Interest-Holders' Experiences with Evaluating Health-Related Outcomes in Community–Campus Engagement Partnerships

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Abstract

Community–campus engagement (CCE) partnerships are increasingly using program evaluation to examine health outcomes; however, little is known about how these evaluations are conducted or the barriers that partners face when implementing them. This exploratory study involved the thematic analysis of 21 semi-structured interviews with academic and community interest-holders in Canadian health-focused CCE partnerships. Most participants described relying on informal feedback or basic monitoring, with fewer instances of structured, theory-driven evaluation. Reported barriers emerged at four levels: individual/project (limited evaluation literacy, data quality and inclusion, late integration of evaluation), organizational (limited resources, lack of institutional commitment), partnership (fragmented data systems, power asymmetries), and systemic (funder constraints, methodological misalignment, attribution challenges). Findings indicate that the relational, iterative, and multi-actor nature of CCE can conflict with conventional evaluation models emphasizing standardized indicators or causal attribution. Practical strategies are proposed to support evaluation capacity building of CCE partnerships, along with priorities for future research, including the skills and supports needed for context-sensitive designs and the evaluation of long-term health impacts.

Community–campus engagement (CCE) refers to partnerships between academic institutions and community organizations that combine resources, expertise, and perspectives to address shared priorities (Bringle & Hatcher, 2002; Drahota et al., 2016). These partnerships typically involve a diverse range of interest-holders (Akl et al., 2024), including post-secondary institutions, research centres, public health professionals, municipal administrations, community-based organizations, and residents (Berkey et al., 2018). Academic partners often contribute research infrastructure, methodological expertise, and access to data systems, while community partners bring contextual knowledge, trust-based relationships, and a deep understanding of local needs and priorities (Drahota et al., 2016; Schwartz et al., 2016).

In recent years, CCE partnerships have become more prominent in the health sector as a promising way to tackle complex local health issues and improve population health (James et al., 2024). These partnerships often aim to co-develop local health initiatives, produce and use context-specific evidence to tailor health interventions to local populations, and enhance health-related policies, funding mechanisms, and service delivery models to promote equity and access (Collins & Hayes, 2010; Naylor & Buck, 2018; Efird-Green et al., 2023; James et al., 2024). Several municipalities are now integrating CCE into their strategic planning, making these partnerships a key part of efforts to reduce local health inequities and improve community well-being (Buetti et al., 2025; CityStudio Global, 2021).

Program evaluation (hereafter referred to as evaluation) is defined by the Canadian Evaluation Society (n.d.) as the "systematic assessment of the design, implementation or results of an initiative for the purposes of learning or decision-making" (para. 3). Evaluation can support learning, accountability, and informed resource allocation and is increasingly recognized as central to sustaining and scaling collaborative, health-focused initiatives (Patton, 2008, 2010; Block et al., 2018; DeZelar et al., 2024). With the growth in the number and scale of CCE partnerships, funders, public institutions, and interest-holders are placing greater emphasis on demonstrating partnership value, particularly through outcome evaluations that offer evidence of broader health impacts (Anderson et al., 2025; Horowitz et al., 2009; Kuttner et al., 2023). However, despite this growing demand, little empirical research has examined how evaluations of health-related outcomes are designed and implemented in practice. Existing

studies often focus on implementation processes or process-oriented indicators (for example, trust-building and shared governance), offering limited insight into the methods, scope, and use of outcome-focused evaluations (Clark et al., 2023; Kuttner et al., 2023).

Understanding how interest-holders in health-focused CCE partnerships approach outcome evaluation and the barriers they encounter is essential to informing evaluation capacity-building strategies and developing approaches that are responsive to the relational, iterative, and multi-actor nature of CCE. This study addresses this need by examining the evaluation practices employed in CCE partnerships to assess health-related outcomes and the challenges interest-holders encounter when implementing such evaluations. The following research questions guided this study:

- RQ1. What evaluation practices do interest-holders use to assess health-related outcomes in CCE partnerships?
- RQ2. What challenges do interest-holders face in implementing evaluations of health-related outcomes within these partnerships?

