examined health promotion reporting and evaluation practices of community health centers (CHCs) in the context of reporting and accountability requirements of their core funder, examining how institutional discourses, organizational practices, and methodological decisions may enable or impede the application of evaluation design consistent with key principles of health promotion. The findings presented speak to the research questions: i) What institutional discourses and organizational practices enable or impede the application of methods and tools that are consistent with key principles of health promotion? and ii) What methodological principles in evaluation support equitable power relations?

Before delving into the discussion of what the study findings might entail for health promotion evaluation, it would be diligent to outline some limitations and strengths of this research.

The knowledge cocreated during this participatory study is limited by the small sample size and the urban context of the participating CHCs. While funding conditions and reporting requirements of the core funder—the Ministry of Health and Long-Term Care—apply to all CHCs in Ontario, how reporting requirements and accountability discourses shape evaluation practices in rural and remote contexts may be different. Although designed as a combination of institutional ethnography and participatory action research, the community-based aspect of the research faced some constraints with respect to the resourcing of community members' full participation in the latter stages of the research such that final data analysis was conducted for the most part by the academic coauthor alone. Furthermore, funding for this research project and institutional research ethics protocols upheld a hierarchical division of labor, thus positioning the academic as the principal investigator in charge of the research process. A de-centering of this bias was to some extent achieved through establishment of the research advisory team, which enhanced validity through collaborative data analysis and member checking as well as co-authorship of this manuscript with a community partner (non-academic health promotion professional). Both actions were intentional and consistent with the commitments of intersectional feminist and participatory action research to sharing power in knowledge production.

The institutional ethnography methodology was of particular strength to the study. Not only did it allow for description of discrete themes related to challenges, successes, and lessons learned, it also enabled the explication of several phenomena as systemically connected and structurally embedded in the reporting and evaluation *system* in community healthcare. Through the undertaking of this research, three interconnected phenomena came to light: i) a clinical model and biomedical view embedded in the structure of reporting requirements; ii) methodological pressures and capacity constraints in health promotion evaluation; and iii) weakened community participation in evaluation. The study further identified how the overlay of these phenomena

generated an upward-oriented functional accountability bias which undermined each CHCs' capacity to design and implement evaluations consistent with key health promotion principles.

The imposition of a clinical model and biomedical view of health in the structure of reporting requirements rendered invisible the CHCs' outputs, outcomes, and impacts related to social determinants of health. Related methodological pressures and capacity constraints (of skills and resources) within health promotion evaluations discouraged attention to CHC principles of interdisciplinarity and undermined evaluation approaches more appropriate to the complex nature of health promotion work, i.e., qualitative, evaluative learning, developmental and participatory approaches. Despite their centrality to health promotion and health equity principles (Rootman et al., 2001; Nitsch et al., 2013) and to effective action in partnerships (Bilodeau et al., 2017), the early design and decision-making involvement of representatives from the communities that health promotion activities intended to benefit was rare. In effect, the CHCs' reporting and evaluation system rendered health promotion evaluation activities less meaningful for all actors involved—managers, frontline workers, and community members—and reduced the likelihood of evaluation practices consistent with key health promotion principles. The results of this study revealed, overall, how accountability discourses and practices for reporting and evaluation are consequential to an organization's strategic directions, resource allocations, and program and service delivery approaches.

To illustrate the systemic synergy and impacts of the three phenomena identified by this study, the coauthors share and describe here a mixed media collage (Figure 2, p. 31) created by Julia Fursova in the process of analysing and describing emerging findings. The collage, entitled *Reporting and Evaluation Puzzle in Health Promotion,* shows, in one top corner, reporting requirements spewing out of "the machine," represented by a vintage typewriter. The machine of functional accountability systems driven by neoliberal economics asks, "how much money did you spend?" Numbers float off, spilling toward the central part of the artwork, but only so far as to intermingle with some monetary coins. Images of birds, butterflies, and everyday paraphernalia (teabags, buttons) float about near the opposite and bottom corner of the collage where they remain distant from and outside the reach of the numbers, i.e., "invisible to the accountability system." These images represent diverse stories, voices, and a multitude of community health and well-being impacts and knowledges that, even when noticed by frontline staff, have no solid connection pathway to the organization's evaluation and strategic learning systems (which lack meaningful community participation). Segregation between the two evaluation viewpoints, or structural "frames," is expressed by an unclear but persistent spatial break between the juxtaposing metaphors and is further illustrated by two sections of a half-assembled puzzle that will not fit together. A few lone puzzle pieces float between. The collage employs elements of steampunk style to convey impressions of the industrial revolution and its logic of mechanisation and automatization, which permeate upward-oriented functional accountability systems. Simultaneously, the steampunk aesthetic conveys potential for curiosity, imagination, and discovery.

