A mixed method study of propensity for participatory evaluation

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ABSTRACT

One way to increase the use of evaluation results is practical participatory evaluation (PPE), which enables non-evaluator participants to join the evaluation process in a participatory mode. We examined the propensity for PPE of health professionals by focusing on four components: learning, working in groups, using judgment and using systematic methods. We interviewed the professionals at a Haitian health institution to determine their positioning on a scale of propensity (low, medium and high) for the four components. The professionals defined each component in relation to the energy puts into them, being more or less proactive. Facilitating elements for all three levels of propensity integration included past positive experiences, external pressure and a desire for better individual and organizational performance. Impeding factors included a lack of available resources perceived responsibilities and commitments toward private patients. The reported advantages included improved organizational performance and idea sharing, and the disadvantages included availability of, difficulty implementing solutions and altered human relationships.

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1. Introduction

More and more resources are being spent on the evaluation of health interventions due to legal obligations and to a desire to be accountable for results produced. We can assume that a better informed management will lead to better health care and therefore better health for the population. However, feeding data to management is not sufficient to ensure evidenced-based decision making, as the use of results, including evaluation results, does not necessarily occur spontaneously unless there are thorough diffusion procedures and/or processes to ensure managers understand reports. The success of PPE depends on the success of its constituent processes, the involvement of stakeholders that is supposed to improve the use of evaluation results, and lead to improvements to health care management.

To ensure the translation of evidence-based findings, including evaluation results, into action, practitioners and researchers have to build long-term collaborative commitments (Sussman, Valente, Rohrbach, Skara, & Ann Pentz, 2006). In the field of evaluation, collaboration is part of participatory evaluation (King, 2004), especially practical participatory evaluation or PPE (Cousins & Earl, 1992). The goal of PPE is to increase the use of results by having non-evaluator actors participate in the evaluation process.

Participatory evaluation is presented as an extension of the stakeholder-based model, which focuses on enhancing evaluation utilization through an increased depth and range of participation of primary users in the applied research process (Cousins & Earl, 1992). PPE aims largely to support programmatic or organizational decision making by involving stakeholders in certain aspects of the evaluation process (Brisolara, 1998). It is part of a larger concern about the use of data and the involvement of actors. Brisolara (1998) refers to the sociohistoric antecedents of PPE that were embedded in the global movement of consciousness-raising and community participation in actions, especially during the 1960s and 1970s. Such philosophical shifts translated into action-research models and eventually into evaluation through participatory evaluation processes (Brisolara, 1998).

Research is now starting to look at professionals’ participation in the evaluation process rather than just focusing on evaluators’ opinions with evaluation tools (Daigneault & Jacob, 2009) or resistance to evaluation.

Resistance to evaluation has long been documented, and it can take different forms, ranging from passive to more active. Resistance to evaluation (Datta, 2001; Monsen, 2002; Taut & Braun, 2003) manifests itself through anxiety (Donaldson, Gooler, & Scriven, 2002), a refusal to act (Hawkins & Sloma, 1978), a sabotaging of work processes (Perloff & Perloff, 1977) and passivity (Wilderman, 1979).
In the field of evaluation, the factors responsible for such behaviors relate to both individual and organizational/environmental factors (Kumar, Kant, & Amburgey, 2007). We were interested in moving beyond the concept of resistance to look at the propensity of health professionals for getting involved and participating in the evaluation process. We agree with Chalkley (2001) that there is interest in seeing resistance in a more positive way and that speaking of resistance might even be a "self-realizing prophecy" (Bennebroek Gravenhorst, 2003). In fact, it has been shown that resistance to change is low in some organizations and that individuals are supportive of change and have positive expectations with respect to change (Bennebroek Gravenhorst, 2003).

Authors previously defined propensity for evaluation as a continuum along which actors travel over time from a neutral position to a positive one, and which is a consistent and evolving orientation toward thinking and acting in an evaluative manner (Smits & Champage, 2008). Propensity for evaluation formalizes sensitizing concepts previously described in the evaluation literature—e.g., evaluative thinking (Patton, 1998) and a culture of inquiry (Hernandez & Visher, 2001)—and participative climate (Jacob & Ouvrard, 2009).

