

**FACILITATING  
COMMUNITY PARTICIPATION  
IN HEALTH NEEDS ASSESSMENT**

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By  
Tanya Dunn Pierce  
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Department of Community Health and Epidemiology  
Health Sciences Building  
107 Wiggins Road  
University of Saskatchewan  
Saskatoon, Saskatchewan  
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## **Abstract**

The importance and benefits of involving community members in health policy making--from the first step of needs assessment through to actual policy development--are increasingly being recognized. This thesis describes the evaluation of a community consultation process which was part of a needs assessment conducted by Saskatoon District Health, in Saskatchewan, Canada. In September 1995, a Children and Youth Working Group was formed, made up of volunteers representing service providers, users, and families. Their mandate was to develop and prioritize recommendations on ways to improve the health status of children and youth in the District, which has a total population of approximately 300,000. In addition to a comprehensive epidemiological assessment, the Working Group engaged in a community consultation process which solicited input from the general community, with a specific emphasis on key groups such as youth, Aboriginal, immigrant/refugees, and service providers in health, education, social services, and justice. In this process, information on perceived needs of children and youth was collected through 20 focus groups (n=213) and a questionnaire (n=1,985). Based on a synthesis of the quantitative and qualitative data, the Working Group drafted a set of recommendations, which were then discussed at a community meeting for input and feedback.

This research evaluates the effectiveness of the consultation process in facilitating community participation using three sources of data: the entire consultation process was observed (from January 1996 until February 1997), including the focus groups, Working Group meetings, and the final community meeting; interviews (2) were held with the Working Group (n=9), with selected individuals who had participated in the consultation (n=7), and with non-participants (n=2); and documentation produced by the Working

Group (i.e., minutes, notes, background material) was reviewed. These data were analyzed thematically according to criteria established jointly by the representatives of the member groups of the Population Health Project (Working Group, Coordinating Group, Research Advisory Group) and the researcher. The effectiveness was gauged by comparing the findings with the criteria and with the components of meaningful community consultation as defined by the Working Group (appropriateness, timeliness, completeness, accuracy, representativeness, relevance). The themes which emerged from the analysis deal with the participants' feelings about their participation or non-participation, the success of the consultation process, the nature of the data collected; by-products of the process, and the consultation's influence on the outcome of the needs assessment. The results of this analysis are presented and conclusions drawn regarding factors that contribute to or impede effective public participation in health needs assessment.

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I would also like to thank my husband, Tim Pierce, my parents, Helene and Mike Dunn, and my sister, Najla Dunn, for their inspiration, perseverance, and faith, especially at times when I, myself, was lacking in these.

## **Dedication**

I would like to dedicate this thesis to my daughter, Jaden Evangeline Dunn Pierce.

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## Chapter 1

### Introduction to the Study Problem

#### **1. INTRODUCTION TO THE STUDY PROBLEM**

The importance and benefits of involving community members in health policy making--from the early steps of needs assessment through to actual policy development--are increasingly being recognized. This is reflected in the mission, goals and values of the Saskatoon District Health Board, an elected board with control of a comprehensive range of health services for Saskatoon, Saskatchewan, and its surrounding district. One of these health goals is: "to place greater emphasis on a wellness philosophy of health including health promotion, the prevention of illness and accidents, and *empowering individuals and the community to take responsibility for decisions affecting their health*"<sup>1</sup>(emphasis added). This goal is based on what Saskatoon District Health values and promotes: "individual health and worth as essential parts of community well-being; health as a constantly changing state unique to each consumer, patient and client; *informed and consultative planning, priority-setting and decision-making*"<sup>1</sup>(emphasis added). The essential elements of these goals and values are based on meaningful participation of communities in decisions affecting their health. From this perspective, maximizing the quality and level of participation is integral to achieving community health; however, much remains to be learned about *how* to facilitate community participation.

In 1993, the provincial government of Saskatchewan mandated that all health districts undergo a needs assessment process. In response, a group within Saskatoon District

Health was formed to design a planning process, called the Population Health Project. The process is meant to assist with identifying priorities that will form the basis for decision making and resource allocation within the broader health district mandate. It brings together three levels of working groups: a Steering Group; a Coordinating Group; and several Population Health Groups. Each of the Population Health Groups represents a stage of the life-cycle, and the volunteer members were service providers and partners, users and families. A fourth group, the Research Advisory Group, was added to assist the Population Health Groups in their task of collecting and analyzing information related to the health of the corresponding target group. The role of the Population Health Groups is to make recommendations to Saskatoon District Health for meeting the health needs of the target group.

The first Population Health Group established was the Children and Youth Working Group. In addition to a comprehensive literature review and epidemiological assessment, the Working Group engaged in a community consultation process which solicited input from the general community, with particular emphasis on key groups such as youth, Aboriginal, immigrant/refugees, and service providers in health, education, social services, and justice. This community consultation process is the focus of this study.

### **1.1 Purpose of the Study**

The purpose of this study was to describe and analyze the use of a community consultation process, designed and implemented by the Children and Youth Working Group of Saskatoon District Health's Population Health Project, to facilitate community participation in health needs assessment.

## **1.2 Significance and Relevance of the Study**

The research process used in this study provides an example of a way to look at the effectiveness of health needs assessments and community participation methodologies. It gave the participants an opportunity to reflect on their involvement in the community consultation process and on the idea of community participation in general.

As part of the Population Health Project, other working groups will be established to undertake a process similar to the one followed by the Children and Youth Working Group. The research findings will therefore have an immediate application for the Population Health Project and the other working groups by providing guidance for their community consultation processes.

Since little research has been done on how to facilitate community participation, the present study makes a valuable contribution to this area. This research identifies factors which may contribute to or impede effective involvement of communities in health needs assessments and community health initiatives. There is widespread interest in involving the community in health policy-making, to which these findings are both useful and relevant.

## **1.3 Research Question**

Little research has been done on specific methodologies to facilitate community participation, and even less on facilitating community participation in health needs assessment. Many authors discuss the importance of community participation in health decision-making and health needs assessment and the literature contains numerous descriptions of community participation in health promotion programs and some in health needs assessments. However, there are still issues to be addressed. Some of these include: How effective are various methods of stimulating communities to identify their

own health problems and to find ways of dealing with them? What factors contribute to the effective involvement of communities in community health initiatives?

These issues are the foundation for this study's research questions: How effective was the methodology employed by the Children and Youth Working Group of Saskatoon District Health's Population Health Project in facilitating meaningful community participation in its health needs assessment? What factors contributed to or detracted from participation?

#### **1.4 Definition of Terms**

It is necessary to this research to have working definitions of the different components of the research question. The *methodology* refers to the community consultation process, described in section 3.1. The criteria used for evaluating the effectiveness, or quality, of the participation (see section 3.3) were set jointly by the Population Health Project's Working, Coordinating, and Research Advisory Groups, and myself. An organizational chart, which shows the relationship between these groups can be found in Appendix A. The *community* can be defined in numerous ways. For the purpose of this study I used the Working Group's definition of who makes up their community since I did not feel it was within my role to challenge their definition. *Participation* of communities in health needs assessment can be placed on a wide continuum, ranging from tokenism to providing direction to having ownership of the process. Meaningful consultation is defined in Working Group documentation as being appropriate, timely, complete, accurate, representative and relevant.

## **Chapter 2**

### **Review of the Related Literature**

#### **2. REVIEW OF THE RELATED LITERATURE**

Most literature of relevance to this study consists of descriptions of community participation in health promotion programs and some in health needs assessments. Many authors discuss the importance of community participation in health decision-making and health needs assessment; however, there has been very little research done on specific methodologies to facilitate community participation, and even less on facilitating community participation in health needs assessment. Sullivan and Scattolon believe that the literature includes "overly simplistic notions of consumer [community] involvement, with little or no specification of the expected role of consumer [community] involvement."<sup>2</sup>,p.319

In this chapter, I review key documents which discuss the role of community participation in health promotion, illustrated by a few examples. I then review the literature specifically related to participation in health needs assessment, both theoretical and empirical.

#### **2.1 Community Participation and Health Promotion**

Community participation is integral to health promotion theory and practice in Canada. Health promotion is commonly defined as "the process of enabling people to increase control over, and to improve, their health."<sup>3</sup>,p.4 A major focus of the Epp Framework for Health Promotion is to foster public participation, which has been interpreted as "helping people to assert control over the factors which affect their health."<sup>4</sup>,p.8 The Ottawa

Charter for Health Promotion states that "people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health."<sup>5,p.426</sup> Reaffirming the Ottawa Charter, Hamilton and Bhatti call for a strengthening of community action, "so that communities have the capacity to set priorities and make decisions on issues that affect their health," and a reorientation of health services, "to create systems which focus on the needs of the whole person and invite a true partnership among the providers and users of the services."<sup>6,p.3</sup>

Those working in and writing about health promotion are increasingly stressing the importance of informed and meaningful public involvement in health policy development and decision-making.<sup>6,7,8,9</sup> Correspondingly, recent health policy documents underline the centrality of community participation to health care,<sup>10,11,12</sup> including the sharing of responsibility, knowledge, and decision-making between community, government and health service providers.

Community participation is described in the literature as a social process by which specific groups of people voluntarily take part in activities to bring about change.<sup>13,14</sup>

"Participation isn't simply a phenomenon that occurs because it is 'offered.' It is also a social skill that varies by the nature of the tasks in which participation occurs."<sup>15,p.29</sup>

Community participation is seen as being important to all aspects of health promotion, from receiving benefits, to taking action prescribed by others, to being consulted, to being part of planning solutions to problems, and finally to planning and evaluating the solutions to problems oneself.<sup>16</sup> "Meaningful public involvement can only develop out of significant community responsibility and control at all stages."<sup>17,p.9</sup>

Community participation is believed to enhance health promotion effects in two key ways. Firstly, it is generally assumed that when community members participate in health

decision-making, they feel a sense of ownership over the issues they identify, and the ways to address those issues. This assumption is based on the belief that if community members feel that the issues are theirs, they will have a stake in addressing those issues: "People tend to reject or accept only half-heartedly plans made for them without their involvement ... [they] like what they plan for themselves, and therefore will be more committed to support their own planning."<sup>18,p.64</sup>

Secondly, participation in health decision-making can increase the real and perceived power experienced by communities and their members as individuals. After reviewing the literature on powerlessness and health status, several authors conclude that low perceived power is a risk factor for poor health.<sup>19,20,21</sup> One source of real powerlessness, which can contribute to perceived powerlessness, is being denied the opportunity to participate in decisions which affect one's life, including those related to health.

There are many descriptions of community participation in health promotion programs in the literature. One of the best known examples is the World Health Organization Healthy Cities (or Healthy Communities, in Canada) initiative. Healthy Cities/Communities was designed to engage communities in visioning a healthy city and taking action to achieve that vision. The main concepts were public participation and intersectoral collaboration.<sup>22</sup>

Various heart health programs have used community participation. The Minnesota Heart Health Program used community boards representing different community sectors.<sup>23</sup> The program began as a university-based project with the goal of forming partnerships for heart disease prevention and health promotion programs. Initially, the boards served as advisory groups, but they eventually evolved into nonprofit corporations with control over planning and implementation of the programs in their communities. The North

Karelia Project in Finland also utilized a citizen advisory group and voluntary organization to disseminate, educate and support their heart disease risk interventions.<sup>24</sup>

Labonte and Edwards,<sup>15</sup> in their study of 31 Ontario "locality" projects' engagement in health policy decision-making, found a number of barriers to participation. Community consultation is often seen to be about meeting the needs of the bureaucracies and not the needs of local communities. When supports for the participation of marginalized groups are not provided, participation can be by elites alone, who have the time and resources to "volunteer." When community consultations focus on deficits, as opposed to capacities, the community members involved may internalize the analysis, decreasing their motivation to participate. Concerns expressed in community consultations are often re-worked and re-written by bureaucracies, resulting in community members feeling they have lost control over their words. Finally, when community members provide input through community consultation and do not receive feedback about how their input has affected policy recommendations, they may become demoralized.

In their review of the literature on public participation in health, Zakus and Hastings<sup>17</sup> identified some important obstacles to fostering community participation in health. Communities are heterogeneous and may have divergent issues, resulting in challenges in the selection, representation and accountability of community members. The choice of community participants can also cause problems in that marginalized people may become "token" or "co-opted" participants. There may be conflicts in the perceptions of why community participation is important:

The formal health system may be reluctant or even fearful to encourage and accomodate extensive public involvement in policy development, operational decisions and evaluation, as these relate to what are considered professional or managerial areas and issues; but instead want mainly cooperation with and supplementation of their professional efforts



and control. Government and bureaucracy may want legitimization of policy and enhanced implementation of programs, or want to diffuse criticism and delay action on thorny problems; whereas community members may want greater direct power, apart or even in opposition to the formal political system. Governments may see certain forms of involvement as compromising their responsibility and accountability for governing.<sup>17,p.9</sup>

Siler-Wells,<sup>25</sup> in her analysis of workshops organized by the Canadian Public Health Association on strengthening community health, identified ineffective community participation as one of the five main barriers to community health. The participants of these workshops also called for changes in the role of the community, to increase self-determination and empowerment, and changes in the role of professionals, emphasizing a move from expert to enabler. "We [health professionals] must move from 'we're the helping people' to 'people helping one another'."<sup>25,p.6</sup> Thus, current health promotion policy and practice places great emphasis on increasing the involvement of communities in determining their own health.

## **2.2 Community Participation in Health Needs Assessment**

Little information is available on ways to ensure community participation in health policy-making; however, needs identification is mentioned most often as one of the first steps of the planning process.<sup>7,26</sup> Within health promotion, community participation is seen as particularly important to health needs assessment, in terms of both content and process. The extent to which communities participate in identifying their own health needs (i.e., the 'content' of the needs assessment) is believed to affect the responsiveness and effectiveness of programming designed to meet those needs. Communities are better informed about their own health.<sup>27</sup> They want and expect to have input into identifying their needs and determining how those needs are met.<sup>28</sup> Community participation in health needs assessment will supposedly ensure that health care providers and planners are more accountable to the communities they serve.<sup>2</sup>

Feather et al.<sup>29</sup> describe a continuum of community participation, specific to health needs assessment. Figure 2.1 shows the range of community participation from low, when the health needs assessment data are limited to existing statistics, to high, when participatory data collection methods such as a community forum are included.