Literature Review

The Role of CCE in Population Health

Population health refers to the health outcomes of a group of individuals, including how those outcomes are distributed across populations due to social, environmental, and structural determinants (Kindig & Stoddart, 2003). CCE partnerships can contribute to improving population health by integrating research, education, and service in ways that are responsive to local health needs and grounded in reciprocal relationships (Anderson et al., 2025; Efird-Green et al., 2023). The literature identifies different forms of CCE (Schwartz et al., 2016). Community-based research emphasizes co-developing studies with local partners to produce actionable knowledge on issues defined by the communities themselves (Horowitz et al., 2009; James et al., 2024). Community service learning connects students with organizations through service activities that apply academic knowledge, while experiential placements immerse learners in settings where they engage with real-world health issues (Berkey et al., 2018; Block et al., 2018). All these forms can yield positive outcomes for both community health and academic learning. In recent years, several municipalities in Canada have formalized CCE in their strategic planning, integrating these partnerships as a central element of their efforts to address local health challenges and improve population health outcomes (Buetti et al., 2025; CityStudio Global, 2021).

The Importance of Evaluation in CCE Partnerships

As funders, public institutions, and local partners increasingly expect CCE initiatives to demonstrate their impact on health challenges, evaluation has become essential to guide decision-making, support learning, and demonstrate results (Anderson et al., 2025). Evaluation can serve multiple purposes depending on the stage and needs of CCE interest-holders (Block et al., 2018). Formative evaluation, conducted during early development or initial implementation, helps identify strengths, challenges, and areas for improvement, supporting program refinement as it evolves (Patton, 2008). Summative evaluation, undertaken once an initiative is completed, assesses overall effectiveness and whether expected outcomes—such as changes in health behaviour, increased service access, or enhanced well-being—have been achieved. Developmental evaluation is particularly relevant in complex and dynamic contexts like many CCE initiatives, as it provides real-time feedback to support continuous learning and adaptation as conditions change (Patton, 2010). Depending on the evaluation goals and questions, evaluators may use a range of methods, including surveys, interviews, focus groups, observations, administrative data, and case studies (Bourgeois et al., 2023). These methods can be applied using qualitative, quantitative, or mixed-method designs, tailored to the context and information needs of interest-holders (Bourgeois et al., 2023).

Challenges in Evaluating Health-Related Outcomes in CCE Partnerships

Despite the recognized importance of evaluation, empirical research on how it is practiced within CCE partnerships remains limited. Much of the existing literature focuses on lessons learned and best practices in implementing CCE partnerships, offering little insight into how evaluations are designed, conducted, and used in applied settings (Anderson et al., 2025; Clark et al., 2023). Among the limited studies that examined evaluation practices used by CCE partners, most describe a focus on relational or process-oriented indicators, such as trust-building and shared governance, rather than health-related outcomes (Drahota et al., 2016; Schwartz et al., 2016). Wanjiru and Xiaoguang (2021) found that few of the 47 university–community engagement evaluations

they reviewed assessed concrete outcomes. While this suggests that outcome evaluation is relatively uncommon, their review did not explore how such evaluations are designed and implemented in practice or the barriers that interest-holders face in conducting them.

One factor that may explain the limited focus on outcomes is the reliance on evaluation approaches that prioritize attribution, often using causal inference methods to demonstrate that a specific intervention directly caused a particular result (Buetti et al., 2025; Kuttner et al., 2023). Such models work best when a single, well-defined intervention operates in isolation. In contrast, CCE partnerships are collaborative and dynamic, involving multiple organizations, overlapping initiatives, and evolving strategies (Bringle & Hatcher, 2002). In these contexts, changes in health outcomes usually result from the combined influence of many actors and broader social and policy factors, making it difficult to isolate the contribution of any single initiative (Kuttner et al., 2023; Levkoe & Kepkiewicz, 2020). To address this complexity, evaluation scholars have proposed theory-based approaches, such as theory of change (Weiss, 2001) and contribution analysis (Mayne, 2019), which clarify how and why change is expected to occur by mapping causal pathways and articulating underlying assumptions (Treasury Board of Canada Secretariat, 2021; White, 2009). These approaches might offer CCE partnerships more robust evidence of health-related outcomes, but there is limited understanding of how, and if, they are actually used in practice to assess these outcomes.