More precisely, propensity for PPE is defined as a propensity toward four different components of PPE: learning, working in groups, using judgment and using systematic methods. Jacob refers to a disposition to learn, to work in teams, to capacity for judgment and rigorous research (Jacob & Ouvrard, 2009). Others relate to the diversity of stakeholders involved in the process (Cousins, 2001; Greene, 1988), their participation at a certain level (Cousins, Moh, Clark, & Lee, 2004; Turnbull, 1999) and the production of knowledge during the evaluation processes (Cousins, 2001; Greene, 1988).

In this research, we examined the factors that influence propensity for PPE by studying these four components in the practices of health professional managers, both as it relates to evaluation and to other contexts. Understanding what influences propensity for PPE and therefore the participation of participants in the participatory evaluation process can reveal ways in which to develop actions, increase participation, improve the effectiveness of the process, and increase the use of evaluation results. This information might help us understand and respond to some of the current controversial benefits of participative approaches of evaluation on decision-making and practices (Orszag, 2009).

In this research, we first developed an ordinal scale using a mixed method analysis to characterize propensity level. We then identified the influences on propensity for PPE—both facilitators and barriers—based on the level of propensity in health professionals. Influences include facilitating elements, impeding elements/barriers, advantages and disadvantages as expressed by health managers and the report when asked about the four components of propensity for PPE in their practice, both as it relates to evaluation and to other contexts.

2. Mixed method design for studying propensity for PPE

2.1. Mixed methodology

For this particular research, the mixed method design consisted of three distinct phases: 1) developing a scale through a triangulation design data transformation model, 2) positioning health professionals using an explanatory design, and 3) using an embedded correlational model to relate the influences to level of propensity for PPE (Fig. 1).

We first used a triangulation design, which involves the collection of both qualitative and quantitative data on the same...
topic (Creswell & Plano Clark, 2006) – in this case, level of propensity on a scale as scored by the individuals and as expressed qualitatively during interviews. We collected both types of data so that we could compare results across individuals. Keep in mind that no standardized scale is yet available for propensity for PPE. The qualitative and transformed quantitative data were then compared to generate an ordinal scale.

In the second phase, we positioned each health professional on the scale for propensity for PPE that we created in phase 1. We used the explanatory mixed method, which involved collecting qualitative data to characterize the positioning of each individual. The reason for the explanatory design, including phases 1 and 2, is to help position health professionals on their propensity for PPE. In the final phase, we used an embedded design in which the position of each health professional on the scale is justified by his or her understanding of the influences on propensity for PPE. The primary purpose here is to highlight the influences on propensity, while the secondary purpose is to relate these influences to level of propensity. See Fig. 1 for a schematic representation of the full methodology.

2.2. Data collection

The quantitative data consisted of scores for each mechanism: learning, working in groups, use of judgment and use of systematic methods. Each mechanism was given a score ranging from 0 to 10, with 0 corresponding to an absence of the mechanism and 10 corresponding to the highest intensity possible.

The data were mainly collected during semi-structured interviews with 16 health professionals (out of a possible 18) from one health institution in Haiti between 2008 and 2009. We targeted potential health professionals who could be involved in PPE. These interviews addressed various elements that might affect an individual’s positioning with respect to each of the four components of propensity for PPE.

The first set of questions concerned the individual’s attitudes and experiences related to learning, working in groups, using judgment and using systematic methods in general. These data and their analysis is presented in another article. The second set of questions revealed how each health professional sees him/herself in comparison to colleagues in terms of learning, working in groups, using judgment and using systematic methods in general. These data form the basis of this article.

Additional documents and observations were added as secondary sources. One interviewer collected data in person and subsequently when there were missing data (that is, data that were not collected during the interview). All but two interviews were taped. In total, 69% of the interviewees had trained as physicians, and 44% were completely or mainly in charge of administrative activities while the rest served as both clinicians and managers for their unit. About two-thirds were male. They had an average of less than one year of management training, an average of almost one year of management work experience and greater integration of learning into activities in daily practice and greater integration of learning into future plans.

2.3. Data analysis

The interviews were transcribed in their entirety. We first analyzed them using an open coding system with QDA Miner v3.0.3., and then using a framework-based axial coding. The coding strategy used emergent and predetermined categories. Predetermined categories included learning, working in groups, using judgment, using systematic methods, advantages, disadvantages, and influencing factors. Emergent categories, such as direction of influence, frequency of actions and type of factors, were also taken into consideration.