Figure 2.1  
Level of Community Participation in Health Needs Assessment<sup>29</sup>

Statistical Data	No personal expression by community members
Survey	Highly standardized, individual consultation
Key Informant Interviews	Selected individuals are consulted with an assumption about their knowledge; some flexibility of expression by individuals
Focus Group	Open expression by people as experts, on a predetermined agenda
Community Forum	People are regarded as experts; set their own agenda

Different types of needs have been described as:

... that which is felt or perceived by an individual; that which is expressed by an individual through actions seeking to alleviate the need (e.g. going to a clinic, or putting one's name on a waiting list, or expressing a complaint); that which is a departure from a norm or standard (e.g. low birthweight is defined as less than 1,500 grams); or that which compares unfavorably with conditions prevailing in the larger society (e.g. a rate of injury that exceeds the national or provincial average).<sup>29,p.4</sup>

The approach to the needs assessment process, therefore, depends on how 'need' is defined. For example, Haglund et al.<sup>30</sup> describe three traditional approaches to health needs assessment: the medical science, health planning, and community development approaches. The medical science approach relies on diagnosis by 'experts,' and considers

factors which influence disease patterns such as demographics, environment, and lifestyle. There is little or no community involvement in the process. The health planning approach emphasizes technical strategies and improvements in medical delivery and preventive services, with a focus on health outcomes. Community members' involvement is usually limited to baseline data collection. In these two approaches 'need' does not include that which is perceived or felt by an individual. The community development approach has as its main tenets that citizen empowerment is vital to the improvement of health status and that health is seen in a broad context of social, educational and economic improvement. In this approach, perceived and felt needs are the main source of data and direct community involvement is essential:

A health needs assessment [using the community development approach] can raise community awareness of health issues, and set the stage for change by building commitment to action. ... It can bring the community into an active and more equal partnership in health decisions, enabling people to take ownership of their own health challenges and to exert some control over health planning decisions, based on a shared vision and community-based analysis of need. It can be empowering and therefore health promoting.<sup>29,p.7</sup>

Various ways of involving the community in health needs assessment have been described in the health promotion literature. The United States Centers for Disease Control and Prevention organized a health needs assessment process called "The Planned Approach to Community Health" or PATCH. The goal of PATCH is to "reduce the prevalence of modifiable risk factors for the leading causes of preventable illness, death, disability, and injury."<sup>31,p.CG-2</sup> The process does include elements of community participation. For example, the "community group," consisting of private citizens, political office holders, lay leaders, and individuals from service and health organizations and private companies, is included as one of the partners. However, in identifying and prioritizing needs, PATCH puts most of its weight on epidemiological evidence.

*Planning Healthy Communities: A Guide to doing Community Needs Assessment*,<sup>32</sup> by the South Australian Community Health Research Unit, describes three examples of community health needs assessments. One project surveyed community members with a questionnaire and sought feedback on the findings through the use of a non-technical report to respondents and organizations, media publicity about the results of the survey, and a Health Issues Day where the community and health workers came together, in a workshop format, to discuss the findings and recommend strategies for action.

Another project was initiated through a grant received to develop and test a model of a needs assessment for community health services. The model incorporated certain values, one of which was community involvement. The health needs assessment began with an extensive literature review followed by comprehensive surveying of the community.

Personal contact was made with many of the participants; workshops were held to discuss the results and to suggest recommendations and ideas for action.

The third health needs assessment followed a format similar to, but more limited than the previous two examples; instead of a random population survey, it relied on a key informant survey and public meetings, as well as published data.

There are also examples in the literature of health needs assessments in Canada. The Moose Jaw-Thunder Creek District Health Board in Saskatchewan planned and implemented a health needs assessment process in their health district. It consisted of: community workshops by invitation; key informant interviews; town hall meetings to present and receive feedback about the community workshop findings; an inventory of health-related services, facilities, and programs in the district; written submissions of health needs; a women's wellness questionnaire; and a teen needs assessment (as part of another program). "The needs assessment process encourages citizen participation by

offering opportunities for community members to participate in assessment and planning activities."8,p.8

Representing a First Nations community in Northern Saskatchewan, the Meadow Lake Tribal Council has a Health Development Plan based on the analysis of their health needs assessment, which involved interviews with a sample of community members, key health informants (professional and non-professional health and related workers) and Band leaders, as well as health statistics.<sup>9</sup>

### **2.3 Summary of the Literature**

In summary, many authors discuss the importance of community participation in health decision-making and health needs assessment and there are several descriptions of community participation in health promotion programs and some in health needs assessments in the literature. However, the field is only beginning to move beyond description to analysis and evaluation. Key research questions which remain unanswered include: How effective are various methods of stimulating communities to identify their own health problems and to find ways of dealing with them? What factors contribute to the effective involvement of communities in community health initiatives? These questions formed the foundation for this study.

Even more fundamentally, there are many unexamined assumptions in the literature about the meaning of 'community,' 'participation,' and how these terms are used. The concepts and issues are not clearly defined and, in fact, the same term may take on multiple wide-ranging meanings depending on who is using it and for what purpose it is being used. For example, as the quote by Zakus and Hastings<sup>17</sup> on pages 8-9 suggests, to some community groups, 'participation' may mean considerably more direct involvement in and control over health policy-making than it does to administrators. Similarly, citizens'

perceptions of what constitutes their community may not agree with the definitions used by health planners. These kinds of conceptual issues are important considerations that were kept in mind throughout this research.

## **Chapter 3**

### **Methodology**

### **3. METHODOLOGY**

This chapter describes the community consultation process which I evaluated. Next, I explain the logic of the research design and the research process.

#### **3.1 Setting: The Community Consultation Process**

Saskatchewan is among the less populated provinces in Canada; approximately 1 million people call it home. In 1992, the provincial government of Saskatchewan began a process of health reform based on three principles: "increasing community involvement and control over the health system; emphasizing disease and accident prevention, healthy lifestyles, and community-based programs; and increasing coordination and integration of health services to provide a more responsive, efficient system."<sup>28,p.1</sup> This reformed system utilizes a broad definition of health; it includes mental, emotional, social and spiritual well-being, as well as physical health. "Health enables individuals, families and communities to function to the best of their abilities within their environment."<sup>11,p.3</sup> Thirty health districts, each of which has a local elected board with a comprehensive range of health services under its control, were formed.

Saskatoon is the largest city in Saskatchewan with a population of approximately 202,000. Along with its surrounding district, the city's health services are governed by Saskatoon District Health. The health district is comprised of close to 228,000 people, with 30% under the age of 20. Saskatoon is also one of two main centres in the province

for specialized care and services, and has three hospitals. One of the hospitals is a teaching and research facility which is adjoined to the University of Saskatchewan.

In 1993, Saskatchewan Health mandated that all health districts undergo a needs assessment process. It was left up to the individual districts to choose the methodology to determine the needs and priorities of the people of their districts. In response to this mandate, a group within Saskatoon District Health was formed to design a planning process, called the Population Health Project. The resulting framework (hereafter referred to as the Framework) for population health planning "considers assessment from a broad health perspective relying on community and Saskatoon District Health Board agency involvement and consultation, integrated into planning and decision making."<sup>33</sup>.p.1 It is meant to assist with identifying priorities that will form the basis for decision making and resource allocation within the broader health district mandate.

The Framework has two components: an operational model and a conceptual model of health determinants (found in Appendices A and B, respectively). The latter is a three-dimensional matrix, made up of influences on health, stages of life-cycle, and indicators of health status. The operational model brings together three levels of working groups: a steering group consisting of senior Saskatoon District Health management; a coordinating group with members from Saskatoon District Health, University of Saskatchewan, and the provincial departments of health, education and social services; and several Population Health Groups, each representing stages of the life-cycle, and consisting of service providers and partners, users and families. A fourth group, the Research Advisory Group, was added to assist the Population Health Groups in their task of collecting and analyzing information related to the health of the corresponding target group. The role of the Population Health Groups is to make recommendations to Saskatoon District Health for meeting the health needs of the target group.



The first Population Health Group established was the Children and Youth Working Group. Volunteers were invited through the media and personal contacts and selected through a process to try to ensure representativeness. The Working Group began meeting in September 1995, with the goal of having recommendations to improve the health status of children and youth (ages newborn to 19 years) in the Saskatoon health district. The Working Group, at various times during its life, represented health professions, education, childcare, students, youth services, and community development. There were 14 women and 5 men, and 2 members were of Aboriginal ancestry. The Working Group collected a variety of data on which to base their recommendations. In addition to a comprehensive literature review and epidemiological assessment, the Working Group was directed to engage in a community consultation process. It is this community consultation process which is the focus of this study.

The community consultation process consisted of two parts: the first part was to develop public awareness and gather information, and the second part was to validate the Working Group's findings from the entire assessment process and add any new information before release of the final report. The first part of the consultation process tried to provide any interested individual or group with a direct means of contacting the Working Group to share information or express concerns they had about the health of children and youth. In addition to hearing from the general community, the Working Group wanted to ensure that information was obtained from key groups (youth, Aboriginal, immigrant/refugees, and service providers in health, education, social services, and justice). Data were collected, in the first part of the consultation, using a questionnaire and focus groups.

The questionnaire consisted of three questions:

1. What issue related to the health of children and youth are you most concerned about?
2. What other issues related to the health of children and youth are you concerned about?
3. What suggestions do you have to deal with these issues?

The parents of children in all public elementary schools in the health district received the questionnaire in their school newsletters. Parents returned the form to the school and schools returned a large collection envelope through the school central mailing system to the central distribution centre for Working Group pickup. Interested high school teachers, identified by the guidance counselors from the Saskatoon public and rural school divisions used one class period for students to respond to the three questions using small group discussion. Teachers were also asked to fill out a questionnaire. They collected group and individual response forms and returned these through the school central mailing system. Parents of children being home-schooled, identified through the home-schooling association, had a questionnaire mailed to them, including a stamped, return envelope.

All physicians listed with Saskatoon District Health and social workers, through the Department of Social Services, also received questionnaires. As well, the questionnaire was published in the Saskatoon District Health employee newsletter, the city and the rural newspapers.

Due to the nature of the questionnaire distribution process, the total number of individuals who received the questionnaire is unknown. In total, 1,985 questionnaires were returned; some of the questionnaires represented the views of more than one person. A breakdown of the consumer and service provider responses can be found in the tables (1.1 and 1.2) found on the next page.

Table 1.1  
Consumer Response

	Total Number	Males*	Females*	Urban**	Rural**
Elementary School-aged Children	25	13	10	22	2
High School-aged Youth	771	354	386	271	473
Parents	769	76	658	632	122
General Public and Saskatoon District Health Employees	57	13	40	40	15
<b>Total</b>	<b>1622</b>	<b>456</b>	<b>1094</b>	<b>965</b>	<b>612</b>

\* Those who indicated gender.

\*\* Those who indicated community.

Table 1.2  
Service Provider Response

	Total Number	Males*	Females*	Urban**	Rural**
Physicians	48	31	14	45	2
Rural teachers	82	23	54	43	34
Urban Elementary Teachers	119	23	91	114	4
Urban High School Teachers	81	38	42	74	6
Social Workers	33	10	21	29	2
<b>Total</b>	<b>363</b>	<b>125</b>	<b>222</b>	<b>305</b>	<b>48</b>

\* Those who indicated gender.

\*\* Those who indicated community.

The researcher hired to support the Working Group (hereafter referred to as the Working Group researcher) sorted the data by respondent group, demographic characteristics, according to the health determinants of the matrix (from Appendix B: biological, psychological, physical, social, economy, lifestyle, gender, and services) and the suggestions on how to address the issues and concerns (education, service, and policy).

The second form of data collection, and the one on which this study concentrates, involved focus groups conducted with specific sectors of the community. Twenty focus groups were held between January and July 1996, with a total of 213 people participating. They averaged two hours in length and usually took place in a nearby neighborhood location or a central work area. Table 1.3 describes the groups who took part in the focus groups. The Working Group also received written submissions from groups who were unable to take part in a focus group discussion.

Table 1.3  
Focus Groups

Description of Group	Number of Participants	
pediatric health service program	7	
rural community	13	
children at risk committee	17	
street youth drop-in group	12	
low income support centre	8-10	(number not recorded)
mental health advisory committee	9	
Saskatoon District Health Mental Health Services	11	(includes 1 who was interviewed separately)
Aboriginal advisory group	11	
immigrant support centre (2 groups)	12	
pediatric nurses	11	
Saskatoon District Health Public Health Services (5 groups)	51	
rural health advisory group	28	
youth action group (composed of youth)	6	
spiritual care providers	11	
community school parents' council	6	

Letters were sent to the department heads of Pediatrics, Family Medicine, and Obstetrics and Gynecology asking them if the members of their respective departments would be interested in participating in focus groups. The Pediatric Nursing manager also received a similar letter. Employees of Public Health Services and Mental Health Services received

memos to the same effect. Other pediatric health service providers who worked at one of the pediatric health service programs were invited to participate in a focus group at that organization. Letters were also sent to the Saskatoon District Health advisory committees, Aboriginal organizations in the city, and an immigrant/refugee support centre inviting them to participate in focus groups. Each Working Group member also approached other voluntary and professional-related committees that they worked with to see if there was interest in participating in a focus group.

Individuals were invited to participate in focus groups according to their interests. The invitation went out to the different groups in the community and, when one responded, the Working Group would find a voluntary facilitator from a list provided by Saskatoon District Health. Those who attended the focus groups were requested to respond to the same questions as the questionnaire and to indicate the priority of the issues identified.

The focus groups were directed by the facilitator from Saskatoon District Health; a Working Group member explained the purpose of the meeting and recorded results. When a facilitator was not available, the Working Group member acted as both the facilitator and recorder. The written summaries of the focus groups as recorded by the Working Group member were reviewed by the Working Group researcher and issues and themes were categorized according to the health determinants of the matrix (similar to the analysis of the questionnaires).

The second part of the consultation consisted of a three hour public meeting held at a Saskatoon high school in September 1996. The purpose of this meeting was to validate the issues, goals, and targets developed by the Working Group and to help establish priorities within the identified issues before completing the final report.

Invitations to the public meeting went to those who had taken part in the focus groups. In addition, parents were notified through school newsletters and Lifestyle teachers and high school guidance counselors were asked to distribute invitations to youth whom they thought would be interested in taking part. Saskatoon District Health employees were informed through the employee newsletter and the general public through local newspapers and radio and television public service announcements.

