



**A Framework
for
Community Engagement
In
Primary Health**

Primary Health and Chronic Disease
Management
Saskatoon Health Region

A FRAMEWORK FOR COMMUNITY ENGAGEMENT IN PRIMARY HEALTH

GPS: "Prepare to slow and take a gradual curve to the right in 500 meters, then resume speed"

Community engagement has been a "motherhood" value of health systems for some time now. Often, health care leaders vehemently espouse the notion of community engagement and promise to make public participation a vital component of their developmental work in achieving healthier people and communities. They genuinely believe in the importance of including communities as active participants in decision-making in the health system. However, ask many of these leaders to give examples of community engagement at work in their health regions or ask them to describe how to accomplish it and many of them are stumped! Unfortunately, the actual follow-through, the increase in knowledge and understanding of community engagement skills and successful practice and implementation has been far less common than all the rhetoric itself. I have never heard anyone recommending not doing community engagement nor anyone disparaging the values of these important activities, however what our health system in Saskatchewan has been lacking is the concrete "how-to" manual and tool kit that tells us not only what it is but how to begin the process and evaluate and change course (and benefit) when individuals and communities actually begin to connect with one another and work with us as an integral part of the health care team.

I congratulate the Saskatoon Health Region Primary Health Care team working with Georgia Bell for having put together this fine piece of work and with perfect timing! In 2012 as the provincial health system is poised on the verge of further implementation of primary health care teams and structure, this Framework for Community Engagement in Primary Health will serve as a useful reference and guide to introduce and support the practice of true successful community engagement. Health Regions, Primary Health teams and practitioners will be able to use common language, share an understanding of the basics and proceed with their practice of engagement in a clear and productive manner using this Framework as a foundation. Now, we will be able to watch and chart successes of community engagement in practice. To use the document's metaphor of a journey, SHR Primary Health Team have produced the **virtual GPS** of community engagement.

As a health care professional with much invested in community health endeavours and firm belief in the importance of communities actively participating in improving their own health and the public health system, I look forward to the application of these ideas and sound community engagement practice being used throughout the province with great results!

Shan Landry, former Vice President of Community Services SHR

Dedication

This work would not have been possible without the vision and guidance of Vikki Smart, Senior Manager Primary Health, Saskatoon Health Region.

Vikki worked with the Primary Health Team to bring this document to fruition.

Publication Data:

Georgia R. Bell, Consultant

Primary Health Development Team, Saskatoon Health Region
who are the heart and soul of this document.

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For further information, please contact:
Sheila Achilles, Director
Primary Health Chronic Disease Management
655.5806

sheila.achilles@saskatoonhealthregion.ca

or

Pat Stuart, Manager Primary Health
655.5364

pat.stuart@saskatoonhealthregion.ca

#9 Evaluation of Community Engagement –	
Knowing When You Have Arrived	32
<i>Capacity Building Goals of Engagement</i>	33
Summary: A Model for Effective Community Engagement	35
SKILL SET FOR COMMUNITY ENGAGEMENT	36
Core Skills	
Enabling Conversations	37
Facilitation and the Role of the Facilitator	39
The Facilitation Journey	40
Collaboration and Partnership Building	46
Partnerships	47
Accessory Skills	
Community Health Assessment	49
Developmental Evaluation	53
Supportive Structures and Practices	
Reflective Practice	55
A Community of Practice	56
SCALING UP COMMUNITY ENGAGEMENT: THE NEXT CHALLENGE	59
Appendix 1:	
An Engagement Planning Cycle	61
REFERENCES	70

PREFACE

A Story about Stories and Making Meaning Together

“A nomadic tribe in Ethiopia, called the Afaris, believe it is a sacred responsibility to listen and share ‘dagu’ – a word that means information, though it implies more than pure data. The Afaris are nomadic cattle herders, and they have existed for thousands of years in a harsh environment where most nomadic tribes have been wiped out. They claim that ‘dagu’ is the secret to their longevity. “Dagu is life” is an Afari expression.

Being nomads, Afari families travel from place to place, seeking better conditions for their cattle and themselves. Every so often they will meet another Afari family, and no matter what they are doing or where they are heading, they sit down to talk and listen, usually for hours. The exchange of ‘dagu’ trumps all other responsibilities. They share what they have seen and heard about the environment, about health issues (both cattle and human), about political tensions, about new relationships. As they talk, they provide the facts as they have seen them or heard them, but also their interpretation of what these facts mean. They collectively make sense of the patterns that are emerging.

Children learn about ‘dagu’ in their families and practice with their parents until they are deemed to be adept at deep listening, astute observation, and sense making or pattern recognition. Their lives depend on ‘dagu’. There are severe punishments for failing to share dagu or for misrepresenting it. To survive, the Afaris need all their members to be sensitive and aware of emerging patterns – both natural and social. The Afaris do not believe that they can control the patterns, but that if they can understand them deeply, they can work within them and potentially nudge them or influence them.” Westley et al, p. 133–134

A community is a place where every person knows that they can have a say in what is happening, every person knows how to make him/her heard and is respected for their contribution, and every person listens to understand. Anonymous

EXECUTIVE SUMMARY

Community engagement, defined as an on-going relationship between citizens, health care providers and other community members and organizations to improve health through dialogue, **is a process rather than an end point**. The process rests on an historical understanding of primary health, as well as modern evidence about health determinants, client-centered care and democratization. Potential benefits of community engagement include: more informed decision-making, an increased sense of involvement and responsibility, an increased range of ideas and options for improvements in health, and increased credibility for health providers. Any particular defined community can be anywhere along a continuum of engagement; it is argued that less engaged communities tend to experience poorer health.

The essential elements of engaging community are the underlying values, principles and relationships involved. **Critical values for effective engagement include honesty, respect, authenticity, openness and transparency, and trustworthiness**. A set of principles for engagement are articulated, which include diversity, accessibility, inclusivity, and capacity-building for all participants; integrity and accountability in engagement practices; outcomes that demonstrate genuine influence and the impacts of the process; and collaboration and improved governance. A case is made that engagement activities must be adequately resourced and supported by the organizational culture.

Personal attributes and attitudes are reflected in the quality of the relationships developed by health providers with community members. It is suggested that an openness to comprehend situations without pre-conceptions, a willingness to listen empathically and appreciatively, and an ability to let go of old intentions and ideas to create a new, different future are key personal qualities of those engaging communities. Stories from Practice are presented and Reflective Questions are posed throughout the document.

Excellent two-way communication is fundamental to engagement. Communication strategies and principles are articulated; different forms and intentions of communication are presented. **Engagement is premised on the existence of certain organizational and community capacities**. In the community, these capacities include

- **leadership**
- **networks**
- **skills**
- **power**
- **resources**

Organizational capacities include a legitimating rhetoric and policies, skilled and educated staff, managers who understand and support engagement, and sufficient resources.