For quality purposes, we discussed the coding grid with a group of experts before starting the coding. The group had both theoretical and empirical training in qualitative data analysis. Members had experience in conducting research and carrying out interventions in healthcare organizations and in developing countries. The group discussed the emergent codes and possibilities for regrouping the preliminary codes.

As another stabilizing procedure, we used inverse coding, looking at the consistency of verbatim with each meta-code. A lexicon of codes helped clarify the codes. The interviewer made notes during and after each interview as well as reflective notes throughout the coding and analysis process. These data, case summaries, interview notes and reflective notes were analyzed along with the transcripts to classify the interviewees on the scale for propensity. For subsequent analysis, we compiled summaries of the code extracts and wrote case summaries for each interviewee.

We obtained an overall ranking for each individual by attributing a score of 1 for low level, 2 for medium level and 3 for high level. We then summed the four scores for each individual. Any individual with a score under 8 was deemed to have low propensity for PPE, while a score of 8 to 10 was considered medium level and over 10 was considered high level.

3. Results

3.1. Identification of propensity level through the development of a scale using a mixed method design

As an initial framework of analysis, we divided propensity for PPE into four components: propensity for learning, propensity for working in partnership, propensity for exercising judgment and propensity for using systematic methods (Smits, Champagne & Blais, 2009). After analysis of the health professionals interviewed, we realized they do relate to each component upon their frequency, more or less often, and level of integration, more or less integrated into their habits.

Based on the opinions of the health professionals with respect to the propensity of their colleagues (Table 1), we elaborated a nominal definition (Babbie, 2001) for propensity for PPE. This definition distinguished levels for each component.

Various levels of propensity for learning emerged from the data (Fig. 2). Propensity was revealed by an individual putting him or herself in a position to learn or through putting into place an important practice aimed at increasing learning for himself and others. The profiles of the health professionals showed varying levels of enthusiasm for learning:

- Opportunistic: The individual functions with his or her acquired knowledge, achieving below expectations on learning activities. At times, he or she joins activities even when they are not directly relevant to his or her present job.
- Motivated: The individual is available when opportunities arise. Participation in activities is common, and the individual responds to the expectations of peers.

Greater enthusiasm for learning is associated with greater seeking of learning opportunities, greater inclusion of learning activities in daily practice and greater integration of learning into future plans.
The health professionals also showed different levels of propensity with respect to working in groups or with partners (Fig. 2):

- **Supportive**: The individual usually works individually when managing his or her team. He or she might, in response to a specific request, consult partners but might not integrate their comments.
- **Active**: The individual is often involved in discussions to fix problems in daily practice. Solutions to problems are often implemented collectively upon problem sprouting. The individual reacts actively to a specific event.
- **Leader**: The individual uses collective discussions to find solutions. We take every decision collectively. We discuss about solutions, not using votes but disagreeing and deciding upon the solution to adopt.

The health professionals also showed different levels of propensity for PPE, as reported by the health professionals (Fig. 2). The data show that the health professionals varied in the level of reactivity: individuals being more or less active in making decisions. These levels were based on the intensity of propensity as reflected in the level of reactivity: individuals being more or less active in learning activities, in group work, in the use of judgment in appreciating information worth, and the use of systematic methods in decision making. These results emphasize the reactivity aspect of individual propensity (iPropensity) for PPE in this article.

Each health professional could be positioned as either low, medium or high for each of the four components of PPE. Some ranked quite low (3, 6, 7, 9, 16), while others ranked quite high (1, 3, 13, 14). The rest fell somewhere in the middle (2, 4, 5, 8, 10, 11, 12, 15). It was expected that those health professionals with greater experience or training would be more open to use structured tools and/or systematic procedures. In the questioning stage.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Levels</th>
<th>Extract of verbatim (translation)</th>
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</table>
| Learning                     | Enthusiastic            | “We could refuse to participate but does never happen and never will. Why? Because we think for X to be trained, we trainers require an outstanding level too. And it is the reason why we have a small library, we try to keep it. The health professionals also showed different levels of propensity with respect to working in groups or with partners (Fig. 2): the questioning stage.