A draft report of the issues developed by the Working Group was distributed prior to the meeting to those who phoned and requested a copy: 74 draft reports were mailed upon request, 21 were distributed to Lifestyle teachers, 35 to health service providers, and 5 to a low-income support centre. Prior to the meeting, draft reports were also distributed at a regular meeting of the Department of Pediatrics of one of the hospitals and the pediatricians were invited to forward any comments or concerns to the Working Group.

Thirty-nine participants attended the community meeting. Twenty of them completed an evaluation form at the end. Table 1.4 describes the community meeting participants.

Table 1.4  
Community Meeting Participants

Group Represented	Number of Participants
High school-aged Youth	16
Affiliated with Saskatoon District Health	5
Parents	4
Health Service Workers	2
Community Agencies	10
Affiliated with Population Health Project	2

Following the public meeting, draft reports were sent to Métis and First Nation health and justice representatives with a covering letter inviting feedback. No responses were received.

All comments from the meeting were recorded and circulated to the Working Group members for integration into the final report.

### **3.2 Personal Statement**

In any research it is important to recognize the potential biases of the research instrument. Since I was the research instrument in this study, I examined my personal background and views and tried to understand how they might influence the data collection as well as my interpretations of the findings.

I believe fundamentally that each individual has the right to good health, as they themselves define it. I believe that individuals should have control over themselves and their environments. I believe that individuals living and working together as communities have great capacity to make change. I believe that communities should participate in defining their own health needs, planning ways to respond to those needs and evaluating the outcomes. And I believe it is the health professionals' responsibility to support each of these to the best of their abilities, in philosophy and in action. I value people and the knowledge that their life experiences have brought to them.

My approach to research reflects these beliefs and values. There are multiple views of a situation depending on the pair of eyes, rather than one single reality. The perspectives of the people under study are the best sources of information for the research; therefore, it is important that they be participants in the research, in a role which goes beyond simply providing data.

I, like many members of the Working Group, am a white, middle-class, university-educated woman. I grew up in a family with a great collective consciousness and strong female leadership and therefore am keenly aware of class and gender inequities.

My work experience has been in the areas of nutrition, food security, community development and international solidarity. I have travelled and worked in Canada and for short periods in Brazil, Uganda and Mozambique.

I came to the Population Health Project through a presentation in the Department of Community Health and Epidemiology, by Kathleen Morpurgo and Nazeem Muhajarine of the Population Health Project's Coordinating Group. I approached them for possible thesis ideas and, after considering my interests, was pointed in the direction of the community consultation process of the health needs assessment. I worked with the Working Group members for over a year and developed friendships with many of them. There were two results of that relationship: one is this thesis, the second is a report entitled *A report on the effectiveness of the community consultation employed by the Children and Youth Working Group, Saskatoon District Health Population Health Project, in facilitating community participation in health needs assessment*, presented to the Working Group, Coordinating Group and the Saskatoon District Health Board in July, 1997.

I felt welcomed into the Working Group and through the time I shared with them, in their meetings and at their meals, I felt close, personally, to the Working Group members. On some occasions, I was torn between my role as researcher and that of advisor (when the Working Group members turned to me for advice). I also felt torn between my role as evaluator and that of friend as I struggled to see and balance the challenges as well as the strengths in the community consultation process. Drawing the lines was difficult for



them, as well as for me. I believe that these conflicts did have an impact on my research. In a positive sense, I was not seen as an intrusion to the process. The Working Group members saw me as one of them and were willing to share and be open with me about all facets of their process. However, I did have difficulty stepping back and separating my thoughts from theirs. I knew the report would not be useful if I could not force myself to do this and to be more critical of the process. In this respect, I found comments from my thesis committee members helpful since they were further removed from the community consultation process. Overall, I believe I grew through this experience, as a researcher and as a person.

### **3.3 Naturalistic Design**

I approached this study from a naturalistic perspective. This is in keeping with McQueen's<sup>34</sup> recommendations that health promotion research look at "natural experiments" taking place in the real world and that it involve the community of interest in the research - key elements of a naturalistic design. The naturalistic approach views reality as a multilayered, interactive, shared social experience that can be studied by first learning what is important to participants.<sup>35</sup> The researcher is interested in the meaning attached to the experience. This is in contrast to positivist research which rests on the assumption that there is one single reality, broken down into independent parts to be manipulated and controlled.

The purpose of naturalistic research is to generate an understanding of a social situation through continuous dialogue between the observer and the situation.<sup>36,37</sup> The experience is also placed within its broader context, incorporating social, cultural and political features as contributors to the meaning of the experience. The research can be transferred only to contexts with the same characteristics. Texts that claim whole and complete truths or claim generalizability across time and contexts are misleading;

information is particular and incomplete, and located within social, cultural, historical, racial, and gender contexts.

In the naturalistic approach the research instrument is the researcher, who can be highly flexible and responsive to changes according to the data being provided. "The human being, however imperfect, is nevertheless virtually infinitely adaptable, ... [and is] the only possible choice [of instrument] during the early stages of an inquiry. Objections that humans are subjective, biased, or unreliable are irrelevant, for there is no other option."<sup>35,p.175</sup> This instrument fits in well with the emergent design of the naturalistic approach, and of this study, because the understanding of the meaning comes from observation, discovery and inductive reasoning.<sup>38</sup>

Naturalistic evaluation, a subset of naturalistic research, is a mutual teaching/learning process between the evaluator and the research participants; it focuses and narrows as the evaluation proceeds.

The stakeholders teach the evaluator--and one another--about their constructions, and the evaluator assists in communicating those constructions from one individual and one group to another. Evaluators help each group clarify its own construction, while at the same time learning from it yet another view of which account must be taken. The process is clearly mutually educative. ... evaluation is a continuous, recursive, and highly divergent process.<sup>35,p.254</sup>

Evaluation requires some kind of criteria or standards for comparison. Kouri argues that the community of interest is the best source of information, and so its members should participate in the research process.<sup>39</sup> Similarly, Labonte and Edwards state that it is important to ensure the help of participants in determining evaluation criteria, and that

"the process of developing evaluation criteria is as important as the rigour or validity of the criteria themselves." <sup>15</sup>,p.73

In this research, the Population Health Project groups' members had valuable 'inside' knowledge about the community consultation process; therefore, I involved the Working Group, the Research Advisory Group, and the Coordinating Group in determining the criteria. The process for developing the criteria included an interview with the chairperson of the Coordinating Group and a member of the Research Advisory Group, and a separate interview with the two co-chairpersons of the Working Group. In these interviews, the individuals responded to the questions, "What kinds of criteria or what standards should be used to look at how successful the community consultation process was? How would we say the community consultation process achieved its purpose, its goal?" The responses were analyzed by themes, representing objectives and measures of success. Approval was then sought and received from the Working Group members.

The criteria that I used as a guide for the evaluation are as follows:

1. *The operational model will get the Working Group closer to the people.*
  - How effective was the Working Group in going right to the people and getting the information?
  - How involved were the Working Group members in the community consultation process?
2. *The community consultation process will gather information from different representatives of the community.*
  - Was the Working Group able to effectively engage members of the community in soliciting needs information?
  - Did the people endorse, support or participate in the process?

- Were people satisfied as participants in the process?
- How did they feel about their participation?
- Would they do it again?
- Who was the Working Group able to get involved in the community consultation process?

3. *The community consultation process will provide evidence for the recommendations.*

- Did the format get the information needed?
- How was the information from the community consultation process balanced with other sources in the formation of the recommendations?
- How much credibility did the Working give to the different methods of collecting information?
- How did the information from the community consultation process influence the report?

The Working Group also suggested a fourth criterion: *The community consultation process will educate about the broad definition of health.* This criterion was described as something that would be desirable but not critical to the success of the community consultation process; therefore, I have not included it as a criterion for success. However, it is addressed as one of the by-products of the community consultation process in section 4.4.1.

It is argued that health promotion research, to be consistent with its practice, should help people and communities increase control over factors which affect their health, should be inclusive and democratic, should make attempts to strengthen communities, and should become more interactive and participatory.<sup>33</sup> The Working Group, composed of

volunteer community members, participated in this research in different ways at different stages. Initially they were involved, along with the Coordinating Group, the Research Advisory Group, and myself, in setting the criteria for the evaluation, as previously described. They also provided information and feedback on the findings, analysis and interpretation. This was achieved through checking of the transcripts, regular updates, informal discussion, two group meetings, and approval of the evaluation report. The participation of the other people involved in the study was more limited, and included providing information and checking their own transcripts.

### **3.4 Data Collection**

I was the main instrument used for gathering information. The data were collected by observation, a review of documents and records, and individual and group interviews. A timeline of the research process can be found in Appendix C.

#### **3.4.1 Observation and Document Review**

Observation of the community consultation process was ongoing, beginning when I first joined the project (January 1996) and ending when the Working Group's report was submitted and presented to the Saskatoon District Health Board (February 1997). I observed the entire community consultation process, from planning to implementation to analysis to recommendations. As Denzin<sup>40</sup> suggests, all observation field notes contained reference to participants, interactions, temporal elements, interpretations, and social organization. Relevant nonverbal elements were also noted. The observations were documented through field notes and a reflexive journal.

The documents reviewed included: minutes from all Working Group meetings, qualitative and quantitative data considered by the Working Group, all documentation provided to the Working Group, correspondence, completed evaluation forms from the community

meeting, and consultation reports published by Saskatoon District Health including the Working Group's final report, *A Call To Action*.<sup>41</sup>

The observations helped me to establish rapport with the members of the Working Group. It also enabled me to meet some of the participants in the community consultation process and thus begin to identify potential participants for this study. Both the observation and the document review provided valuable information about context, increased my understanding about the concerns and issues, and provided cues for interview questions.

### **3.4.2 Interviews**

The primary source of data for this study consisted of one group interview with the Working Group and nine personal interviews with individuals who had varying involvement in the community consultation process.

#### **3.4.2.1 Study Participants**

The Working Group was interviewed once as a group. Not all members of the Working Group were present for the group interview; however, most of the core group that organized the community consultation process participated in the interview. The Working Group members who participated in this study will be hereafter referred to as Working Group participants. Of the nine Working Group participants, eight were women. The sectors (both government and non-government) that the Working Group participants represented on the Working Group included education, health, and childcare.

Of the nine personal interviews, three were with individuals who had participated in both parts of the consultation (selected from at least 4,237 people who had responded by questionnaire, focus groups, or written submissions, as well as having attended the

community meeting), three with individuals who had participated only in the first part of the consultation (selected from at least 4,198 people who had responded by questionnaire, focus groups, or written submissions), one with an individual who had attended only the second part of the consultation (selected from at least 10 people who had attended only the community meeting), and two with individuals who had not participated in either part of the consultation and who represented sectors the Working Group felt were not well represented in the community consultation process (selection process explained later).

The personal interviews conducted with individuals who participated in the consultation (n=7) are hereafter referred to as 'full consultation participants,' and the individuals who represented sectors the Working Group felt were not well represented in the community consultation process (n=2) are hereafter referred to as 'limited consultation participants' because they were representing sectors that had limited participation.

The interviewees were selected through stratified purposive sampling, utilizing snowball and opportunistic methods. The interviews were grouped according to certain characteristics, and then information-rich cases were selected for in-depth study. I grouped those individuals who had attended the second part of the consultation (the community meeting) into priority groups of health service providers, youth/children, or parents/teachers/non-government organizations. I then further grouped these individuals according to whether they had participated in the first part of the consultation or not. I attempted to balance each of these factors. These decisions were made using the returned evaluation forms from the community meeting, on which the individuals were asked if they would like to participate in my study. Some of the individuals were also identified through other people and I followed new leads during the fieldwork as well.

Of the seven full consultation participants who took part in this study, three had attended both parts of the consultation, three had attended only the first part of the consultation, and one had attended only the second part of the consultation, as mentioned earlier. A second interview was attempted with someone who had attended only the second part of the consultation, but the interviewee did not show up at the agreed interview and could not be reached following. The personal interviews with those who had not attended the second part of the consultation, but had attended the first part, were selected based on contacts made from my earlier observations or through individuals initially contacted by the Working Group.

The limited consultation participants were selected according to the priority groups the Working Group felt were not well represented in the community consultation process: Aboriginal people; youth not in school; and physicians. I interviewed two individuals who had not participated in the first or second part of the consultation: one a physician and the other someone who worked with youth not in school. In addition, one of the full consultation participants, who was Aboriginal, addressed some issues related to Aboriginal participation.

The backgrounds of the full and limited consultation participants included in this study were: youth services, social services, community development, education, health, parents, and youth. I continued sampling individuals until I felt the costs outweighed the benefits to the research.

#### **3.4.2.2 Interview Methods**

The interview with the Working Group was one and a half hours long and was documented through tape, field notes and a reflexive journal. The interview took place at the Working Group's regular meeting location.



The personal interviews with the nine individuals described earlier ranged from 20 to 65 minutes in length. They were documented through tape, field notes and the reflexive journal. The interviews took place at a location of the interviewees' choosing, usually at their place of work or in a restaurant.

All the interviews were approached in a similar fashion. The interviewing design was flexible rather than pre-prepared and rigidly followed. Guideline questions for the interviews were formed; however, flexibility and adaptability to the needs of the interviewees were maintained. I asked open-ended questions, so that the interviewees responded in their own terms. The interviews began broadly and became more focused as the participants identified their own claims, concerns and issues. The interview guides can be found in Appendix D; some examples of the kinds of questions that were asked in the interviews are:

- If you were to look back at the consultation process, what would you identify as the key elements?
- What motivated you to become involved?
- What were your expectations before participating?
- From what you know about the members of your community, is the document representative of their concerns, issues, recommendations?
- How did you feel about your participation?
- Would you do this again?
- What could have been done differently in order to have received this group's input?

### **3.5 Data Analysis**

#### **3.5.1 Organizing Documents and Field Notes**

With naturalistic research, the analysis remains open to new perspectives and thoughts. Memo-writing helped capture these when they were fresh. Analytic files provided a way to keep track of the growing amount of information, including notes about researcher subjectivity, as well as themes and dimensions of the research. The files were also the

beginning of a rudimentary coding scheme; the categories eventually divided and subdivided. Each of these techniques, as well as the keeping of a reflexive journal, assisted me in reflecting on, organizing, and interpreting the data.