Another challenge in evaluating health-related outcomes in CCE partnerships is evaluation capacity, generally defined as the combination of organizational resources, structures and processes, and the skills of personnel that enable an organization to conduct and use evaluation effectively (Bourgeois & Cousins, 2013). While little research addresses evaluation capacity in CCE, studies in the nonprofit sector highlight recurring issues, including inadequate or short-term evaluation funding, compressed timelines, and staff turnover that disrupts continuity (Janzen et al., 2017). Buetti et al. (2024) identified six dimensions shaping evaluation capacity in nonprofits: "human resources, organizational resources, planning of evaluation activities, evaluation literacy, organizational decision-making, and learning benefits" (p. 466). However, most of this literature focuses on a single type of organization and does not account for the added complexity of CCE partnerships (Grack Nelson et al., 2018). In contrast, CCE partnerships bring together multiple types of organizations with different mandates, cultures, and resources to deliver activities and produce shared outputs (Bourgeois et al., 2023; Drahota et al., 2016). These dynamics may introduce additional challenges that are not yet well understood in the joint design and implementation of evaluations that are both methodologically rigorous and aligned with partners' priorities.

Summary and Research Gap

Overall, the literature reveals a significant gap in understanding how health-related outcomes are evaluated within CCE partnerships. While prior studies emphasize the importance of evaluation, there is limited empirical research on the design, implementation, and use of outcome-focused evaluations, with most studies instead focusing on how to implement successful CCE partnerships. There is also limited insight into the specific barriers faced by partners when evaluating such outcomes, particularly in multi-organizational contexts. The present study addresses this gap by examining (1) the evaluation practices that interest-holders use to assess health-related outcomes in CCE partnerships and (2) the challenges they encounter in implementing these evaluations.

Methods

Study Design

We used an exploratory qualitative design to answer the research questions, as this approach is well-suited to contexts where empirical evidence is limited and a nuanced understanding of interest-holders practices and experiences is needed, such as in evaluating health-related outcomes in CCE partnerships (Rendle et al., 2019; Drahota et al., 2016). The study received ethics approval from the Bruyere Health Research Institute, Canada (Certificate Number: M16-23-009). Funding was provided by the Canadian Institutes of Health Research (Grant Number: PJT-180529).

Participants

We used a mixed sampling strategy, combining purposive and snowball techniques, to recruit participants with direct experience in health-related CCE partnerships. We first reviewed the Canadian CCE literature to identify relevant publications and contacted corresponding authors by email; however, this yielded fewer responses

than anticipated. We then relied primarily on the research team's professional networks and referrals, supplemented by snowball sampling to broaden representation, particularly from community-based interest-holders. Several participants referred us to colleagues or community partners involved in CCE. All participants provided informed consent prior to the interviews.

We conducted 21 semi-structured interviews with interest-holders involved in health-related CCE initiatives across Canada. The majority were affiliated with academic institutions (57%, n = 12), while community-based organizations represented the remainder (43%, n = 9). Geographically, most participants resided in Ontario (76%, n = 16), with additional representation from Quebec (10%, n = 2), Alberta (10%, n = 2), and British Columbia (5%, n = 1).

Materials and Procedures

We conducted all interviews via Zoom, recorded them with participant consent, and transcribed them using Zoom's automated transcription service. We reviewed and corrected each transcript for accuracy before analysis. Interviews lasted approximately 45–60 minutes and followed a semi-structured guide aligned with the study's research questions. The guide covered three areas: (1) perceptions of CCE's impact on population health, (2) evaluation practices used to measure health-related outcomes, and (3) barriers and facilitators to outcome evaluation. In this article, we report on the latter two, which address our focus on understanding evaluation practices and challenges.

Data Analysis

We analyzed the data using Bingham's (2023) five-step qualitative analysis approach, which combines deductive and inductive techniques. We conducted a thematic content analysis, employing both a priori categories from the research questions and emergent codes identified during transcript review. The analysis began with a familiarization phase, during which transcripts were read carefully and preliminary notes were taken. DB and CC independently coded the transcripts, meeting weekly to compare interpretations, discuss emerging themes, and resolve discrepancies. We used Microsoft Excel, following the cost-effective approach described by Bree and Gallagher (2016), who highlight its practicality for qualitative analysis and provide step-by-step guidance for its use. This method enabled us to organize responses by participant and theme, cross-reference data, and track analytic categories over time. We reached thematic saturation after 19 interviews, using the final two to confirm and refine the coding structure.

Results

RQ1. What evaluation practices do interest-holders use to assess health-related outcomes in CCE partnerships?

Participants described a continuum of practices used to assess or learn from CCE initiatives, particularly about health-related outcomes. These varied in purpose, methodological rigor, and ability to generate credible evidence. Three main categories emerged, ordered from most to least common: (i) informal feedback, (ii) monitoring and performance tracking, and (iii) structured evaluation approaches.