- **Supportive**: The individual usually works individually when managing his or her team. He or she might, in response to a specific request, consult partners but might not integrate their comments.

- **Active**: The individual is often involved in discussions to fix problems in daily practice. Solutions to problems are often implemented collectively upon problem sprouting. The individual reacts actively to a specific event.

- **Leader**: The individual uses collective discussions to find solutions. We take every decision collectively. We discuss about solutions, not using votes but disagreeing and deciding upon the solution to adopt.

Using judgment

- **Active**: The individual can either meet with the journalist directly to learn his opinion, or to inquire into his sources of information. “I can either meet with the journalist directly to learn his opinion, or to inquire into his sources of information.”

- **Reactive**: The individual reacts verbally and promptly without analyzing the root of the issue or problem. “I will try to speak with him, to calm him down and then, I will go to the unit and try to find the staff that witnessed the situation to know what happened.”

- **Latent**: The individual reacts in an emotional manner or does not react at all. “I do not pay attention, I come to work, do my job and then I forget it all. But during our meetings, I tell to the staff to be attentive to their behavior, and relate what I just heard from a journalist.”

Using systematic methods

- **Participant**: Most of the individual's actions are informed. He or her leadership allows for the emergence of reflection. “The data I would seek for would be: where does the information comes from? What can motivate this written comments? Can I see the data that served to draw such comments? And I will use the feedback from the journalist to inform my staff and understand what is happening.”

- **Active observer**: “Well, because I think I am not doing it often enough, for frequency reason, and also I do not really develop any rigorous plan.”

- **Passive observer**: “We know about it, you just have to look wherever they go for trainings, they always stay there.”

The health professionals could exhibit differing levels of propensity for each of the four components individually and for overall propensity (all four components combined). Three levels of propensity could be distinguished: low, medium and high (Fig. 2). These levels were based on the intensity of propensity as reflected in the level of reactivity: individuals being more or less active in learning activities, in group work, in the use of judgment in appreciating information worth, and the use of systematic methods in decision making. These results emphasize the reactivity aspect of individual propensity (iPropensity) for PPE in this article.

Each health professional could be positioned as either low, medium or high for each of the four components of PPE (Fig. 3). The data show that the health professionals varied in their overall propensity for PPE. Some ranked quite low (3, 6, 7, 9, 16), while others ranked quite high (1, 3, 13, 14). The rest fell somewhere in the middle (2, 4, 5, 8, 10, 11, 12, 15). It was expected that those health professionals with greater experience or trainings would be more open to use structured tools and/or procedures. But this was not the case.

### 3.2. Identification of the influences on propensity for PPE

We now describe the factors that influence the reactivity aspect of propensity for PPE, as reported by the health professionals...
interviewed. These were factors that the professionals said affect the four different components of propensity for PPE. These influences are either elements that modify propensity, such as facilitating and impeding elements, or elements that come from the results of participation in activities, such as anticipated advantages and disadvantages.

3.3. Facilitating and impeding elements

Past experience was a common facilitating element across all levels of propensity. Past experiences in the form of past positive activities or observing a role model influenced the approach used in future situations (Table 2):

I used to work for hospital X where everything went smoothly, every time a problem arose, there was a meeting and everyone had to know, so I witnessed how an institution should function properly. That is the reason why I continue to work like this.

The responsibilities of a position that a manager occupies brings with it a specific and expected attitude with respect to level of involvement in an activity and commitment to the process. Two aspects are determinant: the attributes and expectations that come with the position and the limitations imposed on the position by the hierarchy. Some of the health professionals expressed some unease with the upper hierarchy, unable and/or unwilling to capacitate them and to react appropriately in specific circumstances. Thus, the professional sphere “tattoos” a certain level of propensity for PPE on an individual. The social sphere has a similar effect: the position one seeks to occupy in society, as an individual who receives from and owes to his or her fellow citizens, and as a health professional engaged with its patients, “prints” a specific stance with respect to propensity for PPE because this position favors a certain propensity for PPE:

In general I think it is important to assist in whatever training is offered. Not only in respect to my position but also because I should have a diversified knowledge in medicine and people you meet in the streets regularly ask for advice. So we have to be well informed.