Evaluation of the results of any engagement process is critical for on-going improvements in community health.

Immediate results such as:

- **the level of participation**
- **quality of communication**
- **the influence of the engagement in shaping policy and practice**
- **cost-effectiveness**

can be determined through various evaluation strategies.

In addition, it is suggested that the capacity-building goals of engagement:

- **an improved quality of decision making**
- **people's experience of a democratic process**
- **increased competence and knowledge**

should also be evaluated. A summary model for effective community engagement from the literature is presented at the end of this section.

The skill set for community engagement includes the core skills of:

- **enabling conversations**
- **facilitating discussions**
- **collaborating and building partnerships**
- **community health assessment activities**
- **developmental evaluation of engagement in action.**

Each of these is described in detail, with examples from practice.

In addition to the above skills, the use of reflective practice techniques and the establishment of a community of practice is proposed.

Lastly, the importance of an organization-wide adoption of an engagement strategy is advocated. This would provide clarity, consistency, and enable improved engagement practices and defensible outcomes throughout the organization.

Appendix 1 includes a step-by-step engagement planning strategy; Appendix 2 contains a listing of tools and techniques useful in engagement activities. A selected reference list is offered.

BACKGROUND AND DEFINITION OF COMMUNITY ENGAGEMENT

The Historical Root:

Declaration at Alma Ata

The modern affirmation that citizen and community engagement is pivotal to health and is critical in primary health services goes back to the UN Declaration at Alma Ata, U.S.S.R. in 1978. World leaders there agreed that “The people have the right and duty to participate individually and collectively in the planning and implementation of their health care. PHC (Primary Health Care) requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation, and control of primary health care...”. World Health Organization, 1978, p. 6

The Present Movements

More recently, there are three strong movements that have evolved in health care and in communities that support citizen involvement:

One is **patient-centered care**. This is a change that is being demanded by patients and clients to move away from healthcare delivery that has often been hierarchical, provider-driven and depersonalized, toward increased involvement of patients in the direction of their own care. These demands include mechanisms for patients, family members and communities to influence health system interactions, design, and policy. (Sk. Health Quality Council, 2005) Patient-centered care has been empirically shown to improve quality health care outcomes. (Simces, 2003) “Patient-centeredness means valuing everything – everything - that the patient, the family and the community bring into the struggle...for health.” (Westley et al., p.201)

The second movement is **democratic renewal**. “We are striving to live in a democracy. A democracy is a politics that gives us freedom to create our vision and the power to make that vision come true. We strive to be citizens – people with the vision and the power to create our own way, a culture of community capacity, connection, and care.” (McKnight, 2009) While Canada’s public health care system has always embraced and depended on public involvement, there has been a general decline of public confidence in elected and appointed officials in the past decade, resulting in apathy and cynicism. This can be seen in declining voter participation, and (as a last resort) street demonstrations calling for various democratic reforms. Consequently, “creative approaches to involving the public in democratic decision-making processes in Canada are being explored by many systems.” (Vancouver Coastal Health, 2009) Healthy democracies must continually promote opportunities for people to be involved in decision-making in matters of public interest, and nothing is more public or more interesting than our public health care system.

The third movement is an emphasis on **determinants of health**. “Canada has developed a health system that is relatively good at treating illness but ineffective at recognizing and stimulating action to address the determinants of health such as an adequate income, a sustainable environment and good jobs. By associating health with health care, we have largely ignored the important role communities play in creating conditions that support and sustain health. We need to find ways to turn the treatment system into a health system by emphasizing health promotion and by strengthening communities to identify issues, set priorities, make decisions and take action around health issues.” (Quoted in Fraser Health 2009)

People are aware of what keeps them healthy. They understand that a good job, a good education, an unspoiled environment, decent housing and food, and opportunities for recreation and socialization create health. Wide gaps between rich and poor exist in our communities and these are reflected in access to services, life expectancy and disease burden. Based on the premise that what gets measured gets counted, organizations such as the Canadian Index of Wellbeing are developing indicators for things such as environmental quality, living standards, community vitality, work-life balance, and health outcomes. These and other indicators will provide ammunition to argue for some of the critical factors that influence health.

Primary Health Care and People’s Lived Experiences

Primary health care is the most frequently encountered face of the health care system for the public. Most people have some experience of consulting family doctors, nurses, physiotherapists, pharmacists, home care workers or counsellors. They know that these encounters can be better or worse, depending on the particular person they interact with and how the system of care is organized. They are also connected to other family members and friends who share stories of their experiences. ***Given the public’s repeated and continuous experiences, their knowledge of what is working and what isn’t in primary health care is invaluable.***

Community Engagement as a Key – A Definition

Community engagement is a mechanism to respond to these movements and tap into this body of experience and knowledge. Community engagement is not a program or a one-off process. It is an on-going relationship between citizens, health care providers and other community members and organizations. The World Health Organization defines community engagement as “a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.” (WHO1992, quoted in Fraser Health 2009) As such, community engagement becomes a part of the development of both the organization and the community and involves creating trust, building capacity, and working together.

Genuine engagement should be an implicit goal in every clinical encounter, every meeting with health partners, and every conversation that health providers and the health system has with clients and communities.

Some potential benefits of community engagement are:

Value to Communities:

- *Increased access* – to decision-makers, to information, to others’ opinions, to new processes for making decisions, to other parts of the community and the organization.
- *Better information and understanding* – improved understanding of the complexity of health care and greater opportunities to make informed input into a plan, a policy or a proposal.
- *Sense of involvement* – the mutual sense of ownership for all parties is enhanced through shared responsibility. Ideally, this should result in increased capacity and sustainability of the efforts in communities.
- *Better outcomes* – outcomes can be achieved that utilize existing resources and more fully reflect the aspirations of the client and the community.

Adapted from NSW, 2003, p.8/9

Value for Primary Health Providers:

- *An increased range of ideas* – community contributions may surface ideas not apparent to service providers; avenues are opened for the community to raise issues incorporating local knowledge, resources, and expertise.
- *Credibility and accountability* is increased for primary health with communities through dialogue and working together. There are also increased opportunities for explanation - a venue to give an account of the reasons for the organization’s policies and actions.
- *Networks, relationships and processes are established* in the local community that can benefit current and future projects.
- *A deeper understanding is developed around issues* through public information sharing, discussion and deliberation.
- *Improve democratic outcomes*, including the equity or fairness of a policy or project.
- *Better decisions* are achieved that incorporate the communities’ aspirations, have less duplication, and are sustainable.

Adapted from NSW, p.8/9

There is also imprecision and variation in terminology and few theories or frameworks have been tested. This emerging field of inquiry holds great promise.

We do know that involving patients in decision-making about their own care leads to improved quality health care and improved outcomes.