Informal Feedback Practices. The most common approach involved informal, ad hoc strategies that did not constitute formal evaluation. Rather than using systematic data collection, participants relied on anecdotal reflections, casual client follow-ups, and staff observations to judge whether their efforts were making a difference in expected outcomes. As one explained, "Not interviews, but at least check-ins. . . . Our clients at the food bank say, 'Hey.' You know, three months later . . . 'Have you acquired or gotten these [nutritious foods] when you're coming to the food bank now, as opposed to [before]?'" (P2). These informal practices often served formative purposes, supporting real-time decision-making and iterative program adjustments. As one participant noted, "Progress is made, and then new information is provided, and the students go back and they rework some things" (P6). Although such approaches lack the rigor needed to evaluate health outcomes, their widespread use underscores the value of informal, relational learning, especially where evaluation capacity and resources are limited.

Monitoring and Performance Tracking. Participants described using monitoring systems to track service delivery, student engagement, and project activities. These systems served different purposes: some supported ongoing quality improvement, while others were designed primarily to meet funder or institutional reporting requirements. As one participant explained, "When we got the funding, we had to set up performance criteria for that program and report on that . . . there were many different measures.

First, how many kids did we get into the program? Then how many completed the training? Got interviews? Got jobs?" (P6). These systems, often embedded in administrative or educational platforms, enabled routine record-keeping but offered little support for evaluating health-related outcomes. One academic participant noted,"We have these systems built . . . including constant artifact collection that we need to keep as evidence of student learning. It's available to us, should we want to mine it for research purposes" (P11). While useful for accountability and tracking outputs, participants emphasized their limited evaluative value. Monitoring was often described as capturing deliverables rather than outcomes that reflected learning, adaptation, or long-term impact. As one summarized, "We're not actually getting the kind of richness of data and information that we need. . . . It's a checkbox exercise" (P12).

Structured Evaluation Approaches. Only two participants reported using structured evaluation strategies to assess the health-related outcomes of CCE partnerships. They primarily adopted structured approaches to support decision-making and promote shared learning among partners, rather than to meet external reporting requirements. Each participant worked in a health research institute that provides research and evaluation services to community organizations with a clear mandate and dedicated resources for evaluating health-related outcomes.

The first participant used contribution analysis (Mayne, 2019), a theory-based impact evaluation method that tests a theory of change by mapping causal pathways between activities, outputs, and outcomes. They explained, "We're really trying to build a theory of change for every individual project . . . using the fundamentals of contribution analysis to reframe how we talk about [evaluation]." During contribution analysis, partners often combined surveys, administrative data, and interviews with students, community members, faculty, and staff to refine theories and better understand how their activities contribute to improved health-related outcomes.

The second participant employed an impact case-study approach to evaluate the impact of CCE partnerships on social and health outcomes. This method combined documentary evidence and semi-structured interviews, incorporating the perspectives of both community members and practitioners to highlight their roles in fostering social change: "We have taken their case study format. And we've added the community voice to those case studies to reflect the role that community brings and practitioners bring" (P10). The participant described this strategy as a way to capture and communicate impact, using diverse data sources to support the analysis: "How do we capture and communicate the evidence of impact [of CCE]? So to me, the capturing, the evidence, is that semi-structured interview guide and the documents that you collect. And then communicating the evidence is the case study" (P10).

They also emphasized the importance of integrating multiple forms of evidence to tell a more complete story: "I like to say, no numbers without stories, no stories without numbers" (P10). Although they did not report using quantitative measures of health outcomes, this approach emphasized both methodological depth and contextual richness, helping to make the impacts of CCE more visible and meaningful to a broad range of audiences.

RQ2. What challenges do interest-holders face in implementing evaluations of health-related outcomes within these partnerships?

Participants described a wide range of barriers to evaluating health-related outcomes in CCE partnerships. These challenges occurred across four interrelated levels: (1) individual and project-level, (2) organizational-level, (3) partnership-level, and (4) system-level. Together, these reflect both internal limitations and external constraints that affect the design, implementation, and utility of evaluation efforts in CCE contexts.