Overall, the main elements that affect propensity for PPE can be divided into the following themes: past models (either experiences or individuals), the perceived responsibilities of the position, the availability of resources, positional pressure, professional commitment, voyé monté (a Creole term that means the credibility of the source, of the data and of ways to transfer some comments).
### Table 2
Elements that facilitate and impede PPE by propensity level.

<table>
<thead>
<tr>
<th>Influences on low propensity group</th>
<th>Influences on medium propensity group</th>
<th>Influences on high propensity group</th>
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</thead>
<tbody>
<tr>
<td><strong>Facilitating elements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive past experiences</td>
<td>– Positive past experiences</td>
<td>– Past positive individual models</td>
</tr>
<tr>
<td>Responsibilities related to</td>
<td>– Responsibilities related to</td>
<td>– Awareness of limited individual</td>
</tr>
<tr>
<td>university status</td>
<td>hierarchical position</td>
<td>competencies</td>
</tr>
<tr>
<td>Responsibilities related to</td>
<td>– Responsibilities related to</td>
<td>– Search for individual satisfaction</td>
</tr>
<tr>
<td>hierarchical position</td>
<td>hierarchical position</td>
<td></td>
</tr>
<tr>
<td>Pertinence of opinions</td>
<td>– Pertinence of opinions</td>
<td>– Search for professional</td>
</tr>
<tr>
<td>Organization of complex services</td>
<td>– Organization of complex services</td>
<td>recognition</td>
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<tr>
<td></td>
<td></td>
<td>– Importance given to quality</td>
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<td></td>
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<tr>
<td><strong>Impeding elements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment perceived as an</td>
<td>– Environment perceived as an</td>
<td>– Absence of external reflexion</td>
</tr>
<tr>
<td>obstacle</td>
<td>obstacle</td>
<td></td>
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<tr>
<td>Responsibilities toward the family</td>
<td>– Responsibilities toward the family</td>
<td>– Excessive external reflexion</td>
</tr>
<tr>
<td>Responsibilities related to</td>
<td>– Responsibilities related to</td>
<td>– Responsibilities as a parent</td>
</tr>
<tr>
<td>hierarchical position</td>
<td>hierarchical position</td>
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<tr>
<td></td>
<td></td>
<td>– Commitment toward patients from</td>
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<td></td>
<td>the private sector</td>
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</table>

![Fig. 3. Positioning of the health professionals on the four components of propensity for PPE.](image-url)
Health professionals in the low propensity group spoke about favoring elements of propensity in terms of customary daily activities and responsibilities:

*In general, all departments do this — they work in groups —, this is what I see in other departments. Before being appointed chief, I was here, and the previous chief used to meet with us often. So I got used to doing the same thing.*

Those with higher levels included favoring elements of individual and social aspects as well as a concern for quality — in the type of information or in the doing of actions — in their practice:

*[During trainings,] we get to meet new colleagues, learn more about a particular domain and update our knowledge, which can be used to improve performance and services in the institution.*

Finally, facilitating elements include past experiences and models, responsibilities of the hierarchical position, concern for performance, external pressure and personal involvement. Some elements, like past experiences and responsibilities linked to the hierarchical position, were seen in all three groups.

The influence of some elements increased with increasing level of propensity — for example, concern for performance as reflected in the pertinence, productivity and the achievement of results. Other elements emerged at higher levels, including external pressure, which was associated with medium and high propensity. The professionals in the high propensity groups reported a greater number and diversity of favoring elements. A concern for organizational results and individual involvement were specific to the high propensity group:

*I'm the manager so I can't just leave things in that state. I know it's not normal like that. So I wanted it [the unit] to work well, so I pushed for it. In the past few years, I have been pushing myself too hard, I have been pushing everyone to work. Once I get going, I try to get the others going too.*

At a more microscopic level, some professionals found the family to be a source of support, while others found it to be an obstacle. Resources (and lack thereof) were not a predominant category cited by the health professionals.

While facilitating elements cumulate from a group to the other, on group higher propensity express favoring elements from the lower group plus newer ones, each propensity group showed a different subset of impeding elements.