### **3.5.2 Transcribing Interviews**

After transcription of the interviews, I went through each one, line by line, checking for accuracy. The transcripts were then given back to the study participants for their approval.

### **3.5.3 Analyzing Data**

Interview data were analyzed preliminarily immediately following each of the interviews so that they became part of the agenda in all subsequent data collection. The initial development of themes and categories, provided by the interview guideline questions and the criteria for success, created the framework for analysis. The in-depth analysis, following the completion of all the interviews, consisted of further dividing and subdividing, classifying and categorizing, defining and sorting the data. After breaking down the data into codes and subcodes, I then pulled together concepts and connections, or threads, in the data. This was balanced with a constant effort not to lose the meanings the data had for those who had shared them.

## **3.6 Ethical Considerations**

The University of Saskatchewan Advisory Committee on Ethics in Behavioral Science Research approved the research protocol. I was introduced at the beginning of each focus group and the community meeting, and the purpose of this study was explained. All study participants checked and approved the transcripts of their respective interviews. Confidentiality was maintained through the use of pseudonyms. A consent form, accompanied by a verbal explanation, was signed by all study participants before each

respective interview. The consent form outlined the expectations of both the researcher and the study participants. Copies of the consent forms (there were separate forms for the group and individual interviews) can be found in Appendix E.

### **3.7 Delimitations and Limitations of this Study**

The following delimitations were placed on this study:

- A single case of a community consultation process was explored;
- The time frame was from when I came to the project (January 1996) until the Working Group presented their report to the Health Board (February 1997);
- Selecting limited consultation participants to be interviewed was difficult. The decision was made to contact individuals from groups who had either expressed concern themselves or had had concern expressed on their behalf, about the group's lack of involvement in the consultation process.

The main limitation to this research was the time-line. Unfortunately, I was not able to follow the community consultation process to the point where the recommendations were reviewed at the Health Board level. This would have provided valuable evidence about the success of the process.

The decision was made to focus on the perspectives of those Working Group members who attended the meeting in which I was conducting the group interview. Those who could not attend were not asked for input. It is possible that they could have had different perspectives.

The questionnaires were completed anonymously and there was no way to track the respondents, thus I was unable to interview any full consultation participants whose involvement was limited to completing the questionnaire.

The most difficult part of this research was to be true to the naturalistic design, by involving the participants of the research in the research. This design placed many demands on the researcher, the study participants, and the thesis committee, with regards to time, energy, patience, and flexibility.

### **3.8 Trustworthiness**

In the naturalistic design, 'trustworthiness,' as opposed to 'validity,' is gauged by looking at goodness criteria. These criteria are described by Lincoln and Guba as credibility (establishing a match between the constructed realities of respondents and those realities as represented by the study), transferability (checking the degree of similarity between the original context of the research and the context to which the research is being applied), dependability (stability of data over time), and confirmability (assuring that research results are rooted in the data themselves).<sup>42</sup>

Strategies often discussed to improve the trustworthiness, and which were employed in this study, include: prolonged engagement, persistent observation, negative case analysis, peer debriefing, member checking, thick description, triangulation, and the use of a reflexive journal.

Prolonged engagement involved investing sufficient time to learn the context, test for misinformation and build trust between the study participants and myself. Persistent observation helped to identify important characteristics or elements.

Negative case analysis is "a process of revising hypotheses with hindsight."<sup>42,p.309</sup> I looked for disconfirming data in all observations. I consulted with my colleagues, my thesis committee (peer debriefing) and, as already described, the participants of the research (member checking).

Triangulation, Patton believes, is used "...to study and understand when and why there are differences."<sup>43,p.331</sup> However, the idea that employing different methods results in different images of understanding and increases the strength of the evaluation results has been debated. It is argued that different methods produce different understandings of a social phenomenon which we do not know how to reconcile.<sup>44</sup> On the other hand, I agree with Miles and Huberman, who suggest that

triangulation is a state of mind. If you self-consciously set out to collect and double-check findings, using multiple sources and modes of evidence, the verification process will largely be built into the data-gathering process, and little more need be done than to report on one's procedures.<sup>45,p.235</sup>

The reflexive journal was an important tool to ensure that I was not imposing my views on the evaluation results. Sources of these impositions included: my personal history, professional training, gender, social class, and adherence to a particular intellectual paradigm. However, by being conscious of these influences, laying them onto the table to receive the same consideration and criticism as other inputs, the quality of the study was enhanced. Factors of my personal background were examined, understood and accommodated by self-monitoring at each stage of the study.

I also tried to decrease my influence by presenting the voices of the participants, in all reports, as individual voices.<sup>46</sup> I did not collapse them into one through my interpretations.

I compared the data internally (with other responses) and externally (with other studies and with my own observations), and I looked for new themes and concepts in the data, as well as for contradictions or inconsistencies. These strategies allowed for continual checking of inconsistencies and clarification of ambiguity, enhancing the trustworthiness of the study's results.

## Chapter 4

### Findings

#### **4. FINDINGS**

This chapter is organized according to the framework which resulted from the thematic analysis of the data. Aspects of the community consultation process which facilitated community participation are presented in the first part of this chapter. Study participants felt that in order to have a successful community consultation it was important that the people doing the consultation got close to the community, that the community actively participated in the process, that a variety of appropriate opportunities were offered for community input and feedback, that a diversity of representatives of the community were invited to participate, that community input was obtained early in the process, and that tangible outcomes resulted from the process. These elements relate to two of the main criteria of this evaluation, identified in section 3.3: *the operational model will get the Working Group closer to the people*, and *the community consultation process will gather information from different representatives of the community*. In addition, three other factors were cited as being specific strengths of this consultation: the skills of those involved in the community consultation, the support of the Coordinating Group, and the openness and commitment of the Working Group members.

In the second part of this chapter, I describe barriers and challenges to community participation identified by study participants, such as the different philosophies of health needs assessment, an individual's view of health, the climate surrounding the assessment, organizational priorities, and the actual structure of the community consultation process.

The Working Group's lack of experience with consultation and resulting inconsistency, lack of resources, and political context were also seen as detracting from the quality of community participation.

One of the Working Group's motivations for including a community consultation process in this health needs assessment was to provide information that was not available in the epidemiological review (related to criteria 3: *the community consultation process will provide evidence for the recommendations*). This is described in the third section of this chapter.

Finally, outcomes of the community consultation process, besides the actual data collected, are described. These by-products include raising awareness of the broad definition of health and other issues, encouraging dialogue between the community and the health district, and facilitating continued community consultation.

The responses were generally congruent across study participants. Any substantial differences in the data are reported; otherwise the reader can assume there was general agreement.

#### **4.1 Facilitating Community Participation in Consultation**

Several aspects of this community consultation process were cited as facilitating community participation. These include getting the people who were doing the consultation (the Working Group) close to the community, engaging the community, providing a variety of appropriate opportunities for input and feedback, inviting a diversity of representatives of the community, obtaining input early in the process, and ensuring tangible outcomes.



#### **4.1.1 Getting the People Who Were Doing the Consultation Close to the Community**

It is important that those doing the community consultation get close to the community to increase the relevance and accuracy of the data collected. This is one of the rationales for the operational model of the Population Health Project (Appendix A), which has representatives from the community (as the Working Group) doing the health needs assessment. In this community consultation process, the Working Group members were very involved and committed to the consultation process. This is also identified as one of the strengths of this community consultation process, discussed further in section 4.1.7.3.

A number of the Working Group members were directly involved in the focus groups. Having been there added to their ability to analyze the data, to see the whole picture. It also brought some personal gains.

**Working Group member:** That's really hopeful, when you start talking about communities needing to value their children, that that [participation in the consultation] is an expression of doing that, and that is very hopeful. So, it's been a very energizing process for me to be a part of [it and] to see that happen.

They were concerned about the difficulty in compiling the information from the individual focus groups: "...with the focus groups, we lose the sense of the overall discussion and flavor. How can we recapture that [in the report]?"

The Working Group members attached a great deal of importance to the community consultation process; they didn't want it to be a token consultation.

**Working Group member:** There was a feeling that quite frequently community consultation comes after the fact, after the expert has put together a package and they bring it out and defend it to the community. And we didn't want to be defending what we were doing. We wanted to be able to defend what the community said. ... So, we're defending what they said, rather than what we said. ... It would be more meaningful to be community information rather than committee [Working Group] information.

The community input drove the process.

**Working Group member:** ...we wanted to hear what they [the community] had to say, without being influenced by us, other than, here's our definition of health. Health is now the emotional, the spiritual, and all, so when you're thinking about children and youth, think about them in those terms, and what are the issues?

Throughout the community consultation process, the Working Group members had repeatedly expressed concern about the process and whether enough time was given for feedback. They also wanted to make sure the community knew that they were providing a work in progress which could be changed at any time according to feedback received from the community. Parts of the report were rewritten after the community meeting as a result of feedback that the Working Group received there. The Working Group also attempted to identify other groups that had worked or were currently working on child and youth issues, and they collected the groups' published and unpublished reports.

The Working Group began their analysis of the data before all of the data had been collected and were available to them, due to time constraints. They continually reminded

themselves that more data were coming and left opportunities for integration into the analysis. Because of the variety of data collection methods, the credibility the Working Group members gave to the community consultation process, and the involvement of the Working Group members in the community consultation process, balancing of the data from the community consultation process with those from the epidemiological review in the formation of the recommendations did not end up being an issue.

**Working Group member:** I think, as it comes in, and we're looking at the data and hearing it, it will bring with itself a weight, a size, that will come to the discussion ... although it [the information] comes from 12 voices or 14 or whatever in a focus group, we will recognize its weight, and we will balance that. I think that that's something that we can do because it [the community consultation process] is so broad and because we're doing this in a variety of ways. I think information comes with a sense about it. While we may have different senses, I think we'll come to a consensus around the importance and the size and the emphasis that the issues need to have coming out of this committee [the Working Group].

**Working Group member:** ...to come out with a report on health of children and youth and recommendations which bears no relationship to what the community is actually thinking, or ignores what the community is thinking, to me, would be very wrong. So, if there's an issue that keeps coming up in the community, which isn't supported in the [epidemiological] data, then that still has to be addressed in the report, in my view, in some fashion.

#### **4.1.2 Engaging the Community**

Those who participated in the community consultation process generally did so wholeheartedly.

**Working Group member:** I was amazed. The first [focus] group that I did, ... with Public Health, people crashed the party. They said, 'I know that there's only supposed to be 12, but we came anyway, because we have something to say.' And she sat down and said it. That level of commitment. I mean I knew there would be some people but that sort of level of commitment, in other groups that I've seen as well, has been really amazing.

Individuals also took the questionnaires forward and presented them as priorities in their respective organizations. The Working Group received a great deal of written input from the questionnaires. Many of the responses were covered front and back with writing, some had other sheets attached. Based on these examples, as well as my own observations, the community consultation participants appear to have devoted a great deal of their time to the process.

**Working Group member:** Certainly the response from the focus groups, in my experience, has been, when we've gone to people and asked 'will you come and meet with us for two hours?' - that's a long time - people are very willing, if they're asked. And they seem to really appreciate being asked to come and share their opinions ... I think those people have felt good about that.

Some of the consultation participants came with names of other individuals or organizations which could be contacted for input, or brought written materials such as reports to give to the Working Group. Some participants even spoke about their experience among their friends and colleagues.

**full consultation participant:** I told my friends about it, too, at school, and some of them had no idea that it was on and they hadn't heard about it and they're like 'Wow, I wish I could have been there.'

A number of groups and organizations offered to be involved in the implementation process, such as providing input into health planning through making more connections between agencies, or being a resource for ongoing data collection.

The community responded very positively to the report released by the Working Group as evidenced by the requests for presentation of the report. In addition, the media was present at the community meeting.

A good measure for satisfaction is whether people would be willing to do it again; all people I interviewed said they would definitely be involved again.

**full consultation participant:** I think that it [facilitating continued consultation] was achieved, with me anyways, because this is something that I would come to again. I know the youth group [that this person was a representative of] is really interested in coming to this again.

Commitment also comes from knowing that the information is representative of the larger community. Many individuals mentioned that the report was not just representative of the Working Group.

**full consultation participant:** It was definitely a step up. I was very encouraged to see that it [the first part of the consultation] had been followed through on, as indicated by the written report. The written report came from the people who were consulted, as opposed to the people who wanted the consultation done.

There were, however, some concerns about the community consultation process. The feedback at the community meeting, due to the limited attendance, may not have been as reflective of the community relative to the original input of data. The Working Group tried to address this by approaching certain organizations, such as Aboriginal and

physician groups, for additional feedback, without success. Another concern was that the Working Group was "going through the motions" (full consultation participant). This is discussed further in section 4.2.3. Finally, the format of the community consultation process may have been too structured for some groups, such as Aboriginal peoples and youth not in school. This is discussed further in section 4.2.5.

#### **4.1.3 Providing a Variety of Appropriate Opportunities for Input and Feedback**

Study participants felt that it was important to provide opportunities for community input and feedback but that the opportunities needed to be appropriate and offered in a variety of different ways to reach different audiences.

**Working Group member:** I think the communities, the people out there, have ... always wanted to have a say, or to be able to speak their voices. I think we've created and facilitated that process.

The numbers who responded were smaller than what the Working Group originally thought they could accomplish, but that may have been due to their lack of experience and thus high expectations. Some members of the Working Group and others that they had spoken with felt that the numbers were satisfactory.

However, the Working Group looked at the responses from the perspective that the quantity of people doesn't necessarily improve the quality of the information. They were less concerned about the numbers of people who actually responded and more concerned with the numbers of people who had the opportunity to respond. The Working Group and those interviewed felt the opportunity was there for certain segments of the population more so than for others:

**Working Group member:** ...those kinds of written opportunities are really only an opportunity for a certain segment of the population. For a certain segment, though, they are a valid tool.

Those I interviewed, for the most part, were those who had participated, so it is not surprising that they saw the opportunity. The format of the community consultation process may not have been appropriate for other groups, as discussed in section 4.2.5.

The Working Group tried to ensure that there were a number of ways for the community to be asked and to offer input. They wanted to broaden the assessment process by obtaining information from individuals and groups at all levels of the social hierarchy, not just those with more power who have typically had input. The Working Group's efforts came across to many of the participants of the community consultation process.