The three phenomena identified and described in this study are nested within an upward-oriented functional accountability bias that prioritizes reductionist cost effectiveness and performance measurements at the expense of key health promotion principles and goals. Layered together, they hinder the use of evaluation practices consistent with health promotion principles.

In effect, reporting requirements from the core funding body for CHCs in Ontario function as a neoliberal colonizing structure, undermining other forms of accountability, such as social accountability to communities served as well as peer and internal/professional accountabilities. The resulting evaluation system inhibits equitable and empowering participation of CHCs' health

promotion stakeholders in shaping evaluation designs and activities; further, it undermines the social justice and health equity potential of community health promotion practice. Reinforcing technocratic approaches, minimizing community member engagement, lacking contextual sensitivity, and centralizing knowledge production furthers the entrenchment of existing power relationships (Shwandt, 2009; Chouinard, 2013). In other words, the functional accountability bias and its related reporting requirements structurally reinforce the status quo through a system of evaluative regulation (reporting and evaluation knowledge production as "power over"). Meanwhile, such regulatory dynamics are largely concealed as "neutral" and uncritically internalized via texts of reporting and evaluation requirements (Foucault, 1982; Nickel & Eikenberry, 2009; Chouinard, 2013). These texts hinder evaluation design processes and methodologies that could move CHC and similar nonprofits' reporting and evaluation systems away from dynamics of domination and control and towards equitable partnership dynamics that highlight relationality and attend to reciprocity and "power with" (Eisler, 2008).

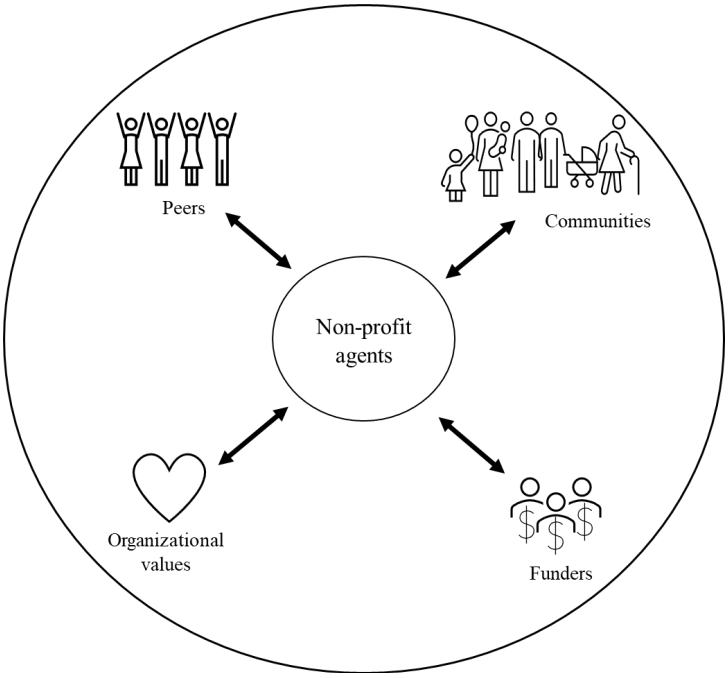
Figure 2. Reporting and Evaluation Puzzle in Health Promotion

An essential element of participatory action research is its action-orientation. In acknowledging the realities illuminated by this research, an important question begs exploration: What internal and external mechanisms could activate wholistic forms of accountability, to replace accountability models rooted in patriarchal and neocolonial views?

A wholistic accountability system framework was developed by the coauthors for the purpose of this paper. The framework was also informed by deliberative discussions in the coauthors' ongoing collaborations with some community members of the research advisory team. These deliberations sought to identify what kind of accountability system framework could align with an evaluative learning approach (reporting and evaluation knowledge production as "power with"), and which relational accountability dynamics would ensure that CHCs and similar community-based nonprofits answer not only to their funders' priorities but also to the priorities of community constituents and to CHCs' internal organizational values and health promotion peers.