<table>
<thead>
<tr>
<th>Advantages of PPE</th>
<th>Medium propensity group</th>
<th>High propensity group</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reinforces organizational performance</td>
<td>- Improvement in practices</td>
<td>- Improvement in the technical and nontechnical quality of services</td>
</tr>
<tr>
<td>- Support for knowledge transfer</td>
<td>- Reinforcement of productivity</td>
<td>- Provides tools for organizational management</td>
</tr>
<tr>
<td>- Support for information awareness</td>
<td>- Control of activities</td>
<td>- Creation of an innovative environment</td>
</tr>
<tr>
<td>- Informing for organizational change</td>
<td>- Improvement in organizational performance</td>
<td>- Identification of problems</td>
</tr>
<tr>
<td>- Exposure to new, stimulating ideas</td>
<td>- Problem solving</td>
<td>- Collective building</td>
</tr>
<tr>
<td>- Distribution of tasks</td>
<td>- Creation of interpersonal contacts</td>
<td>- Individual enrichment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disadvantages of PPE</th>
<th>Medium propensity group</th>
<th>High propensity group</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Unavailability of necessary resources</td>
<td>- Absence of resolution opportunities</td>
<td>- Modification of professional relationships</td>
</tr>
<tr>
<td>- Overlap with time for regular practice</td>
<td>- Lost of time</td>
<td>- Relational side effects</td>
</tr>
<tr>
<td>- Exposure to unpleasant consequences</td>
<td>- Requires personal concessions</td>
<td>- Weaknesses in individual performance</td>
</tr>
</tbody>
</table>

**Table 3**

Advantages and disadvantages of PPE by propensity level.
organizational and societal, and also to the individual/health professional level. They stressed disadvantages related to the individual and social “bubbles,” mainly relationship related in nature.

We initially assumed that a high propensity for PPE would be associated with more advantages than disadvantages. However, these data do not show such an effect, although the groups did exhibit differences in the emphasis placed on results versus process and in the influence of human relational factors. The advantages reported by the high propensity group relate to process tools: PPE and its four components would allow for the development of materials or the elaboration of information to facilitate processes:

If you can get resources you can get it done. Not necessarily financial resources but process modifications that might improve the situation.

By contrast, the other two groups saw the advantages of PPE in terms of results that might emerge from actions:

It goes faster to work together. To get results we have to work as a team.

In addition, professionals in the medium and high propensity groups, but not the low propensity group, mentioned disadvantages related to relational issues, including the need to modify relationships with colleagues and compromise.

Finally, and contrary to initial assumptions, the groups did not appear to vary in the type and number of advantages and disadvantages reported. However, the groups were distinct in that for the high level group, the advantages focused on process rather than results, and the disadvantages focused on human relational aspects.

### 3.5. Summary of influences on propensity for PPE

The reactivity aspect of PPE components was influenced, for all of the professionals interviewed, by experiential elements, advantages and disadvantages, and perceived influences (Fig. 4). Perceived influences belong the political arena – the responsibility of the professional within his or her organization and the upward pressure exerted (or not) on him or her. The social image one wants to project and their social commitment partly influence whether or not a professional will join PPE activities and the type of actions he or she will carry out during PPE (which is also affected by the availability of certain resources). Note the role of positive experiences as a source of motivation and the absence of dialogue around anterior negative experiences. The importance (or not) that health professionals attribute to tool-informed processes and to modifications in relationships are main perceived advantages and disadvantages.

Through the identification of influences, we can distinguish dramatic differences between lower and higher propensity groups. Higher propensity groups see events as opportunities, as events upon which they can act, rather than as imposed constraints. Lower propensity groups have a dichotomous view: an event is by nature an obstacle or a facilitator. They exhibit a more static, almost fatalistic, vision; they believe they do not have much leverage or power. Indeed, the high propensity group reported more facilitating elements for their involvement in PPE than did the low and medium propensity groups. While some facilitating elements were common to all three groups, the high propensity group expressed some elements unique to their group.

By contrast, the impeding elements were group specific. Professionals with high propensity tended to measure the impeding elements according to its strength, while those with lower propensity always perceived these factors to be an obstacle that prevented them from moving forward.
While higher propensity groups envision the environment as having possibilities they can act upon, they consistently perceive actions as a means to an end – as processes –, whereas lower propensity groups display a static vision: results are the aim and less consideration is paid to the ways in which the results can be reached and the benefits of interactions and of building processes. In essence, a shorter-term vision focused on immediate results is pitted against a longer-term vision with a focus on the importance of building solid foundations. Indeed, advantages for the high propensity group related to the development of materials or the elaboration of information to facilitate processes. Such advantages have also been discussed in work based on communication theory, especially in the area of knowledge transfer, where the need to apply relevant communication tools has been stressed (Rich, 1991). The lower propensity groups saw the advantages of PPE as related to the results that could emerge from actions derived from PPE.