**full consultation participant:** ...of all the different consultation processes that I've been involved in, this has been the broadest one. Because it seems to have occurred at many different levels, and they seem to have gone out of their way to try to involve as many people as possible.

#### **4.1.4 Inviting a Diversity of Representatives of the Community** **(especially those not usually heard)**

The people of Saskatoon and its surrounding health district are very diverse in their sociodemographic characteristics and their interests.

**full consultation participant:** We have to find a balance in there [who is invited to participate in community consultation] because Saskatoon District Health is offering a wide variety of services to everyone in Saskatoon.

The Working Group wanted to capture this diversity in their health needs assessment and especially in their community consultation process.

**Working Group member:** One of the things that we wanted to do was to make sure that we had as many voices in the process as possible, and allow the people without a voice to have a voice.

They had identified certain groups as priorities, including youth not in school, Aboriginal peoples, and children.

**Working Group member:** We prioritized any group that we thought represented those unheard voices and put a lower emphasis on groups such as health care providers, that would likely be easier to get together in a group. But just in terms of how much time we had left, we tended to prioritize the groups that we felt needed more representation.

There was disagreement amongst the members of the Working Group whether physicians were a priority group.

**Working Group member:** I think they [physicians] have a role to play in the medical system here. And I'm not sure whether they have been all that receptive to our process. We have a terrible time trying to get somebody sitting here [as a member of the Working Group], and I'm not sure how good a response we have had [in the community consultation process].

**Working Group member:** I would be less concerned about the physicians ... being hurt by this [working] group because they are a very powerful group, collectively, and have historically directed the system. And the opportunity had been offered [to the physicians], and many [physicians] did respond.

The Working Group felt that they had made every attempt, within their resources, to reach the priority groups. They recognized, though, that youth not in school were not well represented in the data:



**Working Group member:** Probably one of our biggest gaps is the youth not in school. We have had a very difficult time trying to reach them.

Also, there was a limited number of male respondents and thus no attempt was made to analyze the data according to gender.

#### **4.1.5 Obtaining Input Early in Process**

The Working Group thought it was important to receive input early in the community consultation process so the report would reflect what the community members were saying and they would not feel their input was tokenistic.

**full consultation participant:** People feel that they have been listened to when they have been involved early on in the process, because then you kind of buy into it. When you hear about it the day before something major is going to happen, you think 'Oh, well, they don't care. They didn't bother involving us, or asking us what we thought' or whatever, so it's not the perspective of people.

The Working Group recognized, however, that their timeline represented an imperfect process and to compensate tried to have "a number of opportunities to revisit and return to the information to make sure we don't miss anything."

It was felt by some of the study participants that those who did not have input into the first part of the community consultation process might not have felt linked to the draft report and might have been less likely to have become involved in the second part of the consultation. Despite the Working Group's efforts, some groups did not feel like they had had timely input.

**limited consultation participant:** Some people had read the report beforehand or looked at it at that time [at a meeting between the Working Group and physicians] if they hadn't [beforehand], and there were comments made that were well received - sensible ones. But there was an impression that this was a done deal by the time we looked at it, so there wasn't a whole lot of enthusiasm.

**full consultation participant:** These people [general public when invited to the community meeting] were coming in at the end [of the community consultation process] and may have felt like it [the Working Group's report] was already set.

Those that were missed out may not have felt a sense of ownership over the product.

**full consultation participant:** In terms of the follow up or the ownership of what was coming out of it, I'm assuming that there wasn't a sense amongst our staff that they were connected to that outcome.

#### **4.1.6 Ensuring Tangible Outcomes**

**Working Group member:** ...there's got to be a full process of speaking, hearing and action.

People are more willing to contribute if they believe they are being listened to and that some positive action will be taken as a result of their input.

**full consultation participant:** ... we're all humans, so when we speak and somebody listens to that and reflects on it and captures it, you feel 'oh' you know 'okay, maybe this is important.' And you might have thought it wasn't important before. You're sort of validated that way.

**full consultation participant:** You have asked us for our opinion; we provided it ... to you and we trust you that you will do something with it.

**full consultation participant:** I feel if it's not a waste of time and it will be used, I will participate in it.

All the participants in this study felt that they had been listened to in this community consultation process.

**full consultation participant:** ...if people, however, continue to think that upper management is not going to listen, then they're not going to come forward with ideas at all. This [the Working Group's draft report] was a very clear indication that, yes, they were listening.

**full consultation participant:** ...I felt very strongly that they [the Working Group] were trying to listen and trying to capture the essence of the feeling or the comments of the people who participated, not their own.

**full consultation participant:** I felt that we had spoken and they [the Working Group] had listened. ... I felt validated that way.

The response from the full consultation participants indicated that the draft report was representative of the input from the community consultation process and addressed issues that had come up. The report was seen to be grassroots-based, "as opposed to what upper management sees is in the community" (full consultation participant).

The report is only the first step of being heard, though. Step two involves the follow-up by Saskatoon District Health and the implementation of the recommendations.

**full consultation participant:** ...if you say that this is important enough to do, then the report should be important enough to be taken seriously.

**Working Group member:** An ultimate evaluation of the whole thing [the community consultation process] will be the reaction to our goals and recommendations by the [Saskatoon District] Health Board. Otherwise, if that doesn't happen, the community will say, 'Well, what the heck, we go through a process, we voice our opinions, we know it was heard by the facilitators, but the people who can make it act aren't doing anything anyway.'

The Coordinating Group and the Working Group each recognized their role in ensuring that action is taken by Saskatoon District Health.

**Working Group member:** The onus is on us, though, now that the consultation has been done, to make sure that the input is made known, and that it's handled in such a way that those that responded feel that they were heard. And that people who need to hear will be listening. It will be a big responsibility on our part, to ensure that we address that.

There was quite a bit of preliminary work done by the Coordinating Group (i.e., meetings with Saskatoon District Health department heads affected by recommendations, vice-presidents, general practitioners, and general managers) to provide information about the release of the Working Group's report. The CC and the Working Group asked for wide release of the report and called for some action to come following its release. A press conference was called by Saskatoon District Health to announce their plans for implementation. The press conference took place in March 1997, at which time my involvement as researcher had ended.

#### **4.1.7 Factors that Strengthened the Consultation Process**

Certain factors were cited as positive influences on this community consultation process: the skills of those involved, the support of the Coordinating Group, and the openness and commitment of the Working Group.

#### **4.1.7.1 Skills**

The quality of the community consultation process depended to a large extent on the skills of the people working on it.

**Working Group member:** I think, with the focus group, if the facilitator has good skills it enhances the process. If the people who are putting together the survey have good skills and good information, it increases the strength of the survey. The skills of the research person, taking that data and putting it together, that expertise increases the value. The people, and their expertise, certainly raises the value of the process.

There were many positive comments about the skills of those who undertook this community consultation process.

#### **4.1.7.2 Support of the Coordinating Group**

The Coordinating Group was very supportive by providing positive feedback to the Working Group. The Coordinating Group also organized meetings with Saskatoon District Health department heads affected by the Working Group's recommendations, vice-presidents, general practitioners, and general managers, to support the presentation of the Working Group's report to the Saskatoon District Health Board.

The Coordinating Group represented a strong ally with regards to the Working Group's health needs assessment philosophy:

**Working Group member:** I think an important thing was that the whole consultation grew out of either a direction, or a sense from this larger committee [the Coordinating Group] that, not only were we going to the literature and making recommendations, but that we wanted to hear from citizens, and thought that it was important that they had a voice in this.

#### **4.1.7.3 Openness and Commitment of the Working Group**

##### **Members**

The full consultation participants did not feel judged by the Working Group and felt comfortable in sharing information with them.

**full consultation participant:** I felt that they [the Working Group] were really open to anything that people had to say. They weren't trying to lead or provide the answers. They were really open to say 'This is what we thought you said and it's captured now on paper. Did we hear you? Is this correct?'

Generally, the Working Group members devoted themselves to the philosophy of community participation in health needs assessment and were willing to put in extra time and energy which they saw as necessary to achieve meaningful participation.

**Working Group member:** I think it [the community consultation process] does have some merit, despite all of the problems that you [the critics] may perceive with it. And there has been some good work done, and there is some merit in doing what we have done, as we could. I mean, the alternative is what? For the system to sort of carry on and do what they've been doing, or we've been doing, in the system, that hasn't served people well? Well, the alternative for us would have been to have only what we could glean from our experience and the data from our [health] district and a literature review. And completely not hear the voice of the people. So, within our framework, we may be nuts, but that's the timeline that we have, so we didn't have much option, if we wanted to do what I think we, around this table, believed ... was important ... Within that time we just have to go for it.

#### **4.2 Barriers to Community Participation in Health Needs Assessment**

The barriers to participation in the community consultation process identified in this study are: differing beliefs about the value of participation in health needs assessment; lack of

interest in health among some members of the public; a climate of skepticism surrounding the community consultation process due to past experiences; organizational priorities which result in less emphasis on health; and the actual structure of the community consultation process which may inhibit participation by marginalized groups. There were also other more specific factors which detracted from the community consultation process, such as the Working Group's lack of experience and the resulting inconsistencies in the process, the lack of available resources for the process, and the political context surrounding the process.

#### **4.2.1 Philosophy of Health Needs Assessment**

The individuals' philosophies on health needs assessment affected the extent to which they were involved in the community consultation process. Those who felt public input was important were more likely to value the process of community consultation and become involved.

**full consultation participant:** ...because of the diversity of the population it [input into the process of health planning] is absolutely necessary.

One limited consultation participant questioned whether public input was necessary to health needs assessment: "...the results of that [community consultation process] I think would be from a scientific point of view, probably uninterpretable. You couldn't really analyze it in a statistical way and get a truly meaningful, scientifically significant interpretation of it."

This person saw service providers as important intermediaries for gathering information from the community.

Direct providers of health care ... and the patient ... know clearly what the requirements are to strive to insure the best possible health care. We as providers of health, knowing the needs and desires of our patients and clients, should develop the plans and programs and solicit feedback, input and ideas from the administration with respect to how realistic the programs are in the context of budgetary and logistic constraints. Direct providers of health care should be afforded the opportunities to be proactive in terms of restructuring the health care system rather than reactive to the ideas and proposals that emanate from those who do not provide direct health care.

The same individual questioned whether it is necessary to involve the community in health needs assessment.

It's nice always to be perceived as being open and communicative, and that is important. But the process by which you give a questionnaire to all the children in the school system, and all the newspapers--I don't know if that told us anything more than those of us who provide care for children already knew. ... I think [physicians] need to be approached by the Health Board and say ... do you think a working group is necessary, or what would be the structure, what would be the agenda, and mission of that group. And is it necessary or can we go out for lunch for an hour and come to the same conclusions - you know, with the three of us or the four of us.

These questions were based on doubts about whether new information would be provided through the community consultation process, as well as the idea that the people who respond to community consultation are not representative of the community. This latter idea was also mentioned by other study participants.

**full consultation participant:** It's people who read and who are motivated who will read that and take the time to take it to heart and act on it or not.



**Working Group member:** We've either got the really busy people who can't find time in their schedule and carry cell phones, or you've got the hard-to-reach voices which take more time to organize and bring together and discuss. So, I don't think our second process [the community meeting] is going to, really, serve either. And we seem to be getting, more and more, in our society, into those two lifestyles.

**full consultation participant:** But there's a whole other large percentage of the population that doesn't quite understand [that the invitation to participate] is important, can't read it, doesn't make sense to them, and they're just going to toss it in the garbage can. And that's probably the people that you need to be getting your feedback from because they're the ones with most of the needs.

**limited consultation participant:** What I think tends to happen when you ask for feedback from the community [is] you get feedback from people who are either dissatisfied, disgruntled or have a personal agenda. And while I think it's definitely important to nurture that kind of feedback, I don't know if the form in which it was done is necessary...

The Working Group felt that the data gathered from the community consultation process reflected the same major concerns as had the epidemiological review. This agreement convinced them that the community consultation process did not only get the "dissatisfied, disgruntled or [those who] have a personal agenda."

The physician interviewed indicated some confusion as to who makes up the community.

I'm not sure whether going to one of those [consultation meetings] would have been to go for information for us, or to go as informers... Are they looking for input from us at those, or are they looking for us as part of the team that's hearing what's gone on?

Generally, though, the community consultation process was seen by the study participants as a necessity for public input into health planning.

**full consultation participant:** ... I know, having worked for 23 years, that a lot of things are achieved best when there's some community support and snowballing behind them. ... Professionals can say all they want, but when you get the community and people interested in a particular issue...

#### **4.2.2 View of Health**

Health is seen as an urgent issue but seems not to grab people's attention as much as, for example, property taxes being raised. One person in this study theorized that it is because decisions about amounts of money that people have to pay deserves attention whereas how the money is actually spent is less important.

Another person felt that the public may not feel that health involves them and/or their lives. For example, if someone thinks of health just in terms of doctors, nurses and yearly physicals, they may not feel it is a priority to provide input to a health needs assessment. If their understanding of health does not include individual or community participation then they may not pay attention to the requests for input.

**full consultation participant:** I think people pick up on something that interests them. Like when it advertises Garth Brooks is coming. I don't care, 'cause I don't like Garth Brooks, so I don't pay attention to what it says.

This individual commented that if someone is healthy or has a healthy child they may feel less urgency about responding to a health needs assessment because at the present they may not feel that they have any health needs.

### 4.2.3 Climate

In this study, a lack of trust and frustration existed due to past experiences with other community consultation processes. In the general public, many groups and individuals have been involved in community consultation over the previous years as it has become the 'trendy' thing to do. However, when the study participants felt as though they, or other members of the general community, were not being listened to and their contributions were not represented in action, they became cynical and less motivated to participate in future community consultations.

**full consultation participant:** It can be a futile attempt as administrators often do not accept the input of non-health care parents and professionals - often we are listened to but not heard.

**full consultation participant:** People may have thought they [the Working Group and Saskatoon District Health] are going to do what they want to do anyhow, so, I'm not going to go [to the community consultation process].

There was some skepticism about what action would be taken following the community consultation process. Many study participants had, in the past, taken part in 'token' community consultations.

**full consultation participant:** I just hope it's carried through. Instead of, they've already decided, but to put a good face on it, they want to make it feel like people are having some input into it.