Individual and Project-Level Barriers. This category focuses on staff capacities and the design of specific initiatives. Participants identified three primary barriers:

Limited Evaluation Literacy. Several community partners valued evaluation but reported limited methodological knowledge to assess health outcomes systematically. Although confident in their initiatives' positive impact, they struggled to translate this into credible, evidence-based findings. As one participant said, "I intuitively know that it's [the impact] there. I just don't know how to necessarily, empirically be able to show that" (P8). Another echoed this sentiment, highlighting the difficulty of demonstrating outcomes despite strong convictions about program value: "There's definitely an impact . . . but proving that . . . yeah, I don't envy anyone" (P1).

Data Quality and Inclusion. Participants emphasized difficulties in collecting data that

Table 1. Reported Barriers to Evaluating Health-related Outcomes in CCE Partnerships

Level	Barrier	Description
Individual and project	Limited evaluation literacy	Interest-holders valued assessing health outcomes but lacked the skills or confidence to conduct evaluation.
	Data quality and inclusion	Challenges in collecting inclusive, relevant, and representative data, particularly from marginalized groups.
	Late or absent integration of evaluation in project design	Health outcome evaluation was often added late or omitted from planning, resulting in weak alignment between data collection and intended health goals.
Organizational	Insufficient resources for evaluation	Staff lacked the time or funding to conduct evaluation of health-related outcomes.
	Lack of institutional commitment	Evaluating health-related outcomes was not embedded in organizational strategy, reducing its priority and limiting resource allocation.
Partnership	Lack of data integration across partners	Partners used different data systems and protocols, limiting opportunities for shared access and joint analysis of health outcomes.
	Power asymmetries between partners	Academic institutions often led evaluation efforts, reducing opportunities for equitable participation in defining and interpreting health outcome measures.
Systemic	Funder-driven constraints	Short funding cycles and rigid reporting requirements restricted the ability to capture longer-term health impacts or adapt evaluation to emerging community priorities.
	Methodological misalignment and attribution complexity	Dominant evaluation models often prioritize direct attribution and short-term outputs

accurately reflects the experiences of equity-deserving groups. Reaching marginalized populations required more time, resources, and intentional effort than relying on easily accessible participants. As one explained, "Do not go to your white middle-class folks who come out to focus groups. Go to people that are hard to reach. . . . It takes more time, more resources, more energy, but without that, we're really at risk of leaving people out" (P12). Others highlighted concerns about survey reliability due to response bias and low participation: "It's hard to get people to fill out surveys. . . . There's a lot of bias in surveys, because it's usually either people who are really happy or really mad who will fill them out." (P17). A further challenge arose in rural settings, where participants noted that small cohort sizes limited the reliability of outcome measurement. As one remarked, "We haven't measured it yet, and there's small numbers, and that's the challenge of me working in rural . . . small cohorts . . . but I anecdotally know it will lead to improved population health outcomes" (P4). Together, these observations underscore the need for inclusive and context-sensitive data-collection approaches that move beyond standard tools, especially in settings with small populations

or underrepresented groups.

Organizational-Level Barriers. These relate to the internal structures, priorities, and resources of a single organization. Participants identified two key constraints that hindered evaluation efforts:

Insufficient Resources for Evaluation. Community partners frequently cited the lack of dedicated time, personnel, and funding. Frontline staff often had to conduct evaluations alongside core service delivery without adequate training or support. As one participant described, "[Lack of time and staff capacity for evaluation] would definitely be in the top three, if not the top one. . . . Most staff are focused on program delivery . . . building a framework for evaluation . . . It's just not in the job descriptions" (P2). Another echoed this concern, stating: "We're resource limited, and if I assign a portion of it to measure impact, then I'm not serving the community" (P14).

Lack of Institutional Commitment. Several participants described an absence of organizational leadership or strategic direction regarding evaluation in CCE partnerships. In these contexts, evaluation was viewed as an optional or peripheral activity, rather than a core organizational function. One participant noted, "From a strategic mindset of the organization, we haven't had a strategic mandate to measure" (P1). Without an internal culture that prioritizes learning and assessment, evaluation efforts remained fragmented and under-resourced.

Partnership-Level Barriers. This category addresses collaboration between academic institutions and community organizations. Participants identified two main challenges affecting evaluation:

Lack of Data Integration Across Partners. Participants described how collaborating organizations often operated with distinct data platforms, collection methods, and protocols, which impeded efforts to share or analyze information across institutional boundaries. One participant noted, "They're the ones [community partners] that can capture that data. The researcher doesn't have access to that, only through the partners" (P9). Another added, "Everyone has their own database . . . hard to link" (P15). This fragmentation was seen as a major barrier to meaningful evaluation, particularly in assessing health outcomes, since the most relevant data were often dispersed and inaccessible across organizations. As a result, evaluations tended to measure outputs such as participants served or workshops delivered rather than health outcomes that required integrated data to demonstrate.