The impact of public involvement in planning and development of health care services is less clear in its outcomes. Fortunately, there has been significant analysis of the many collaborative community-based initiatives to address health and social issues. These initiatives can have an impact on improving quality health care and health outcomes, if certain conditions are present. As well, specific techniques and approaches such as deliberative dialogue, citizen juries, community collaborative practices ^(see Tools for Engagement Appendix 2), especially if used in combination, seem to result in more effective engagement outcomes.

Becoming Engaged and Recognizing Disengagement

Becoming engaged can take a crisis, such as a change in health, or a threat in the environment. It could be an inequity or discrepancy between what people desire and what is actually occurring – the kind of treatment they are receiving or undesirable outcomes. It can also be the result of conflict or a lack of trust that impels community members to want something better. Sometimes, outside forces dictate a change, for instance, a policy on transportation or primary care delivery that changes conditions for organizations and communities and spurs new engagement.

Engagement – the state of being involved in something.

O.E.Dictionary

“How do you bring them together if it is about something positive? They come when it is about something negative (perceived threat). It would be ideal if they invited us to work with them – they initiate coming to the table.”^{Syntegrity, p.33}

Engagement can also be the result of positive deviance, some innovator or opportunity that brings new energy, ideas, or resources, including resources or money. Engagement can also be built on telling stories, and mining those stories on ‘coffee row’ for deeper meanings through processes such as participatory research. These ‘mining’ operations may need a catalyst, a person who picks up a conversation, knows its value, keeps it going, and has the skill to build and extend trusting relationships through the stories, to make them deeper and scale them up.

A community may be disengaged because members do not see how community conditions affect them personally or are unaware of their impact on their health and well-being. They may not like or be able to access the ways people are typically engaged, through meetings or newsletters or partisan politics. There may be serious divisions in the community along racial, ethnic, gender, or age lines. Or, people may already be engaged in personal commitments (work, family care giving) or behaviours (addictions, etc.) that make it impossible to become engaged. There may be real physical barriers to becoming engaged, such as lack of food or transportation, language, childcare, or a lack of electronic

communication available. There may also be psychological barriers, such as lack of trust, safety issues, a history of conflict or past failures, jealousy, personality type (introverted or passive) or mental health issues.

No community is ever totally unengaged; there are always some connections between people and organizations.

Less engaged communities might be experiencing or characterized by:

- Loss of hope
- Lack of trust
- No sense of a future
- Unhealthy individual behaviours and poor self-care
- A blaming, punishment mentality
- Poverty
- High rates of preventable illness
- Physical and psychological barriers to services

These kinds of communities certainly exist in our province. Engagement with them will be more difficult; facilitators may need to work on building relationships of trust and experiencing some 'quick wins' of success. Arts, sports, food, and having fun are community builders. Working together to satisfy what the community identifies as a need - is it cracked pavement? better bus service? youth sports programs? - may be a way to mobilize interest. As this is happening, the 'parallel track'^(Labonte et al, 2002) is to build safe and trustworthy interaction and dialogue in citizen groups to eventually tackle bigger projects and become advocates for further health improvements. There will always be individuals who are marginalized and therefore there will always be room for improvement.

A more engaged community might be characterized by:

- Concern for the common good
- Resources - education, health, recreation, socialization - available and easily accessible to all
- Sustainable resource use and a healthy environment
- Connections and linkages vertically and horizontally in the community
- Adequate incomes; no big gaps between rich and poor
- Good housing and safe neighbourhoods
- Robust political debates where everyone is involved; responsive governance
- Intergenerational caring

This list is of course, a 'utopia', but there is long-standing historical and international evidence that through engagement and people-centered resource mobilization, health improvements can be realized.

Reflective questions:

What experiences have you had in community engagement?

What/who brought the group together?

What worked to hold the group together?

What work did the group accomplish?

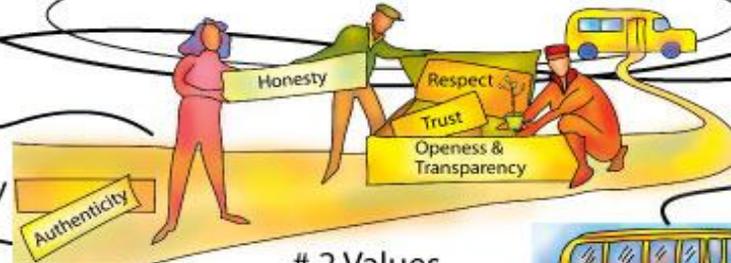
What relationships were built?

What did you learn about yourself and what was effective to engage you?

Community Engagement Essential Elements



#1 Defining Community



#2 Values



#9 Shared Evaluation



#3 Principles



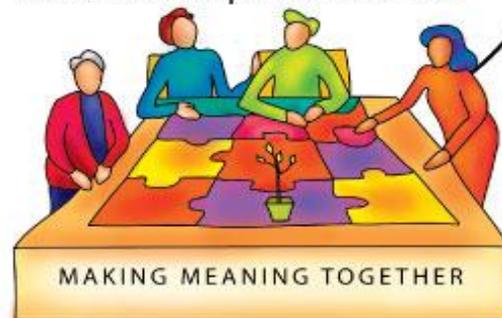
#5 Relationships Are Essential



#8 Building Capacity



#4 Ways of Being



#6 Communication



#7 Ways We Engage

Saskatoon Health Region,
Primary Health
November 2012

Transitions Inc.,

ESSENTIAL ELEMENTS OF COMMUNITY ENGAGEMENT

The essential elements of community engagement are not what technique is used or what structure is created, but the values and principles on which it is based. These are reflected in the qualities of the relationships and kinds of communication that occur. The results are both the tangible progress in primary health and the capacity that is built in taking action together. All of these elements might best be discussed using a travelling metaphor: the following discussions will demonstrate what the journey of community engagement looks like: what kind of vehicle to take, how to drive, what the vehicle will run on, deciding where to go and what the best route is, and who is going on the trip.



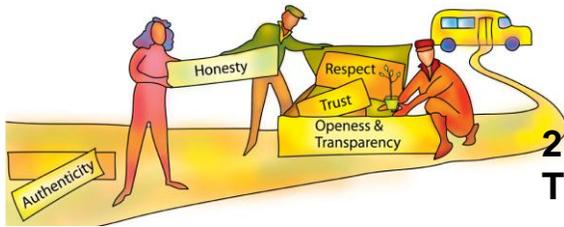
1. Defining Community - Who is Going on This Trip?

The ultimate goal of community engagement is for the community and the health system to work as partners to have an impact on conditions that influence the health of that community and improve population health. Engagement has a means-and-ends effect: it stimulates the growth of healthier citizens and it also achieves and promotes more sustainable, context-appropriate decisions for a healthier community. But what do we mean by 'community'?