**limited consultation participant:** It's all very fine and well to go through a consultation process and see what people think are health issues, but where are you going to go from there with it? Is it an exercise in futility, or are you going to take it further and actually adopt some of those ideas?

#### **4.2.4 Priorities**

Organizations have their own agendas for action and their own priorities to follow, which may have limited their involvement in this community consultation process.

**full consultation participant:** Initiatives will be led by one particular department because that's in their budget or where they wish to go, and they look, as they should, to involve other departments. But each one has its own priorities around the things that they're doing. ... it's really difficult at times to get everybody on the ground floor with that initiative and everybody having the same priority.

One of the individuals interviewed, from a non-health sector, felt that that sector is at the bottom of the hierarchy and, as a result, turns inwards and does not collaborate with other sectors. This individual speculated that other non-health sectors may not have participated in this community consultation process because health is also not one of their priorities.

Lack of time was also cited as a barrier to participating in the community consultation process. Service providers in the community are often overwhelmed with requests for information and descriptions of present initiatives.

**full consultation participant:** From this position [as supervisor] you get information, hierarchy of bureaucracy... but it's not the same when you're carrying a caseload up to here, and you're not attending any of those [between organizations] meetings. You don't have time... So if you're a staff person and you hear about a meeting on such and such, on a Saturday, or even if you saw a poster, would you necessarily distinguish what this is about compared to all these other things that are going on? Chances are you wouldn't.

Where the funding is coming from helps determine the priority level for different sectors:

**full consultation participant:** ...we still have a budgeting process in government where each department through each cabinet minister then goes to cabinet finalization when you're trying to get funds for your particular area. There's some capacity there for department Ministers to work together on things; but in many respects, it's not our system.

The vertical structure of government is a barrier to collaboration between sectors, as reflected in these previous comments.

One of the study participants described a special concern with Aboriginal groups in that health is a treaty right and, in trying to honour that, Saskatoon District Health and the Tribal Councils may have conflicts regarding who is seeking and providing the information for health needs assessment and who is delivering services.

#### **4.2.5 Structure**

Some study participants expressed concern about the structure of the community consultation process, related to race and class, specifically for marginalized groups.

**Working Group member:** ...part of that process is very white and middle class and directed by the system, and we're saying to people, come and join us for a period of six months, tell us what you think we should do, give us your information, we will take care of it, and we will pass it on to somebody that we don't know, they've given us some verbal reassurance that they will take some action on it.

The Working Group had a close connection with an organization that works with youth not in school and had set up a focus group with youth at this organization. However, the youth did not contribute in the focus group. One of the study participants who works

with youth not in school thought that the lack of involvement was related to the structure of the focus group:

...in certain group-type situations, they're [youth not in school] not really free to open up and also ... having new people ... older people come in and talk to them makes them feel uncomfortable ... with the whole situation. ... It was more of a question and answer period, which I think turned them off a little bit.

The Aboriginal person interviewed, when asked why more Aboriginal people had not participated in the community consultation process, commented:

...quite often when we [Aboriginal people] get involved in the committee [in general], we feel because the process is unfamiliar, it's a different background we bring to the table, we have to try and make it less structured. The structure has to be there, but not so rigid.

Related to this, the structure of the health needs assessment may have been an issue for physicians.

**Working Group member:** I think the ... consultative process and the ... sharing of power is not always one of their [physicians] ... immediate experience.

However, the Working Group also had difficulty, with some groups, in the actual identification of channels to go through.

**Working Group member:** ...one of the things that we have struggled with is identifying ... finding the tap lines, into the community.

**Working Group member:** I think what we have done is identified, and are willing to go where the doors are open and where we can make a connection.

#### **4.2.6 Factors that Detracted from the Consultation Process**

The following factors negatively influenced this community consultation process: lack of experience and consistency, lack of resources, and the political environment.

##### **4.2.6.1 Lack of Experience and Consistency**

The Working Group members did not have previous experience with community consultation, although some had had experience with health needs assessment.

**Working Group member:** ...we wanted the committee [Working Group] to take ownership and develop it [the community consultation process], and yet, ...because we were all so new at figuring out how to do it on such a scale, ... we spent more time figuring it out and maybe used some of our resources that might have been ... used in better ways.

They had difficulties knowing who to go to for advice, and because there is little research on community consultation and community participation (as discussed in Chapter 2), there was little agreement, by the advisors, on the approach to take.

**Working Group member:** We didn't know what to do, so we went out and asked for advice and we got three different kinds of advice. And they couldn't agree as to what was the best way to consult.

The result of this, therefore, was a lack of consistency in the format of the community consultation process, which affected the consistency of the data collected. Similar issues were identified across the community and there was repetition across the focus groups. However, some groups focused more on policy where other groups focused on action, and the extent to which the issues were identified and strategized also varied.

There was also a lack of consistency in the way in which the data from the focus groups were recorded. There was no pre-determined format to follow and thus the notes were sketchy. The person who did the analysis did not attend many of the focus groups and was therefore not aware of the discussion behind the issues brought up in those gatherings. This resulted in a simplistic approach to the analysis of the resulting data.

#### **4.2.6.2 Lack of Resources**

The Working Group members felt their work was limited by time, money, and personnel.

There is a gap between the vision and the reality [of the resources] Saskatoon District Health is willing to put [into the community consultation process], and [what they are] able. That keeps hitting us every day. The vision is wonderful. The ability to actualize that ...

It takes a certain amount of time to get it [the community consultation process] organized, and then to fruition. The smaller committee struck met over three months, to even develop the format and questions, and then get feedback from the committee [the Working Group] as a whole, and then feedback from advisors and people who we were most intent on getting their assurance that yes, this in fact will be valid. So, it just takes a chunk of time just to get it started. But then there was the actual implementation of the plan. To me that was also a real stumbling block because we had a great plan, it was a wonderful plan, but how were we actually going to do that, given the resources that we had?

These resources were also influenced by the fact that all of the members of the Working Group, with the exception of the Working Group researcher, were volunteers.

**Working Group member:** A lot of it was because the volunteerism - if we'd have been full-time employees or whatever, that could have really happened quite quickly. ... You go to the meeting and you follow up on all of these things, you go back to your own job the next day and you've got all of this work that needs to be fit in too. So, I think it was really that implementation part that slowed us down.



It was felt that with an ongoing process the lack of time, and thus lack of energy, might become less of an issue.

**Working Group member:** If the process was ongoing, or at least very long term, so there was some evidence of some positive experience and outcome in this, then I feel we would have some more time and energy to do this. Because, as volunteers, it has been a big commitment.

The lack of resources may have influenced the quality of the data collected.

**Working Group member:** We could continue this process longer and have better input, but we had a limited timeline and resources.

**Working Group member:** It gets away from giving everybody the opportunity. It's just a matter of efficiency of process and time consumption.

#### **4.2.6.3 Politics**

The political environment, within Saskatoon District Health, within the community, as well as generally, may have influenced participation.

During the community consultation process the Health Board changed from an appointed system to an electoral system, "a more open-ended, more political kind of arena" (Working Group member). This conflicted with the approach to the community consultation taken by the Working Group.

**Working Group member:** ...the electoral process tends to really focus on single issues, whereas we've taken a very holistic, and asked people to take a very holistic, look. So that's a bit different as well, it's unfortunate that it's different, but it is.

It appeared that changes in leadership of some sectors of the community contributed to the loss of communication between the Working Group and those sectors of the

community. Changes in the health care system, although motivating some parts of the community to participate in the community consultation process, inhibited the motivation for others.

**Working Group member:** There's a real turf protection right now. The GPs [general practitioners] are afraid that the care of children are being taken over by the pediatricians and they're not having much say in care of them. There's really a lot of turf protection. And I think the GPs are feeling really threatened by the changes that have occurred in health care.

It was thought that this may have affected physicians' participation in this community consultation process.

#### **4.3 Providing Information not Available in the Working Group's**

##### **Epidemiological Review**

One of the Working Group's motivations for including a community consultation process in this health needs assessment was to provide information that was not available in the epidemiological review. They tried to improve the accuracy and completeness of the data by combining quantitative (the epidemiological review) and qualitative methodologies (the community consultation process).

In the world of data collection there is a perceived dichotomy between quantitative and qualitative methodologies. This working group was no exception. The Working Group resolved this conflict by seeking a balance. Quantitative methods were seen as being more respected by certain segments of the population, for example decision-makers and service providers.

**Working Group member:** I agree that they [the community] probably have a pretty good picture of it, but I think if you're going to take just that information to a Health Board or to physicians or to those kind of people who tend to be a little more quantitative ... they want to see the quantitative as well as the qualitative. I think that has to be there in that process, both sides.

The Working Group also saw quantitative methods for health needs assessment as having the potential to be more representative of the longer term and less "issue of the day" than qualitative methods:

**Working Group member:** We have to keep in mind that this [data from the community consultation process] is a snapshot of now ... it is of today and may not be exactly the same response a year from now. And is influenced by issues of the day.

However, the Working Group members acknowledged that certain voices are not heard and are not represented in quantitative methods, traditionally included in epidemiological reviews, and that "without people input, some issues don't get dealt with" (full consultation participant). This was why a balance between qualitative and quantitative data was sought.

**Working Group member:** I think that whenever there's a consultation process, you also need to have the hard data and the other information as well. Because in any consultation process, the people who respond are the people who have an interest or who see particular issues or who are in that venue or who are led through it by a teacher or some other reason. But there's a huge group of people who don't take the time to respond. They may have the same issues, but then again they may have other issues. ... There may be things that we miss in the consultation process just because of what's built into people participating, or taking the time to participate in a process like that. So I think it's important to combine those things, to make sure that you don't have a lot of

special interest groups or a lot of people with a particular frame of reference, sort of leading that process, and that you are looking at other things that will validate that, or invalidate what you're finding in the consultation process.

The Working Group members who had been involved in the focus groups found that this involvement added to their understanding: "Being there is certainly a different experience than simply reading the notes." Working Group members often, during the analysis as well as the forming of the recommendations, referred to the focus groups that they had attended and what they had heard there: "The work that was done at the focus group really helped shape the future work of our [working] group."

#### **4.4 By-products of Community Participation in Health Needs**

##### **Assessment**

Besides the actual information collected, other products resulted from community groups and members participating in the health needs assessment. These by-products included raising public awareness about health and other issues, encouraging dialogue between the community and Saskatoon District Health, and facilitating continued consultation.

##### **4.4.1 Raising Awareness of the Broad Definition of Health and**

##### **Other Issues**

The Working Group members wanted to raise the community awareness of the broader definition of health. They felt that the community consultation process in itself helped to educate and increase community understanding. The Working Group members and the volunteers who facilitated the focus groups felt that they had learned a great deal about the determinants of health in their community.

However, raising awareness of the broad definition of health was seen as being not solely the task of community consultation process and not accomplishable by community participation in health needs assessment alone.

**full consultation participant:** I think that [raising the awareness of the broad definition of health] will come slowly over time. I don't think they, as one working group, can have significant impact on that. I think it has to be from many different areas.

Bringing people together in the community consultation process also helped raise awareness of other issues. The individuals who had participated in the community consultation process learned a great deal from the others in the process about their particular concerns.

**full consultation participant:** I think all the other participants in the group really listened to one another and we learned a lot from people in the various groups.

They benefited from the group interaction and felt a sense of solidarity on certain issues.

**full consultation participant:** I think as a group, if there's a large enough group [coming together] and if we all know that the other person is [bringing up the same issues] ... if we [come] together, then it's excellent.

My observations of some of the individuals when being interviewed led me to believe that this sense of togetherness built into a feeling of control. One full consultation participant agreed:

And by sharing that [our concerns], I think that [raised awareness] might spread to their contact with people. Again, this whole idea of just raising the awareness of, 'Yes we have a say, we should have a say.'

Working Group members were convinced that the increased community awareness of the broad definition of health and of other issues would thus translate into increased involvement in health policy.

I think the more educated they [members of the community] are, the more influence they can have on the Health Board and the direction [of health policy].

The initiating of changing policy - that's what this whole process is about. That's what will have to happen if the community is saying that there have to be changes, then policy will have to change.

#### **4.4.2 Encouraging Dialogue Between the Community and the Health District**

Study participants saw the community consultation process as contributing to improved communication between the community and the Health Board in several ways. The community consultation process prepared the way for some new, and strengthened some existing relationships.

**Working Group member:** Even the process itself, whereby the message gets out to principals, to teachers, that the Saskatoon District Health Board has a teacher ... on the committee [Working Group], and they're [Saskatoon District Health] interested in our [Education's] opinion about health, they're recognizing that we make a contribution to health, that we have some ideas and opinions about health.

It also increased community understanding about health needs assessment, program planning and resource allocation.

**full consultation participant:** I appreciate being involved in the process and now have an understanding of the extensive job Saskatoon District Health is faced with.

The members of the community were provided with a better sense of who and what was working for their health and were encouraged to become more involved in setting that direction.

**full consultation participant:** Definitely, I got a better understanding. ... I had no idea that ... people were trying to achieve goals about mental health ... I didn't know people were out there working for us to do this [become involved], and definitely I think that it's an excellent thing.

**full consultation participant:** I do remember one girl saying that 'well that's good that they did that. At least somebody cares about us, and somebody's thinking about our future' and things like that.

#### **4.4.3 Facilitating Continued Community Consultation**

Generally, the study participants felt that the community had been heard in this community consultation process. Among those who participated, this, in itself, might facilitate continued community consultation as the process has increased these individuals' confidence and trust in Saskatoon District Health. They are not looking through rose-colored glasses, however, and expect the dialogue to be ongoing.

**full consultation participant:** They've done a good job of facilitating consultation, and if they continue it [needs assessment process] in the way they've started it, it should be very good.

Working Group members thought that the public nature of the community consultation process raised certain expectations in the general community and that community members would expect to provide input and to be listened to with regards to their health needs.

**Working Group member:** I think a lot of the communities, right now, they're in a mindset that they have something to say but they don't expect to get a chance to do it. I think that this [the

community consultation process] has opened up that expectation, and when [the Saskatoon District] Health Board does it [health needs assessment] now [with future working groups], that expectation will be there. And once you have that expectation, it's pretty difficult to say, 'we're stopping that process now.' Because they [the community] will say, we know the process, and they'll just carry it on. They'll take it and make it part of their way of doing.