Power Imbalances Between Partners. Several participants described persistent hierarchies within CCE partnerships, especially regarding who controls evaluation processes and who ultimately benefits from their outcomes. Academic institutions were often perceived as dominant actors, shaping agendas and framing results in ways that did not always align with community priorities. As one community partner reflected, "We don't even realize what a hierarchy there is between the university and community; we have to work actively at breaking it down" (P12). Another academic participant noted, "When I start a community-based project . . . I tell people, 'I've got to publish out of this . . . I need that to be able to continue this work'" (P7). These dynamics were compounded by the resource constraints discussed earlier: while universities typically had staff, funding, and institutional support for evaluation, many community organizations lacked these capacities, which limited their ability to participate fully in the design and interpretation of evaluation findings.

Systemic-Level Barriers. These encompass the broader policy, funding, institutional, and methodological context in which CCE initiatives operate. Participants identified two types of barriers:

Funder-Driven Constraints. Many participants cited rigid funding structures, short project timelines, and inflexible reporting requirements as significant obstacles to evaluating health-related outcomes. These external conditions often left little room for iterative evaluation or long-term outcome assessment. As one participant explained, "We asked for five years because we said that was a minimum to evaluate impact . . . but they gave us two, which basically makes it impossible to do meaningful evaluation of outcomes" (P12). Another noted, "The funding cycles we work under are so short that by the time you've built the relationship, the project is already over, and there's no budget left for any follow-up or outcome tracking" (P11). Even when negotiation was possible, evaluation priorities were frequently shaped more by funder expectations than by local relevance: "Funders come in with their own criteria and indicators. . . . You can negotiate a bit, but at the end of the day, you're still reporting on what they care about, not necessarily what matters most to the community" (P6).

Methodological Misalignment and Attribution Challenges. Participants highlighted a disconnect between traditional evaluation models often

demanded by funders and the realities of CCE initiatives. Several pushed back against expectations of direct attribution, noting that CCE is not a linear intervention with predictable outcomes. As one participant explained, "What we try to do is remind funders that this isn't a linear intervention with a direct outcome. It's not like: if we do this, then this will happen. There are multiple players and multiple systems involved. So we push back on this idea of direct attribution" (P3). Participants also emphasized that evaluations focused on short-term outputs or annual changes failed to capture the gradual and relationship-driven impacts of CCE. As one noted, "It takes time for that kind of work to have impact. So, it's not going to be something that you can see in a year or two. It's something that will take a longer period of time" (P14). These reflections point to a need for more longitudinal and adaptive evaluation approaches that align with the realities of trust-building and sustained community engagement.

Discussion

Before this study, little was known about how CCE partnerships evaluate health-related outcomes or the obstacles they encounter. We addressed this gap through an exploratory qualitative study with academic and community partners actively involved in CCE partnerships, delineating current evaluation practices and barriers. Our findings corroborate and extend existing scholarship.

First, our findings reinforce earlier observations of the limited emphasis on outcome evaluation in CCE partnerships (Horowitz et al., 2009; Wanjiru & Xiaoguang, 2021). Consistent with earlier research, most participants did not conduct formal evaluations of health-related outcomes, instead relying on informal feedback or monitoring and performance tracking systems. While useful for formative purposes or internal reporting, these approaches do not provide strong evaluative evidence of health-related impacts. This pattern aligns with critiques that dominant evaluation models often overlook or are poorly suited to the complex, relational, and systems-oriented goals of CCE (Kuttner et al., 2023; Levkoe & Kepkiewicz, 2020) and may also reflect constraints in evaluation capacity. Participants frequently described a disconnect between the traditional models favoured by funders and the realities of CCE initiatives, with several explicitly challenging expectations of direct attribution.