Most of us belong to multiple communities: **geographic** communities such as a town, a municipality, or a neighbourhood; **communities of interest** such as sports, arts, or environmental groups or faith communities; **communities based on personal attributes** such as age, gender, ethnicity, or dis/ability - this includes people who define themselves as aboriginal people, as seniors, as wheelchair athletes, or as clients of specific health services; **economic and professional communities** such as businesses, unions, customers, and colleagues/ employees (of the health system or other organizations); and **political communities** such as voters or activists. And, while citizens may share interests or attributes, they are also diverse and have differences of opinion, which can lead to conflict. But all of the people that belong to these real or virtual communities have a stake in the well-being of the broader community.

What does community engagement actually look like? Is it consulting with community members on a regular basis? Is it a democratically elected council that fairly represents people's interests? Is it a feeling that one's views matter and can be expressed? Is it knowing who to go to when you have a concern? Is it an on-going dialogue? - and does the dialogue have to have immediate results?

It is all of the above.



2. Values of Community Engagement – The Kind of Bus You Drive

People act not just in service to personal needs, but also out of a broader sense of what is important and meaningful. Values are the deepest and most powerful motivators for action. Standardized procedures and management control, enforced by supervisors, was the norm for employee actions in health organizations of the past. The present reality in primary health care entails working in and with communities that are complex, undertaking initiatives that are uncharted and emergent, and sometimes experiencing messy chaos. In such circumstances values-based action must replace slavish adherence to standard procedures.

Honesty – being sincere, truthful, sharing what is truly possible

Respect – consideration for the feelings and rights of others

Authenticity – being real, genuine

Openness and Transparency – accessible, available, not concealing thoughts, information, or feelings

Trustworthiness - reliable

To live by the values of honesty, respect, authenticity, openness, transparency, and trustworthiness is critical in Community Engagement, whether by health authority or community members. It is especially important to foster and nurture these values when engagement processes get 'messy'. Living our values are energizing, motivating and inspiring for ourselves and others.

Not everyone shares or lives by the same values in terms of attitudes and behaviours. Personal and community history, experiences, and belief systems vary among staff and among community members. So, while it is important to clarify one's own values, attitudes and behaviours it is also important to understand the values of community members.

What if values clash, or if people are not acting according to their values or the agreed-on values of the group? This is where skilled communication and mediation becomes necessary. There may need to be difficult conversations if there are differences that interfere with working together; participants may need help to work through differences. (See Tools in Appendix 2 or Ury and Fisher)

Reflective Questions:

What are your most cherished values?

How are your values reflected in your actions?

Have your values changed over the years?



3. Principles of Community Engagement Practice – How’s Your Driving?

Principles are values put into action. Effective community engagement for primary health is based on a core of value-based practices for health practitioners/the health authority and community members/organizations.

The Canadian Network for Public Engagement in Health ^(Abelson and Li, 2011) has developed a discussion document of the principles and supportive rationale for community (public) engagement, adapted below. This group is concerned with establishing principles of community engagement and linking them to outcome indicators in order to be able to evaluate community engagement activities. ^(See Appendix 1: An Engagement Planning Cycle, Step 5) They are proposing a set of principles for most promising practices in community engagement, based on extensive literature, which include:

1. The principles of inclusivity, diversity, capacity and accessibility guide the selection, support and involvement of participants in all community engagement activities

Supporting statements:

- opportunity for a diverse range of values and perspectives to be freely expressed and heard (Hendricks, 2007)
- representative of the population (Hendricks, 2007)
- appropriate and equitable opportunity for all to participate (Hendricks, 2007)
- equitably incorporate diverse people, voices, ideas and information to lay the groundwork for quality outcomes and democratic legitimacy (LHIN CE principles, 2011)
- build capacity and confidence for people to participate meaningfully
- participants should have access to sufficient resources to enable to fulfill their roles (Burton, 2009)

2. The principles of integrity, accountability and transparency guide the design and implementation of all community engagement activities

Supporting statements:

- Openness and honesty about scope and purpose (Hendricks, 2007)
- Appreciate respective roles and responsibilities (Hendricks, 2007)
- Ensure that the design, organizing and convening of the process serve both a clearly defined purpose and the needs of the participants (LHIN CE principles, 2011)
- Participatory tasks should be clearly defined (Burton, 2009)
- The process should be conducted in an independent and unbiased way (Burton, 2009)

- The process should be sufficiently transparent so that the decision process is clear to all (Burton, 2009)
- Be clear and open about the process (LHIN CE principles, 2011)
- Provide a public record of the organizers, sponsors, outcomes, and range of views and ideas expressed (LHIN CE principles, 2011)
- Engage at the appropriate time in the process so that participants can see that their input has the potential to be considered

3. Community engagement activities are undertaken to influence and exert impacts on participants, organizations and decision making

Supporting statements:

- Ensure each participatory effort has real potential to make a difference, and that participants are aware of that potential (LHIN CE principles, 2011)
- The outcome of the exercise should have a genuine impact on policy (Burton, 2009)
- Participants are aware of how their input will be considered
- The output from community engagement processes is considered in decision making
- Participants are informed of how their contribution was utilized

4. Community engagement activities which seek to promote the principles of collaboration, shared purpose and improved governance are supported by a participatory organizational culture and sufficient resources to be effective

Supporting statements:

- Promote a culture of participation with programs and institutions that support ongoing quality public engagement (LHIN CE principles, 2011)
- Provide sufficient resources for participants (public and other stakeholders) and staff (PH facilitators and other staff in the organization) to carry out their roles in the engagement activities (Jabbar & Abelson, 2011)
- Support and encourage participants, government and community institutions, and others to work together to advance common goals (e.g., improved health outcomes, enhanced experiences with health services, improved community engagement practice. (LHIN CE principles, 2011)
- Recognize and communicate the needs, interests and values of all parties, including decision makers

For practitioners and community members, these principles can be translated into specific actions:

Show Up and Be Present – be consistent in your involvement; be fully present in the discussion, demonstrate facilitative leadership, respectful behaviour, and self-management.

Be Clear about the Purpose – establish clarity about your intent; focus on the common goal of the engagement, make it clear how long and involved the process might be (is it an on-going relationship or is it a specific undertaking?), why it is occurring, what's next, and what will be done.

Act Democratically and Inclusively – establish and use transparent processes in which everyone is heard and has a say in decisions that affect them (equity); ensure people have the information they need beforehand to participate meaningfully.

Honour the Presence and Contribution of All Participants – keep a focus on building relationships and ensure that the process in which people are engaged makes a difference in the decisions reached.

Create Safety and Inclusiveness – utilize deliberate methods and flexible choices in ways to participate; reduce physical and psychological barriers, and create a safe, hospitable environment. Ensure that diverse voices are made to feel welcome, honoured and heard, particularly marginalized populations and individuals. Aim for a result that is a true cross section of the community being actively involved.

Complete the Circle – following any specific engagement process, all participants should have an opportunity to reflect on what happened, provide feedback, and understand how their input affected the ultimate decisions and outcomes.