The disadvantages reported by professionals with low propensity never referred to relational aspects, or to the need to modify relationships with colleagues or compromise, factors which were mentioned by professionals in the high propensity group.

4. Conclusion

The objective of this study was to determine what factors facilitate versus impede propensity for PPE. When managers had previous experience with activities related to PPE, they were influenced by the consequences of this past experience and distinguished advantages and disadvantages. The environment in which the managers lived and worked also influenced their propensity for PPE. Accordingly, the image that society expected them to reflect as professionals, and their work environment, both macro and micro, contributed to determine their PPE. Further analysis enabled us to distinguish the characteristics of managers at various levels of propensity for PPE.

Using a mixed method study, we were able to characterize individual propensity for PPE based on three levels of integration into habits: low, medium and high propensity. These levels of propensity were based on four components: learning – high versus low enthusiasm for learning; working in groups – following versus initiating; using judgment – depth of reactions; and using systematic methods – high versus low level of expertise. We determined the propensity level for each health professional by questioning them about the influences that facilitate and impede PPE and about the advantages and disadvantages of PPE components.

In general, the low propensity group was affected by a constraining environment and a focus on short-term results. They did not consider events to be actionable: rather, they viewed events as being by nature barriers or facilitators. They saw themselves as having little leverage to instigate or contribute to change. By contrast, the high propensity group viewed events as actionable: they exhibited a focus on processes, an attention to individual achievement and a long-term perspective. They considered the external environment to be a resource upon which they could act. They saw themselves as active actors able to modulate processes and achieve better individual performance.

The existing literature reflects some of these findings. The key role played by support from upper levels in the organizational hierarchy has been highlighted in a number of different research areas: the conditions necessary for evaluation capacity building (Newcomer, 2004), the acceptance of measurement (Franklin, Mackie, & Rigby, 2005), and the role of broader political support in empowerment (World Health Organization, 2006). Resources (and lack thereof) was not a predominant factor cited by the health professionals of this study, a result that confirms the findings of an earlier study on the development of measures (Franklin et al., 2005). An awareness of an existing lack of competencies did not seem to be a barrier to PPE for the managers interviewed, as has been previously found with teachers’ participation in evaluations (Ziobrowski, 1993).

In general, these results suggest some promising avenues to explore for funders, evaluators and professionals.

The disadvantages reported by professionals with a high level on PPE highlighted concerns for and interest in individual performance.

Another lesson is that care needs to be taken to ensure that the PPE experience is successful so as not to impede future PPE activities. This is clear from our finding that past positive experiences have a positive influence on propensity for PPE. Concomitantly, negative experiences might have a negative influence on future propensity for PPE, although the health professionals interviewed did not mention extracting lessons from these negative experiences. This result is complemented by action-research, which shows that negative experiences with action research impede the next research process for both researchers and community members (Israel, Schulz, Parker, & Becker, 1998; Sullivan et al., 2001a, 2001b). So it is important that particular attention be paid to positive experiences.

Evaluators have to be aware of such human aspects during PPE, in particular as they pertain to professionals with higher propensity because these individuals seem to be more preoccupied with such aspects. The field of evaluation already considers this human aspect as a part of identifying evaluator competencies (Doré & Marceau, 2006).

These results are based on an analysis of qualitative and quantitative data from health professionals at one institution. Transferring these findings to other institutions in Haiti and to health professionals in other developing and developed countries should be done with caution. We selected a design that would enable us to examine propensity for PPE in detail, rather than on that would allow us to statistically extend our results to other institutions and countries. However, while the results cannot be extended based on numerical logic, they can be extended based on theoretical logic. Several aspects could limit such extrapolation: the availability of financial resources, the national and local organizational context, and the familiarity of health professionals with evaluations. In Haiti, as well as in other developing countries, resources for carrying out daily activities in the health sector, including evaluation, are limited or lacking. Resources in the health care sector are also limited in developed countries, with a considerable portion of overall national budgets going to this sector (World Health Organization, 2006). So the level of resources dedicated to evaluation in both developed and developing countries becomes an important issue, one that may significantly influence propensity for PPE.