Second, our findings extend evaluation capacity scholarship (Bryan et al., 2021; Janzen et al., 2017) by demonstrating that barriers manifest in distinct ways within multi-actor CCE settings. These barriers operate across four interconnected levels: (a) individual and project, including limited evaluation literacy, data collection challenges, and the late integration of evaluation; (b) organizational, including scarce resources and limited strategic prioritization; (c) partnership, including fragmented data systems and power imbalances; and (d) systemic, including short-term funding cycles and attribution complexity. While some individual- and organizational-level challenges mirror those documented in the nonprofit sector (Buetti et al., 2024; Janzen et al., 2017), we also identified constraints unique to multi-organizational partnerships that have received limited attention in the nonprofit-focused literature (Grack Nelson et al., 2018). These include incompatible data platforms, inconsistent collection methods and protocols, restricted access to partner-held information, and power imbalances in which academic actors can prioritize professional goals, such as publications or funding renewal, over shared learning.

Third, although relatively uncommon in our sample, the use of structured theory-based evaluation approaches such as contribution analysis and impact case studies demonstrates that assessing health outcomes in CCE partnerships is both feasible and potentially more meaningful when guided by designs that embrace complexity. In these cases, participants used evaluation to examine causal pathways and integrate qualitative and documentary evidence. These applications respond directly to calls in the literature to adopt theory-based approaches such as theory of change and contribution analysis that clarify contribution rather than claim attribution (Mayne, 2019; Treasury Board of Canada Secretariat, 2021; White, 2009). For organizations engaged in CCE, these examples offer options for evaluating health-related outcomes in ways that align with the organizational structures, collaborative partnership dynamics, and flexible timeframes characteristic of community-engaged work (Drahota et al., 2016; Patton, 2010).

Limitations and Implications for Future Research

This study has several limitations that suggest avenues for future research. It relies on qualitative, self-reported accounts from a limited number of interest-holders, which may not fully capture the scope, diversity, or quality of evaluation practices

across CCE initiatives. Future research could address this by involving a broader and more diverse group of interest-holders and employing mixed methods to gather a wider range of evaluation practices and experiences.

Our study also did not differentiate among specific forms of CCE, such as community-based research, service learning, or experiential placements. Even though the evaluation of health-related outcomes and associated challenges likely varies by form, future research should examine how outcome evaluations are conducted within each form and identify context-specific barriers and opportunities. Future studies would benefit from focusing on CCE partnerships that use structured evaluation approaches for health-related outcomes to better understand the skills, supports, and organizational conditions that enable such evaluations. These insights could inform strategies to build evaluation capacity and tailor approaches to the collaborative nature of CCE partnerships.

Implications for Practice

Our findings have several implications for evaluation capacity builders and other practitioners seeking to strengthen evaluation practice in CCE partnerships. Evaluation capacity-building efforts should reflect the multifaceted nature of the challenges identified. At the individual and project levels, interest-holders require support to enhance evaluation literacy and to integrate evaluation earlier in project planning. Addressing data quality challenges, particularly when engaging underrepresented groups, also requires additional time, tools, and skills. At the organizational level, capacity building should focus on securing leadership commitment, dedicating resources, and embedding evaluation within strategic priorities. At the partnership level, efforts could focus on identifying complementary data sources across organizations and coordinating evaluation planning to build a more complete picture of impact. This includes clarifying who holds what data and involving all partners in the interpretation of results. At the systemic level, more flexible and longer-term funding arrangements are needed, along with evaluation models that move beyond attribution to reflect better the relational, iterative, and long-term nature of CCE work. Based on our findings, contribution analysis and impact case studies may be suitable approaches for evaluating health-related outcomes in CCE partnerships. Together, these strategies can foster more inclusive, rigorous, and sustainable evaluation practices across diverse CCE contexts (Block et al., 2018; Collins & Hayes, 2010; Janzen et al., 2017; Bryan et al., 2021).

Conclusion

Evaluation holds significant potential to advance CCE partnerships in demonstrating and improving health-related outcomes. However, this study reveals that current evaluation practices among interest-holders are frequently informal, inconsistent, and insufficiently rigorous to capture these outcomes systematically. Interest-holders encounter complex barriers at multiple levels, including individual, organizational, partnership, and systemic, that undermine effective evaluation. Building evaluation capacity within CCE partnerships requires more than isolated training; it demands sustained organizational commitment, collaborative and equitable evaluation processes, and systemic support that reflects the relational and context-specific nature of CCE initiatives. Achieving this will require coordinated action across the broader CCE ecosystem, including funders, academic institutions, community organizations, and policy-makers, to support more flexible and context-sensitive approaches to evaluating outcomes.

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