(from SK. Health 1999, Zena Simces 2003, Fraser Health 2009, Vancouver Coastal Health 2009, Syntegrity 2012)

Reflective Questions:

What actions and behaviours would indicate you and others:

Are truly present?

Share a common intent?

Are feeling safe?

How does social media affect our ability to organize using principle-based practices?



4. Ways of Being – What Kind of Travel Companion Are You?

As important as the values and principles are the ‘ways of being’ that individual practitioners hold themselves to when engaging with community members. Some key behaviours identified by the Primary Health Development team in the Saskatoon Health Region are:

- Listening deeply and maintaining an awareness of all that is happening in the context
- Using “skillful means” (Chevalier and Buckles 2008) to stay attuned to the needs and capacities of people
- Developing positive relationships with the wide variety of community members
- Being flexible and adaptable - let go of one’s own agenda and embrace community wisdom, energy, and ownership
- Bring energy and curiosity to the work – and work hard!
- Accepting where the community is at, and the necessary ‘messiness’ of engaging with community members and organizations
- Working towards a common understanding of the situation
- Looking beyond the ‘usual sources’ and ‘usual suspects’ for information and participation
- Being alert to innovation and places where there is ‘positive deviance’
- Cultivating support for the engagement among leaders – both in the community and at all levels in the organization
- Always engaging with integrity to build trust and credibility

Reflective Questions:

Having identified your principles and values, think about what the principles and values of the group members are, as reflected in their behaviours. Where are there differences? How will you handle it if this results in conflict?

What is the value of humour in engagement? How can you bring humour to the work you do?

How have I handled it when what community members are asking for doesn’t fit in with my agenda? How could I improve my response?



5. Relationship as the Basis of Engagement: What Does this Bus Run On?

"...the success of primary health care stems from learning more about the community and feeding these learnings (sic) into what we do, and the key to learning more about the community will be building relationships." (p. 17 Syntegration)

Community engagement is fundamentally about human relationships. Engagement can be as informal as having a chat with the mayor on the street, a discussion with the First Nations Councillor after a meeting, or addressing the seniors club. It can also be as complex as undertaking a multi-stakeholder comprehensive community health assessment with teams and committees or establishing a permanent health advisory council. However, all engagement activities are premised on human relationships. The relationships in which community members engage with health providers must be genuine,

respectful, and trustworthy.

How do we optimize these relationships to deepen our ability to understand and create new energy for innovation and change? Otto Scharmer has developed a theory that illustrates how we can, as Gandhi said, 'be the change you wish to see in the world'. Scharmer holds that we routinely participate and function in the world in a 'downloading' mode – reclassifying and reworking old information. It is only when we pay close attention that we begin 'seeing' real conditions ('what is') more clearly. As we begin to 'see', to understand our own constraining mental models, to connect with others and with what the situation looks and feels like to them, and reflect on the differences – do we begin to sense beyond our own experience to become fully 'present' with others. This 'presencing' requires an open mind, an open heart, and an open will. The open mind, as above, is the capacity to see with fresh eyes, to inquire and to reflect. The open heart is the "capacity for empathic listening, for appreciative inquiry, and for exchanging places with another person or system. The open will is the capacity to let go of old identities and intentions and to tune in to an emerging future ...of possibility."

(Scharmer, p 244.)

This presencing requires that we overcome inner, resistant voices of fear, cynicism and judgement. Scharmer believes that by doing so, we will come to honour each person's whole self, see the world realistically, and achieve performance levels that will produce satisfying, innovative, and sustainable solutions to problems.

There is necessarily a dynamic tension between the professional role a primary health employee must adopt and the

*We are longing for profound renewal and change in our collective structures and institutions. We have been waiting, consciously or not, all our lives. And now, it seems, a window is beginning to open.
Otto Scharmer in Berkana Institute AofH, p.27*

kind of investment of self that engagement requires. We are not suggesting that ethical, professional behaviours are left behind, but that genuine engagement often means confronting one's own biases about oneself and others and entering into relationships on a new footing. The social work literature has grappled with this dilemma, whereby 'clients' have, through an empowering relationship, become 'co-activists' and even 'colleagues' in some endeavours. There are many stories of effective social action which began with those with power shifting their perceptions of 'others' and beginning to address problems as equals.

The importance of relationship-building is a foundation for later action. By being present and actively participating in community suppers, walking groups, and ceremonies, community members got to know the facilitator as a person, and built mutual respect; this became the basis of a relationship that eventually improved health services available in the community. It also reminds us that a lot of engagement work does not necessarily take place at official meetings!

Reflective Questions:

People may use different language, come from different backgrounds, and have different life experiences. How can these differences be bridged to form genuine relationships?

The parents of disabled children organized PLAN to increase their children's long-term security and well-being. They mobilized around the principle that "Relationships did not lead to quality of life; they were quality of life". How true is this in your life or in your work?



6. Communication – Deciding Where We’re Going

An underlying activity in all community engagement is communication: the two-way process of providing accurate and timely information and demonstrating that feedback is being heard. **A good communication strategy begins with the core skill of hosting conversations** (Berkana Institute, Art of Hosting, 2011) and is fundamental to effective engagement. Various models (hub and spoke, core team and extended) for multiple or single communities have been proposed for the organizational design of primary health care services; each of these models implies the need for effective linkages among team members and to a variety of community stakeholders. Communication is therefore a critical skill for the effective functioning of whatever model is adopted.

Some principles for good communication in groups include:

- Communicate openly, honestly and accountably with those you are seeking to engage. If you cannot provide every detail, or there is politically sensitive information, acknowledge this.
- Ensure that those engaging with the community are well-informed so that they can answer questions during the process.
- Communication is multi-faceted. It does not just include information giving, but also information gathering, information sharing, collaborative discussion, and decision making.
- Clearly communicate the purpose and limitations of any specific community engagement process at the outset. If it is a formal engagement, agree to the basic procedures and techniques at the planning stage.
- Acknowledge community input and the time and resources people put into the process; think about how to support and celebrate their engagement.
- Remember that the abilities of people to hear, listen, and understand vary; plan to use multiple channels appropriately so that the messages are understood.
- Be clear in your communications; minimize jargon, acronyms, and technical terms.
- Employ new technologies to increase communication to diverse audiences (social media, the arts, etc.).
- Communicate with others who may be doing other assessment or engagement processes to avoid duplication.

Adapted from NSW p. B05



7. A Continuum of Communication Strategies – Different Routes to Take

The International Association of Public Participation has developed a model of communication strategies for increasing levels of commitment in an engagement process. **The five distinct communication intentions are: to inform, to consult, to involve, to collaborate, and to empower.** Each strategy might be appropriate in certain situations and has a clearly-stated objective and an implicit promise being made to the public (community). Another, more explicitly political tool is Arnstein's ladder of engagement which demonstrates degrees of citizen power in engagement, ranging from manipulation to citizen control. (See also Appendix 2 which describes and categorizes over seventy Community Engagement Techniques using these five categories, as well as Community Development.)