In terms of the organizational context for evaluation, the constraints imposed by international funding agencies in developing countries are often not that different from those imposed in developed countries. For example, the policies governing the evaluation process and the technical requirements for evaluation are not dramatically different between these two contexts. However, the overall purpose and use of an evaluation commissioned from outside may bring political factors to the forefront and influence managers’ propensity for PPE. It may, for example, influence the responsibilities that health professionals are required to assume, which may in turn influence their propensity for PPE.
We can also assume that top managers in ministries, managers at the regional level and local managers are all working under different constraints.

The influence of health professionals with evaluation would affect propensity for PPE: one would expect that the more familiar a professional is, the higher his or her propensity for PPE. Indeed, our results show that past experience is a facilitating factor for professionals across all levels of propensity. The health professionals that we interviewed had either no or only limited previous experience with evaluation per se. This lack of familiarity with PPE will most certainly also be found in other developing countries because many internationally funded evaluations are done by external evaluators.

In developed countries, even internal evaluations are not usually carried out by the manager itself but more often by commissioned staff.

In general, then, differences between settings in certain factors may not be so great as to prevent the translation of results to other settings. At this stage, we do not have specific reason to believe that we could not apply our knowledge of, and reflection about, PPE and propensity for PPE to other sectors. For instance, the health sector certainly has some similarities to other fields, such as the education field: both health professionals and educators sometimes join their respective fields for ideological reasons and/or because of personal conviction. Differences in the degree of personal involvement may make extrapolation from our results difficult; for example, to a sector in which higher level managers are not in direct contact with patients/clients, they may show different level of concern for the organization of direct patients’ services and for PPE.

One main recommendation that arises from our findings on what elements positive versus favor propensity for PPE is the following: evaluators and evaluation commissioners could work to move participants from a low to high level of propensity. This could involve strengthening the factors that facilitate propensity and emphasizing the advantages of PPE, and/or addressing the factors that impede propensity and the perceived disadvantages of PPE. When evaluators work with groups of managers with a low propensity, they could show them the individual benefits of their participation in such an enterprise. The PPE process could be structured so as to allow more time on building and developing processes. Emphasis could be placed on the managers’ environment and how managers can respond to what appears, at first sight, to be non-actionable events. Of course, it is important to consider the initial level of propensity: moving managers from a low to higher level may require different approaches than moving managers from a medium to higher level.

Our recommendation that organizations attempt to move managers to higher levels of propensity for PPE is based on the assumption that higher levels are related to more involvement in the practice of PPE, which increases the quality of the evaluation process and the quality of evaluation results. While these links still need to be investigated further, there is some support for such an assumption. In this study, managers in the high propensity group exhibited a positive attitude toward the basic mechanisms of PPE: learning, working in group, using judgment and using systematic methods. As assumed by participatory evaluation’s theorists, learning would have significant repercussions on the understanding of evaluation results and on the use of these results in decision making. High-propensity managers should, therefore, display a higher level of understanding and use of evaluation results.

High propensity for PPE is associated with a recognition of the importance of both organizational and individual performance. As some researchers have argued (Nonaka, Toyama, & Byosiere, 2003; Smits et al., 2005), organizational changes emerge when an organization’s individual members mobilize to create future organizational learning and a culture of evaluation. Therefore, managers with high levels of PPE and a concern for organizational performance are expected to bring about the organizational change related to evaluation.

High propensity for PPE is associated with a focus on process rather than results. This aspect is consistent with a participation dynamic and the long-term anchoring of evaluation in individual and organizational investigational practices. In general, it is expected that higher levels of propensity for PPE will generate the conditions needed for a more effective participatory evaluation process and an increased quality of evaluation results.

Future research on PPE and propensity for PPE could address the development of formalized tools for environmental scanning and the detection of opportunities; for example, a questionnaire to measure level of propensity. Researches could also examine the influences on propensity and verify if different levels of propensity for PPE emerge in health professionals over time. One could also examine the relationship between propensity for PPE and participation in PPE, and determine whether propensity for PPE and the use of PPE process and/or its results are correlated.

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