It was urged that community consultation not be a one-time activity but a long-term, ongoing process.

**full consultation participant:** [Defining our community] is one of the steps to take in the consultation process, to listen, to be open, and to know that it's going to take time to build up that trust.



## **Chapter 5**

### **Discussion**

#### **5. DISCUSSION**

This chapter brings the study findings together with the criteria for success established by the Working Group, Coordinating Group, Research Advisory Group and myself, to discuss the effectiveness of the community consultation process in facilitating meaningful participation in health needs assessment. Facilitating factors and barriers/challenges to the community participation are also discussed. The larger health promotion context is brought into the discussion through the use of relevant literature.

The chapter ends with a discussion about components of this study relevant to health promotion practice, specific to community participation in health needs assessment, and suggests possible future research.

#### **5.1 Evaluation of the Community Consultation Process**

The Working Group wanted to fulfill its mandate while, at the same time, achieving certain goals as reflected in their criteria for success. Important issues to address in order to evaluate the use of the community consultation process are: Did the Working Group enable meaningful consultation by citizens and care providers? Did the community consultation process meet the established criteria? How effective was the community consultation process in facilitating meaningful participation in this health needs assessment?

### **5.1.1 Meaningful Community Consultation**

The mandate of the Working Group was to ensure meaningful consultation by citizens and care providers. Meaningful consultation is defined, in Working Group documentation, as that which is *appropriate, timely, complete, accurate, representative and relevant*. All of these qualities of meaningful community consultation are dependent on each other. The more timely and appropriate the consultation, the better the community representation. Increasing the representativeness of the consultation will increase the completeness and the accuracy of the data, as well as ensuring its relevance.

Ownership of the product appeared to have played an important role in the community participation. In a process such as this, it is difficult to reach everyone and those that are missed out feel isolated and 'left out of the loop.' This also leads to a lack of a sense of ownership over the product. It seems to have been important to include as many people as possible as early as possible (i.e., cast a wide net). Once the net was cast it was difficult to facilitate participation of others due to this feeling of lack of involvement and ownership.

There were obstacles in the channels of communication, which slowed down the timeliness of the input of some groups. In some cases this resulted from the Working Group's difficulty in identifying ways to reach certain groups. In other cases, the obstacle was the change in group leadership or organization.

The Working Group valued the need for timely feedback from the community on the draft report and allowed a good amount of time, within the limits of their process, to integrate that feedback into the final report. The Working Group researcher responded relatively quickly to vast amounts of information collected in a short period of time.

By prioritizing certain groups, the Working Group maximized its limited resources. However, the structure of this community consultation process was not appropriate for some groups who, even though they were prioritized, were not a part of the data. There were examples, particularly with youth not in school, where the Working Group members had succeeded in accessing the priority group, but had not succeeded in providing an acceptable or appropriate format for hearing the issues. The concerns about format relate to race and class; nondominant segments of society require special approaches.<sup>4,15</sup> As Labonte and Edwards<sup>15</sup> suggest, structures and supports can be carefully and deliberately considered in order to engage historically marginalized groups to participate.

Although representation does not in itself guarantee meaningful participation,<sup>2</sup> there is a relationship between those not represented on the Working Group and those not represented in the community consultation process. Most of the Working Group members were white women, employed in professional capacities. Many more women than men responded to the consultation. Attempts to have an Aboriginal and a physician representative on the Working Group failed, and there was no street youth representative on the Working Group. These groups were not well represented in the consultation. Labonte and Edwards suggest a remedy of guaranteeing spaces on committees to ensure that class, gender and ethnocultural qualities are representative of the community, and being aware of the different ways issues are socially constructed and mediated by class, gender and ethnocultural backgrounds.<sup>15</sup> This will not ensure that specific groups will come forward in the community consultation process; however, there is an increased likelihood of the representatives being familiar with internal networks and ways of accessing other members of those groups.

The community consultation process offered a number of ways for the community to be asked and to offer input, and accessed a wide variety of representation from the

community. This created some difficulty by using up resources, but it was also a strength by enriching the representativeness and relevance of the data. The community input was placed as a priority; it drove the process. This attracted community interest. And because of the Working Group's willingness to go anywhere, hear anybody, read anything, some members of the community responded by putting in extra efforts. By providing other modes, such as focus groups or community meetings, this consultation provided opportunities for those who do not prefer writing. This is supported by the report of Labonte and Edwards.<sup>15</sup>

In this community consultation process, the choice to use groups or individuals as the communication channel was an important consideration and affected the representativeness of the community consultation process data. Consulting with existing groups is an efficient way to gather information and opinions; however, it must be assumed, then, that the groups are representative of their communities. The voices that are not heard in a 'try-to-reach-the-individual' approach may not be heard in a 'try-to-reach-the-organization' approach because those people are not likely represented in the groups.

### **5.1.2 Criteria for Success**

There were some difficulties in gathering information from a diversity of representatives of the community, especially the 'unheard voices,' which were a specific priority of this community consultation process. However, the consultation effectively engaged other members of the community, especially youth, in participating. The full consultation participants were pleased with and spoke very positively about this experience. The number of people who attended the second part of the consultation was low, thus decreasing the representativeness of the feedback to the Working Group's draft report.

The Working Group members were volunteers, and through their connections were able to bring the consultation close to certain sectors of the community. Having the Working Group members attend the focus groups facilitated analysis and helped them understand the broader and underlying issues being discussed by the community. As a result, the focus groups had greater impact on the analysis than had the returned questionnaires.

The format of the community consultation process was very successful in engaging the parts of the community who respond to requests for information, and the data were consistent across those who did participate. Efforts were made to receive input from the parts of the community not usually heard from in consultation. Many of these efforts were successful; those that were not have already been discussed. The data from the community consultation process were integrated into the final report; although, due to the problems in recording and analysis described earlier, the quantitative data had a stronger presence in the final report. However, this was not due to the efforts of the Working Group members, who worked at balancing the sources of information in their analyses.

The Working Group members attempted a balance between qualitative and quantitative research methodologies. They did not have a clear plan as to how they would deal with any discrepancies or discordances between the information from the community consultation process and that from the epidemiological review. Despite the lack of a plan, they achieved balance in the analysis of the data; however, they did not achieve it in the presentation of the data evidenced by the emphasis on quantitative data.

A community consultation process may only reflect the current dominant views. In this research, it was important with reference to diversity to have multiple ways of collecting data. More important, however, was the deliberate attempt made to seek out and hear from the less dominant.

The community consultation process may provide other benefits besides adding to the content of the health needs assessment. In this study, these benefits were identified as raising awareness of health, encouraging dialogue between the community and the health district, and facilitating continued consultation. In their study, Labonte and Edwards suggest that providing opportunities for group support and collective social action strengthens the ability and resolve to act on health determinants.<sup>15</sup> The opportunity was there; however, due to the time limitations of this research, I cannot comment on whether it was realized.

### **5.1.3 How Effective was this Community Consultation Process in Facilitating Meaningful Participation?**

Examining the findings of this study in light of the qualities of meaningful participation and the criteria for success of the community consultation process suggests that the process was effective in facilitating meaningful participation of certain sectors of the community. Despite the Working Group's efforts to hear a diversity of voices, certain ones still remain unheard. Of the groups prioritized, these unheard voices include youth not in school and Aboriginal peoples.

A major challenge to the effectiveness of this community consultation process was in identifying and using appropriate formats to reach different sectors of the community and access their information. Once the individuals had been reached they were impressed and pleased with the process and their participation in it.

## **5.2 Facilitating Factors**

Several authors have identified the implementation of the decisions made by participants as an important factor in the process of participation.<sup>7,13,15,23</sup> Labonte and Edwards also stress the need for feedback on community consultation, regarding how the community

input affected policy.<sup>15</sup> The Working Group's final report was seen by the study participants as representative of community needs and concerns, and they saw it as essential for ongoing consultation that the words of community members are listened to. They also felt that the Saskatoon District Health Board, the Coordinating Group, and the Working Group have the responsibility to ensure action is taken based on the report.

The structure of the Population Health Project facilitated community participation by involving members of the community in the planning (i.e., members of the Working Group were volunteers from the community). This allowed the Working Group easier entry into certain sectors of the community. Knowledge of the community, including resources, structures and networks contributes to successful citizen participation.<sup>2,7,26</sup> The skills, commitment, and philosophies of the members of the Working Group encouraged participation through a shared agenda and local ownership of the health needs assessment. These are also contributors to successful citizen participation.<sup>2,7,26</sup>

The commitment of the Working Group and Coordinating Group members to the principles of meaningful consultation is a strength of this community consultation process. The Working Group built a process for input into health needs assessment with which the full consultation participants were both comfortable and satisfied. The Coordinating Group supported the Working Group's decisions and actions and prepared the conditions for quality discussion of the Working Group's final report, at the community and policy levels. The degree of commitment to policy change by those who design policy affects the level of community participation; a strong "inside champion" facilitates successful participation.<sup>15</sup> In this community consultation process, the Coordinating Group was a strong inside champion.

### **5.3 Barriers and Challenges**

To be representative, community participation in health needs assessment should include all those groups and individuals who will be affected by the outcomes of the needs assessment. This was difficult in the present community consultation process given some community members' past experiences with consultation, as well as the varied philosophies involved. Skepticism and mistrust had been built up over the years by token consultations, whose processes were not meaningful to those involved. Labonte and Edwards found that community projects often perceive consultations to be token, coming after policy decisions have been made.<sup>15</sup> They also report that policy documentation used in community consultations is often vague and abstract, and that local issues and voices are not considered in policy debates and decisions.

While the move to community consultation is important and valued, it is not always clear whose interests are being served most. There is concern that consultation is becoming a ritual, devoid of critical reflection on how it might be more or less empowering for the communities affected. In the end, bureaucrats become more empowered because they can say, 'I've consulted with the community, therefore my conclusions have more politically correct weight.' If these conclusions truly do benefit local community groups, this is not necessarily a bad outcome. However, there is considerable doubt that this is usually the case.<sup>15,p.53</sup>

Similarly, Lord and McKillop Farlow, in their interviews with key informants regarding community participation and empowerment, found that the trust of community members was compromised when the invitation to participate suggested tokenism or a "one-shot deal."<sup>47,p.6</sup>

These past experiences cannot be erased by one positive experience. Rather, this community consultation process was just the beginning. Some participants of this study suggested that the meaningful process, the dialogue, must be ongoing, must be supported by political will, and must result in tangible outcomes. "Trust is something that takes time to develop. When policy consultations are 'one-off,' or when ... such consultations



engage many groups over many meetings but in the 'revised' policy report appear to ignore completely the various advices citizens provided ... [this] foments distrust, rather than reducing it."<sup>15,p.64</sup> An ongoing process may avoid jeopardizing the opportunity for urgent issues to be addressed. It can also allow for some of the community capacity-building required for the by-products of a community consultation process.

Defining the community, however, is critical. The confusion on the part of some service providers as to whether they were to provide or receive input, may have resulted from lack of communication between Saskatoon District Health and these groups. It may also represent a lack of clarity about and shared ownership of the values and goals that Saskatoon District Health espouses.

In this community consultation process, the challenge of power relationships in the process of participation<sup>2,7</sup> was especially apparent in the attempted involvement of physicians. Future Directions for Health Care in Saskatchewan also identified concerns with physicians and the practise of medicine. Among these concerns was "inadequate communication and consultation."<sup>12,p.107</sup> Sullivan and Scattolon<sup>2</sup> state that professionals and administrators, who hold high status positions relative to community members, often challenge the legitimacy of community involvement in health.

The Working Group did not discuss their philosophy of health needs assessment. In this study, it was apparent that there were contradictions regarding the Working Group's approach to community consultation, such as how the data from the community consultation process were perceived.

Political changes, in the health care system as an example, as well as leadership and media issues, were especially relevant to this community consultation process and may have

affected its findings. However, there was no social context, such as a community analysis, for the data collection and the interpretation of the findings of the community consultation process in the Working Group's final report.

The Working Group members felt the community consultation process and thus the community participation was limited by time, money and personnel, especially considering the Working Group members were all volunteers, with the exception of the Working Group researcher.

#### **5.4 Implications for Health Promotion Practice**

Knowledge about community participation and of appropriate methodologies for facilitating it is essential for those working in health promotion. Some of the implications for health promotion practice, specific to community participation in health needs assessment, drawn from this research are:

- Community consultation is a process; therefore, it is not a one-time thing but long-term and ongoing.
- People coming together is valuable in itself. The process of the health needs assessment can be as important as the content.
- Representativeness, in those doing the community consultation (especially regarding race, ethnicity, class and gender, as well as the different sectors), may contribute to the representativeness of those who participate in the community consultation process.

- From the outset, participants should define their philosophies of health needs assessment and continue to come back to them to make sure they are on track.
- The clear identification of who is part of the community is an important step in health needs assessment and there need to be appropriate data collection methods and channels built into the process.
- All those who will be involved in the implementation of the policy resulting from the health needs assessment (i.e., service providers, clients) must be already onside during the planning stages.
- A balance between qualitative and quantitative may engage those with different philosophies of health needs assessment as well as reveal different pieces of the big picture.
- It is important to provide plenty of time for the community to respond, and to ensure that those organizing are willing to listen and have the political will and ability to follow through.

### **5.5 Future Research**

Many areas for future research have become apparent throughout the course of this study. While the present study mainly focused on the perspectives of those who participated in the consultation, it would be valuable to identify individuals and/or groups who did not participate and look at this aspect more closely.

An important piece of research would be to follow the implementation of the recommendations at the policy level. This could also include a follow-up study with the

same participants as in this study to see if their feelings about their participation had changed.

As the Population Health Project continues, other Working Groups will be established, with the same mandate and the same Coordinating Group. It would be interesting to look at their community consultation process and compare their effectiveness with that of the Children and Youth Working Group.

### **5.6 Conclusion**

This study identifies factors that contributed to the effective involvement of community members in a health needs assessment. The community consultation process is an important contributor to the process and content of the health needs assessment. Meaningful consultation is a first step to achieving community participation in health policy-making.

The community consultation process employed by the Children and Youth Working Group was generally appropriate, timely, complete, accurate, representative, and relevant to the community. The Working Group got close to certain sectors of the community, the community consultation process provided evidence for the final recommendations and gathered information from a relatively diverse cross-section of the community. However, the Working Group was not successful in facilitating the participation of some sectors of the community. Overall, this study found that the community consultation process employed by the Children and Youth Working Group was effective in facilitating meaningful participation in health needs assessment, but only with certain sectors of the community.