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Objective	Objective	Objective	Objective	Objective
To provide the community with balanced and objective information to assist them in understanding the problem, alternatives, or solutions.	To obtain community feedback on analysis, alternatives, or decisions.	To work directly with the community throughout the entire process to ensure that community and organizational concerns are consistently understood and considered.	To partner with the community in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the community
Promise to the community	Promise to the community	Promise to the community	Promise to the community	Promise to the Community
We will keep you informed.	We will keep you informed, listen to and acknowledge your concerns, and provide feedback on how community input influenced the decision.	We will work with you to ensure that your concerns and issues are directly reflected in the alternatives developed and provide feedback on how community input influenced the decision.	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	To place final decision making in the hands of the community.

Source: IAP2 International Association for Public Participation

Reflective Questions:

When might 'informing' be the most appropriate strategy to use?

Can you justify why you might chose NOT to use an empowerment communication strategy?



8. Building Community and Organizational Capacities

The community engagement journey necessitates that those going on the road have to be ready, willing and able for it to result in a pleasurable and productive experience. We have addressed the values and guiding principles that the organization and health practitioners should bring to the engagement, as well as the underlying elements of relationship and communication, and the particular behaviours and attitudes of the facilitators of community engagement processes. It is also helpful to assess the community to determine what capacities exist within the community that will facilitate effective engagement.

“We’ve lumped community together and said ‘we are going to build you a team’. We need to step back and learn first.”
Syntegrity, p. 34

Robert Goodman and colleagues ^(Goodman 1998) identified a number of dimensions of community capacity that can be assessed and measured. Using these as a guide may give the health organization and the practitioner insight into where developmental support might be needed to foster engagement, or alternatively, where abilities and resources

exist to call on for support. These dimensions have been developed into checklists for a variety of community health promotion activities. It may be a useful exercise to assess capacity together with community members, using such a checklist, before undertaking an engagement initiative. Note the following list

Dimensions of Community Capacity (Goodman’s checklist):

Citizen participation: characterized by citizens who are willing to participate, are connected into the diverse networks of their community, are prepared both to listen and speak, who see the benefits overriding the costs associated with participating, and who are affected by the decisions made.

Community leadership: formal and informal leaders who can encourage participation from many diverse community members, who facilitate the sharing of resources and information, who have a responsive and accessible style, and who can focus on both task and process to get things done.

Resources: there exist in the community communication channels, meeting spaces, natural social capital, and cooperative relationships. Resources also exist outside the community that can be accessed (grants, etc.).

Social and inter-organizational networks: characterized by reciprocal links, frequent supportive interactions, some membership overlap, the ability to form new associations, and cooperative decision-making processes.

Skills: community members are able to engage constructively in group processes, conflict resolution and problem solving, program planning, information sharing and analysis. They also understand how to engage in an optimal resource exchanges (how much is being given and received).

Sense of community: there exists a high level of concern for community issues, a belief in respect and service to others, and a sense of connection with the place and the people in the community. This also includes knowing the history of the place – the important social, political and economic conditions in the past and the present.

Community power: the community understands and exerts its influence in positive ways.

Community values: the community has defined norms and standards; there is an on-going dialogue about what is valued.

Critical reflection: community members are able to reflect on information, ideas and actions. They are able to reason logically and argue a position effectively. They understand how the environment affects individual and social behaviours. Community organizations recognize the need for adaptation and change.

Stakeholder Identification and social analysis is another tool for assessing capacities of communities. Two Canadian researcher/activists, Jacques Chevalier and Daniel Buckles, have developed sophisticated tools and techniques for engaging communities in change processes. ^(Chevalier and Buckles, 2008) Their stories and applications from the developing world demonstrate how engagement and capacity can be built in a variety of communities. Tamarack, a Canadian community engagement organization, also has extensive resources and learning events on assessing community's capacities.

Organizational Capacities for Community Engagement

As well as looking at the community's capacity to engage in primary health initiatives, it is important to reflect on what capacities the health system has to respond to community needs and issues.

- **Do they have the mandate to make decisions?**
- **Are they prepared to support a community-identified issue (and to what extent) and build trust for the issues they want to work on?**
- **Do they have the skilled staff to negotiate mutually-beneficial agreements?**
- **Can they mobilize resources for enhancements to primary health?**

Labonte and the Saskatoon District Health Community Development Team (1999) put forward a set of necessary organizational capacities for successful community development, which have been expanded here for community engagement activities. They include:

An expansive and legitimating body of knowledge: This has been provided in recent years through international, federal, provincial and local inquiries and studies that have all made recommendations for public participation as a route to health improvement. The federal *Social Union Framework in 1999* outlined an intergovernmental agreement between the federal government, nine provinces and territories that included concrete commitments to providing opportunities for Canadians to participate in developing social and health priorities and reviewing outcomes. This was followed by a series of public consultations such as *Saskatchewan's Commission on Medicare (Fyke Report 2001)* and the *Commission on the Future of Health Care in Canada (Romanow Report 2002)* which though their conduct and recommendations valued the input of individual citizens in setting the direction for the national health care system. It called for the establishment of the Canada Health Council with citizen and provider representatives to, among other things, provide advice on key areas of reform such as primary health care. In turn, the *Canada Health Council* has developed a Primer on Public Participation. Saskatoon Health Region in their mission and value statements also supports community involvement: one of SHR's four strategic directions is to "Partner to improve the health of the community".

SHR's promise: Every moment is an opportunity to create a positive experience in the way we treat and care for people, in how we work and interact with each other, and in how we deliver quality service. We promise to seize every opportunity.

Enabling internal policies: Engaging communities sometimes has unpredictable outcomes. The health organization needs to recognize this and have policies in place that support communities in demanding changes to social conditions that damage health, and to recognize the importance of community relationships and participatory processes. These policies need to support the primary health facilitators and other staff who undertake engagement work, to be prepared for active citizens. Don't blame the facilitators if the communities they work with become empowered!

Managers who understand and are prepared to foster community engagement: Those involved in community engagement are dually accountable to the organizations they work for and the communities they interact with; they need to act as a bridge between the two. Hence, managers need to be knowledgeable and skilled in community engagement in order to effectively mobilize, manage, and coordinate resources. Managers need to establish goals

and outcomes for the work, be alert to strategic opportunities, recognize the training needs of staff, and advocate for sufficient resources to carry out the work. They also need to set up effective accountability mechanisms (see below) to ensure they get their money's worth and that the engagement activities further the work of the health organization. Most importantly, Heifetz and Laurie (1997) suggest that leaders don't need to know all the answers; they just need to ask the right questions.