In Figure 3 (p. 35), we present a framework titled "wholistic accountability system." This framework shifts the funder-oriented functional accountability interest away from the "top" and brings its locus into balance with community, organizational values, and peer accountability loci. These three loci, and their reporting and evaluation priorities are equally essential to effective social justice and health equity practice. As articulated by participants in this study (as well as in CHC and health promotion principles, vision, mission, and values texts), while community, organizational values, and peer loci may also have functional accountability concerns, they favor a more complex wholistic accountability framework characterized by broader evaluative learning objectives and activities. Functional concerns would show up as a smaller portion of their reporting and evaluation responsibilities and resources, and may emphasize different indicators.

Figure 3. Circular Framework for a Wholistic Accountability System



Building reporting and evaluation systems aligned with wholistic accountability can support the complexity demands of community and systems change processes for social justice and health

equity. Moreover, wholistic accountability favors empowering, participatory, and developmental evaluation approaches consistent with evaluative learning and aligned with critical social theory and health promotion principles. A wholistic accountability framework and system could facilitate CHC and other nonprofits' organizational change toward knowledge cocreation, as a part of a transformative systems shift toward "power with."

The literature already notes that approaching accountability and evaluation critically, and as a key strategic lever, may help social justice driven nonprofits redefine and achieve their highest values (Brown & Moore, 2001; Chouinard, 2013; Phillips & Carlan, 2018). Shifting nonprofits' axis of accountability in ways that reposition funder "agency" from relations of regulatory patronage to relations of partnership (Bilodeau et al., 2017; Kranias, 2018; Bilodeau & Kranias, 2019) and that integrate anticolonial commitments of community reciprocity (Wilson, 2020; Absolon, 2022) can reorient accountability toward a balanced, circular system of continuous learning and emergent strategy for social justice and health equity.

To enable evaluation practice consistent with key health promotion principles and to realign and rebalance accountability and governance systems toward equity, diversity, inclusion, and decolonization, we propose the following actions for stakeholders involved in evaluation activities and resourcing.

Funders, especially those who fund health promotion and systems change, can remove constraints and resource facilitators to advance the change they seek via these actions:

- Resource evaluation to inform organizational learning and program development.
- Ensure the designated budget for evaluation activities can sufficiently support program participants and service users to meaningfully participate in shaping and driving reporting and evaluation.
- Require evaluative learning considerations as a part of project proposals, using questions prompts that encourage participatory evaluation.
- Assess evaluation strategies for their alignment with key health promotion and systems change principles, and for their appropriateness to context, e.g., enabling equitable inclusion of people with lived experiences of an issue at hand.
- Build comprehensive capacity for participatory evaluation within the funding agency, and resource and motivate capacity development among grantees.

At an organizational level, to adopt participatory ways to knowledge cocreation and aligned governance, we propose to the executive leadership of community-engaged nonprofits:

- Ensure a designated core budget that supports comprehensive participatory evaluations.
- Integrate evaluative learning activities in organizational workplans, planning cycles, and general organizational culture.
- Continuously nourish organizational capacity for participatory evaluation.
- Sustain equitable participation of community members by sufficiently compensating their time, skills, and knowledge.

For frontline practitioners, we offer the following considerations:

- Integrate participatory evaluation principles and techniques in all forms and stages of evaluation, with particular attention to enabling community participation in codesign.
- Enable participation of a broader range of stakeholders by addressing access barriers such as child/eldercare, transportation, food security, meeting schedules and locations.
- Compensate community members for their time, skills, and knowledge.
- Stay committed to evaluative learning and reflective practice.

Conclusions

Using the example of two urban CHCs in Toronto, this research examined evaluation practices in community health promotion with respect to their alignment with key health promotion principles. The research revealed three interconnected phenomena shaped by the existing reporting and evaluation system and demonstrated how evaluation practice consistent with key health promotion principles is in fact impeded. The findings of this study highlight how CHCs and other nonprofits that increasingly pursue their social justice and health equity goals through a "systems change" commitment must grapple with their own positionality inside neoliberal and neocolonial accountability, reporting, and evaluation systems.

In their discussion of findings, the authors present a wholistic accountability framework as a lens for reorienting upward-oriented accountability systems toward a wholistic and relational system that balances accountability priorities among diverse stakeholders. Finally, the paper offers action pathways for funders, executive leadership, and frontline staff, all of whom are actors with essential responsibilities in systems change. We hope this article will contribute to broader awareness about the non-neutrality and multilayered impacts of accountability systems and how shifting to a wholistic accountability framework can support knowledge production choices and resourcing that work in synergy with CHC and nonprofits' passionate commitments to systems change for social justice and health equity.

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