The questions that this study did not or could not address and that remain unanswered are related to the limitations. Because of the scope of this research, it was difficult to identify those people who did not respond to the community consultation process.

Representatives of the groups who had limited response were interviewed, but these were still individuals who responded, in some form, to the community consultation process.

The study did not truly include those who did not respond at all to the community consultation process.

Since the questionnaires were completed anonymously and there was no way to track the respondents, the full consultation participants did not include the questionnaire respondents, unless they had also participated in the second part of the consultation.

Therefore the study findings are based more on the responses of those who responded to certain formats, i.e., the focus groups or community meeting, than of those who responded in writing. This study cannot compare the levels of effectiveness of these formats.

The research explored only one example of a community consultation process. It may have been dissimilar to other community consultation processes in many ways. The reader is encouraged to use the thick description provided to check the transferability of the findings.

I did not challenge the Working Group's definition of who made up their community; in reality, Saskatoon District Health encompasses many different communities. Since a community consultation process will be shaped by the various participants' conceptualizations of 'community,' it is important to address and challenge unexamined assumptions about community, and about participation.

Finally, part of the success of this community consultation process rests on the response by decision- and policy-makers to the community consultation process. The participants of this study described this response as an important contributor to their participation in community consultation. As well, the response was one of the criteria for the evaluation of this community consultation process. The main limitation of this study, therefore, was that I was not able to follow the community consultation process to the point where the recommendations were reviewed at the Health Board level. As a result, I cannot make conclusions regarding this aspect of the community consultation process's effectiveness. If the community participants' expressed concerns are not translated into action, there is a danger that the consultation may be perceived as co-opting the support of community members.

As Patton notes, an important test of the credibility of an evaluation report "... is the response of decision-makers and information users to that report."<sup>43,p.339</sup> The true test of value of this research is if the participants and the readers can apply it to practice. It is my hope that they can.

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**APPENDIX A:**  
**Population Health Project - Operational Model**

**POPULATION HEALTH  
STEERING COMMITTEE**

**Senior District management**

**POPULATION HEALTH  
COORDINATING GROUP**

**District community health  
District community development  
District planning & development  
District information & research  
District rural health development  
Epidemiology support  
Affiliated agencies/partners**

**POPULATION HEALTH  
GROUPS**

**District service providers -  
acute, community services,  
and continuing care  
Current service users & families  
Current service partners -  
non-profit, municipal and  
provincial**

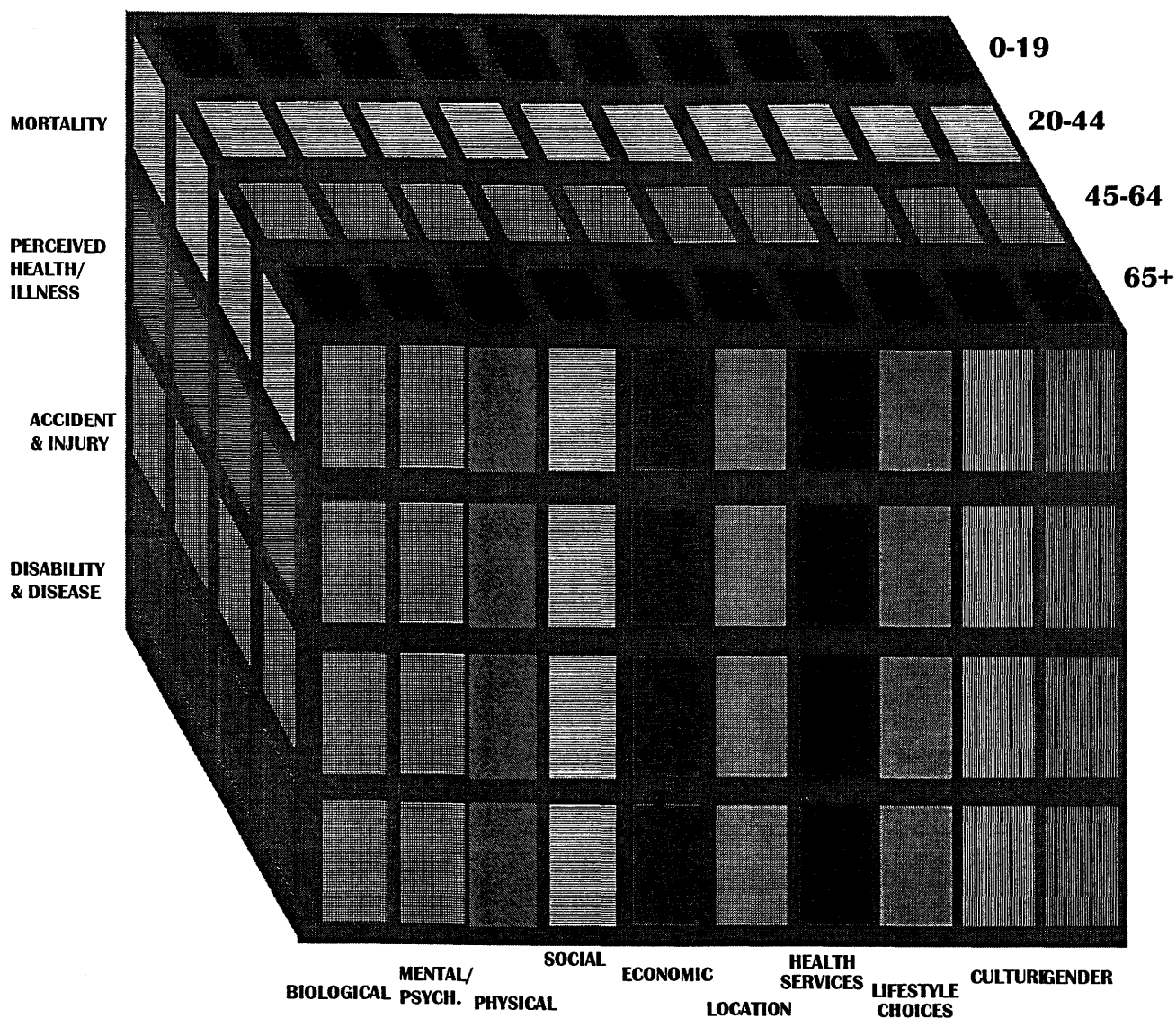
## **APPENDIX B:**

### **Population Health Project - Conceptual Model of Health Determinants**

# **“HEALTH INDICATORS”**

*INDICATIONS OF  
HEALTH*

**AGE**



## **“HEALTH DETERMINANTS”** *FACTORS AFFECTING HEALTH*

**APPENDIX C:**  
**Research Timeline**

		jan96	feb	mar	apr	may	jun	jul	aug	sep	oct	nov	dec	jan97	feb
TT/WGT	working group meetings	X	X	X	X	XX	XX	XX	XX	XX	XX	XX	X	X	
WGT	questionnaires sent out	XXX													
TT/WGT	focus groups	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX								
TT	criteria established			XX											
TT	group interviews					X								X	
TT	individual interviews												XXX	XX	
TT/WGT	community meeting									X					
TT/WGT	report to SDHB presented														X

**TT**            **Thesis Task**  
**WGT**        **Working Group Task**  
**X**            **Approximate weeks in which the task was performed (X = 1 week)**

**APPENDIX D:**  
**Interview Guides**



**Working Group:**

- If you were to look back at the consultation process, what would you identify as the key elements?
- Early on, the WG talked about why you wanted to do a consultation and what you hoped to achieve. Would you change this now, add or take anything off? Were these achieved?
- The WG identified priority groups and ways to reach them through consultation. Could you describe how this was decided? Was this followed?
- Has the community response met your expectations? How do you feel about the response so far?
- If you were to do the consultation process again, knowing what you know now, would you change anything?
- Is there any advice, with regard to the consultation, that you would like to pass on to future working groups?

**Individuals who participated in both first and second parts of the consultation:**

- How were you consulted?
- What motivated you to become involved?
- What were your expectations before participating?
- Were these met? Why or why not?
  - yes: What did they do to meet these expectations?
  - no: What could have been changed to meet these expectations?
- Did you feel that your input was represented in the draft recommendations?
- From what you know about the members of your community, is the document representative of their concerns, issues and /or recommendations?
- Are you satisfied with how your input had been received in the consultation?
- How did you feel about your participation?
- Were you able to participate as you would have liked to?
- Would you do this again?
- From your experience, comment on the extent to which the committee has achieved its goals (given a sheet with goals listed).

**Individuals who participated in the first part of the consultation only:**

- How were you consulted?
- What motivated you to become involved?
- What were your expectations before participating?
- Were these met? Why or why not?
  - yes: What did they do to meet these expectations?
  - no: What could have been changed to meet these expectations?
- Were you aware of the second consultation that took place in September?
  - yes: Was there any particular reason you did not attend?
  - no: Would you have gone had you known about it?
- Have you had a chance to see the draft recommendations?
  - yes: \*Did you feel that your input was represented in the draft recommendations?

\*From what you know about the members of your community, is the document representative of their concerns, issues and /or recommendations?

- Are you satisfied with how your input had been received in the consultation?
- How did you feel about your participation?
- Were you able to participate as you would have liked to?
- Would you do this again?
- From your experience, comment on the extent to which the committee has achieved its goals (given a sheet with goals listed).

**Individuals who participated in the second part of the consultation only:**

- Did you know about the first consultation?
  - yes: Was there any particular reason why you did not respond at that time?
  - no: \*Would you have participated if you had known?  
\*In what way?
- What could have been done differently to have received your input?
- What motivated you to come to the second consultation?
- What were your expectations before coming to the second consultation?
- Were these met? Why or why not?
  - yes: What did they do to meet these expectations?
  - no: What could have been done differently in order to meet these expectations?
- Did you feel that your input was represented in the draft recommendations?
- From what you know about the members of your community, is the document representative of their concerns, issues and /or recommendations?
- Are you satisfied with how your input had been received in the consultation?
- How did you feel about your participation?
- Were you able to participate as you would have liked to?
- Would you do this again?
- From your experience, comment on the extent to which the committee has achieved its goals (given a sheet with goals listed).

**Individuals who did not successfully participate in the consultation:**

- Did you know about the consultations?
  - yes: \*Was there any particular reason you did not respond at that time?  
\*Please describe your experience with this consultation.  
\*Why do you think the consultation didn't work with this group?
  - no: \*Would you have responded had you known?  
\*In what way?
- What could have been done differently in order to have received your (this group's) input?
- Have you had a chance to see the draft recommendations?
  - yes: From what you know about the members of your community, is the document representative of their concerns, issues and /or recommendations?

**APPENDIX E:**  
**Sample Consent Forms**

**Consent Form - GROUP**  
**Facilitating community participation in health needs assessments.**

I understand that Tanya Dunn Pierce, graduate student of the Department of Community Health and Epidemiology, University of Saskatchewan, is doing a study about ways in which members of our community can participate in decisions affecting their own health. This study is examining the process being undertaken by Saskatoon District Health to gather information from the community about health needs and priorities of and for children and youth, in our district. The information collected will be beneficial to Saskatoon District Health as they continue the needs assessment process and will improve the quality of information that they collect.

It has been explained to me that if I take part in this study, I will be interviewed as a group member, one to two times, for approximately two hours each. The interviews will be tape-recorded and I can have the tape recorder turned off any time I wish. I do not have to answer any questions I do not want to. I can end the interview any time I wish. I will have an opportunity to look over and make changes to what I have said in the interview. I can withdraw from the study entirely at any time, without any penalty or loss of health services. The final report will be available to me, if I so wish.

I understand that the information I give during the interview is **strictly confidential** and that neither my name, nor anything else that could identify me, will be known to anyone other than the research team. All reports coming out of this study will be written in such a way as to not reveal the identity of any of the participants. **I agree to keep what is said during the group interviews to myself, in order to protect the other group members' confidentiality, unless the group agrees otherwise.**

I, \_\_\_\_\_ (please print), the undersigned, agree to take part in the research study described above.

My questions have been answered, and I understand what the study involves. I know that my participation is voluntary. I acknowledge that I have been offered a copy of this form to keep.

\_\_\_\_\_  
signature of participant

\_\_\_\_\_  
date

\_\_\_\_\_  
Dr. Kathryn Green, Research Supervisor

\_\_\_\_\_  
Tanya Dunn Pierce, Graduate Student

If you have any further questions about this study at any time, please call Tanya Dunn Pierce at 966-7935 or 653-3425(home), or Kathryn Green at 966-7839. Thank you for agreeing to participate.

**Consent Form - INDIVIDUALS**  
**Facilitating community participation in health needs assessments.**

I understand that Tanya Dunn Pierce, graduate student of the Department of Community Health and Epidemiology, University of Saskatchewan, is doing a study about ways in which members of our community can participate in decisions affecting their own health. This study is examining the process being undertaken by Saskatoon District Health to gather information from the community about health needs and priorities of and for children and youth, in our district. The information collected will be beneficial to Saskatoon District Health as they continue the needs assessment process and will improve the quality of information that they collect.

It has been explained to me that if I take part in this study, I will be interviewed once for approximately one hour. The interview will be tape-recorded and I can have the tape recorder turned off any time I wish. I do not have to answer any questions I do not want to. I can end the interview any time I wish. I will have an opportunity to look over and make changes to what I have said in the interview. I can withdraw from the study entirely at any time, without any penalty or loss of health services. The final report will be available to me, if I so wish.

I understand that the information I give during the interview is **strictly confidential** and that neither my name, nor anything else that could identify me, will be known to anyone other than the research team. All reports coming out of this study will be written in such a way as to not reveal the identity of any of the participants.

I, \_\_\_\_\_ (please print), the undersigned, agree to take part in the research study described above.

My questions have been answered, and I understand what the study involves. I know that my participation is voluntary. I acknowledge that I have been offered a copy of this form to keep.

\_\_\_\_\_  
signature of participant

\_\_\_\_\_  
date

\_\_\_\_\_  
Dr. Kathryn Green, Research Supervisor

\_\_\_\_\_  
Tanya Dunn Pierce, Graduate Student

If you have any further questions about this study at any time, please call Tanya Dunn Pierce at 966-7935 or 653-3425(home), or Kathryn Green at 966-7839. Thank you for agreeing to participate.