How do you 'lead' if you are a manager who is responsible for employees doing community engagement? Because CE practice is emergent and uncertain, managers have to be able to inspire creativity instead of proscribing outcomes. Inspiring creativity is best done by recognizing that each person/employee desires growth and self-actualization - the manager's job then becomes finding the opportunities to support this growth, whether through coaching, training and retreats, encouraging reflective practice, or providing feedback and new opportunities. As well, managers need to work with whatever reality emerges in the engagement process, even if that was not the first desired outcome, and even if it involves difficult conversations.

Using an **Appreciative Inquiry approach** can turn what seems like a 'failure' into a new path of discovery and design. "Appreciative inquiry (AI) is the cooperative search for the best in people, their organizations and the world around them. It involves systematic discovery of what gives a system "life"...(it) involves the art and practice of asking questions that strengthen a system's capacity to heighten positive potential...AI gives way to imagination and innovation instead of negation, criticism and spiralling diagnosis..." (Cooperrider and Whitney,p. 10-). Implicit in this way of leading is recognizing the proximal, process, and relationship-based outcomes as well as the distal, final, or more concrete outcomes of community engagement.

This means that managers can hold employees accountable for excellence in:

- Establishing positive relationships and good communication with co-workers, community members/groups, and health agency personnel
- Fostering growth and development of inclusive, diverse, democratic community groups
- Mobilizing information, connections, and resources useful to community members and the health organization
- Engaging with community members in strategic planning, taking action, and evaluation activities to support primary health initiatives
- Dealing with conflicting priorities or positions constructively

Mutually supportive teams: The organization needs to support the development of primary health teams that can take the time to build solidarity and knowledge through reflective practice; communities of practice, learning opportunities and critical analysis of their work. There needs to be allowance for practitioners to work flexible hours and have a degree of autonomy to collaborate on projects. In turn, practitioners need to be prepared to account for their work.

Skilled primary health staff and facilitators: Practitioners need to be skilled in relationships, communication, facilitation, assessment, planning, and evaluation activities appropriate to their work. (See above and Skills section below) They need to be able to analyze, think creatively, make connections, recognize opportunities for win-win situations, and mediate different interests. They need to reflect on the efficacy of their work and make corrections as necessary.

Who should do community engagement?

While it is ideal to have every health provider engaging with the community, is there also a specific role for a 'community engager' in primary health? The experience of many Health Regions would be to answer in the affirmative. Firstly, primary health is undergoing tremendous growth and development which generates demands for developmental assistance. Secondly, the particular skill set, the accountabilities, reporting relationships, time commitment, and personal interest for community engagement entail a distinct job description. Thirdly, community engagement is not a static, formulaic art; it is emergent, evolving, unique in each community and situation; as such it demands an on-going commitment by a competent, consistent person. And lastly, if the goals of primary health are to be realized, there needs to be a skilled, knowledgeable 'midwife' present to guide the process; such skill comes from being fully immersed in, educated for, and committed to the practice.

There is a little story about four people named Everybody, Somebody, Anybody and Nobody. There was an important job to be done and Everybody was sure that Somebody would do it. Anybody could have done it, but Nobody did. Somebody got angry about that because it was Everybody's job. Everybody thought that Anybody could do it, but Nobody realized that Everybody wouldn't do it. It ended up that Everybody blamed Somebody when Nobody did what Anybody could have done.

Should such employees be called Navigators? Community developers? Liaison workers? Change facilitators? Translators? As long as the work is focused on the definition of community engagement, the label is not as important as that there is a specific person and a specific body of work identified, the processes are compatible with the values and principles of engagement, and the expectations are congruent with the stated outcomes.

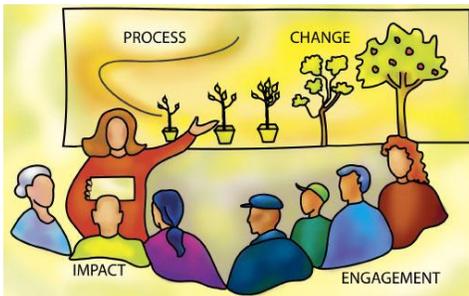
Reflective Questions:

What does building community capacity mean to you?

How much responsibility does the community engagement worker have for building capacity, and how much becomes the responsibility of community members?

Can a community facilitator play a 'strange attractor' role, provoking new patterns of interaction? What is the risk in playing this role?

What is the distinction between community development and community engagement?



9. Evaluation of Community Engagement – Knowing When You Have Arrived

(Part of this also appears as Step 5 in Appendix 1, An Engagement Planning Cycle)

Evaluation is a useful learning and organizational development tool to determine whether a community engagement process has achieved its objectives, and whether the most suitable techniques were used. At its simplest, “evaluation is about finding out if the community process, strategy, or event was a useful thing to do, what it achieved, how it could have been done better and what might be done next.” NSW p. 56

One-off community engagement events

There are different perspectives and stakeholders involved in any community engagement strategy, and these individual audiences’ opinions need to be rolled together into a comprehensive evaluation. Evaluation of one-off events should examine all these different perspectives, perhaps using different questions and methods. Some aspects of the engagement that should be evaluated include:

- participation level and characteristics of the participation – whether it was diverse, inclusive, representative
- quality of communication – clearly indicated purpose, provision of needed information, skilled impartial facilitation, thorough reporting-back processes
- the influence of the engagement – to what extent participants expressed their views and how influential they were in determining the outcomes; how the views differed across different audiences
- equity and cost-effectiveness – participants were provided with adequate support to contribute, timing was adequate, resources were used cost-effectively etc.

An effective evaluation strategy will be one that is tailored to the planned engagement process, and is an integral part of the community engagement plan. There are a variety of mechanisms to evaluate consultation processes, including:

- informal discussions
- questionnaires and surveys (pre-post)
- qualitative observations to assess the qualities of participation
- content and qualitative reviews of process and outcomes documentation
- comparisons of participation to demographic characteristics of the population
- budget commitments and expenditures

(See also: Skills for Community Engagement, Developmental Evaluation)

A careful analysis of the evaluation results should be completed and compared to the objectives established for the process. This evaluation should be available to participants and to the community so people understand how their input has been understood and used. A variety of reporting mechanisms can and should be used, including web pages and interactive methods. Documenting the issues or problems encountered and how they were addressed in the reports can give confidence to the community about the transparency of the process and can also be useful in future engagements.

Evaluation of on-going engagement activities

While some engagement activities have an established beginning and end, and it is reasonable to evaluate their specific impact, many of the activities of community facilitators involve on-going relationships. How do you evaluate their effects? The best practice is to evaluate on an on-going basis. After each meeting, reflect on the processes and outcomes of the meeting, either with community members, by yourself, or with colleagues. After each milestone is achieved, take some time to think and talk about what was accomplished and how (and celebrate, if appropriate). And periodically, take the time for community members to give anonymous feedback on their satisfaction with the processes and results of their work together, using some of the methods above. Reflective practice is covered in the Skills Section; these techniques can be very useful in process evaluation of community engagement and action.

Capacity Building Goals of Engagement

Just as in health promotion initiatives, where there can be evaluation of the proximal impact of a program (did people exercise more?) as well as the capacity-building aspects of the same program (did new leadership for active living emerge?) (Labonte et al 2002) community engagement activities can and should be examined for evidence of meeting capacity building goals beyond the immediate objectives of the initiative. The goals of community engagement, after all, are about improvements in health decision-making, participatory democracy, and developing trustworthy relationships between communities and health systems (instrumental, developmental and democratic goals). These higher-order goals should be pursued simultaneously along with more immediate objectives, such as numbers of participants or formation of a committee. They can apply to individual events or to the whole organizational strategy for community engagement. They are why it is so important to understand the values and be skilled in the practice of community engagement – for it has impacts beyond the immediate success or failure of a specific initiative.

Some examples of goal statements and indicators might be:

If the instrumental GOAL is: **An improved quality of decision-making** – measure how community participants' input was valuable in terms of process and outcomes, as indicated by the diversity of perspectives and new ideas being considered and incorporated and compromises identified for win-win outcomes.

If the democratic GOAL is : **People experienced/participated in a democratic process which increased trust and confidence** – measure if there was equity among the participants' voices (including health care providers), there were clear options to choose from, the process of making decisions was transparent and fair, and those accountable for the outcomes accepted responsibility to act.

If the developmental GOAL is: **Community members and health care providers became more knowledgeable and competent** – measure if there was useful information exchange and opportunity to participate meaningfully that resulted in growth and positive change in knowledge, attitudes and behaviours.

Reflective questions:

For the community facilitator, it might be useful to ask two questions:

- 1. 'How has my role with this group changed over time?' and to reflect on what function you played with the group at the beginning of the engagement, and what role you play now.*
- 2. What is different now, in this community, as compared to when we began working together?*

Summary: A Model for Effective Community Engagement

Based on a literature search in 2003, a summary of the key elements of an effective model of community engagement includes:

1. Readiness

There is a commitment to effective community engagement by all decision makers, feasibility and opportunity costs are assessed, community capacity is understood, real influence and control by participants over the process and decisions are planned, timeliness and early involvement of all participants are considered, long-term commitment is outlined, and accountability for results is established. "...when they (the community members) are ready, we had better be ready – for example make sure there isn't a barrier at the ministry level."

Syntegrity, p. 33

2. Common Goal

There is clarity of goals (addressing particular issues or problems or a joint concern), clearly defined results to be achieved for the immediate and long-term, transparency of intent, and sufficient scope for comprehensive problem-solving or meaningful results.

3. The Right Participants

Individuals are willing to participate, and the opportunity to participate is inclusive, representative, broad, diverse, and engages those who are affected by decisions. "Sometimes only the loud voice is heard. We need to hear from all groups in the community (e.g. young people)."

Syntegrity, p. 33

4. The Right Process

The process is fair and competent, is a good fit with goals, utilizes methods of involvement that are most likely to have an impact on quality health care, enables meaningful dialogue and collaborative practices, and facilitates productive group dynamics.

5. The Right Leadership

There is leadership to guide the processes toward desired results, and facilitation assistance to enable relationship building, ensure required features for effective community engagement are implemented, adapt to changing needs, and coordinate follow-up.

6. Appropriate Supports

Supports include: ongoing access to needed and usable information, information and knowledge sharing, training and education opportunities, appropriate tools, sufficient time, sufficient financial and staff resources, and elements needed to build community capacity for effective involvement.

7. Evaluation

Both process and impact evaluation is incorporated from the start of the initiative. There is an evaluation framework based on evidence and theory, clear identification of definitions and methodologies used, and clarity of goals to be achieved.

(Zena Simces and Associates 2003)

SKILL SET for COMMUNITY ENGAGEMENT

As a practitioner charged with engaging the community in primary health care, there is no particular degree or singular experience that will provide the breadth of skills needed for effective practice. People who do this work come from a variety of backgrounds: social work, nursing, sociology, psychology, human resources, health promotion, geography, etc. Most have supplemented their work with significant experience: leading teams, being involved in political processes, doing community-based research, developing funding proposals, collaborating in partnerships, and being engaged by volunteering in their own communities.

There is, as well, a real diversity of roles played by primary health facilitators and community developers involved in community engagement. One day they may be asked to plan and facilitate a meeting of major stakeholders, the next, to take notes at a meeting with people living in poverty. On some occasions they serve as an information-gatherer for a committee, or coordinate and ensure the continuity of another committee. They may be a leader in an initiative, charged with planning and executing a major health assessment, or they may be a representative member, bringing wisdom gleaned from their experience to share equally with others. They may initiate a difficult conversation within a partnership or mediate between community members. Consequently, there are a variety of skills and resources that practitioners need to have available to them, depending on the circumstances. The following suggested skills are divided into:

Core skills: building on relationship and communication skills, these are fundamental abilities that every primary health facilitator/community developer needs to function effectively in engaging communities including enabling conversations, facilitation, and building collaborations and partnerships.

Accessory skills: those abilities that may be called on in specific situations to support the engagement process including community health assessment and developmental evaluation; and

Supportive structures and practices: those conditions that support skill development including reflective practice and communities of practice.

As primary health grows and changes, as we have a better understanding of community dynamics, and with new opportunities for practice, the necessary skill set may also change. Each discussion of a skill below gives only a 'taste' of the particular topic. References, resources, and experienced practitioners should be consulted for more thorough treatment and understanding of these broad topics.

Core Skills

One of the things we need to learn is that very great changes start from very small conversations held among people who care. Margaret Wheatley

Enabling Conversations

It is hardwired into human beings to engage in conversations; we have been doing it since we sat around fires. Conversations build relationships for belonging, innovation and survival. As such, it is probably the most important tool in the community engagement skill set. Actually practicing dialogue using some simple techniques will improve the quality of our conversations to make them more clear and meaningful. The following hints are from the Art of Hosting, Berkana Institute; practice them and invite others to practice them with you; observe what happens in your conversations.

Focus on what matters. Don't waste time on trivia. That said, what might matter most is getting to know the person you are talking to – what they care about, what their experiences mean, how they see the world. Also, remember that there are cultural differences in how conversations are held.

Suspend judgements, assumptions and certainties. It is not about right or wrong, better or worse. All of these attitudes can prevent your ability to see what might 'become' through the mutual exploration of the conversation.

Speak one at a time. Invite to speak with intention.

Listen to each other carefully. Invite to listen with intention.

Listen together for insights and deeper questions. Be curious about what you do not know yet, and dig deeper than the surface.

Link and connect ideas. This is where you will learn, create, innovate.

Be aware of your impact on the group. Do not monopolize with what is in your mind, make sure everyone can be heard. Ask, "Who is doing most of the talking?"

Accept that other opinions are okay. Consensus isn't necessary in most conversations; at this time, you are trying to understand differing perspectives.

Contribute with both mind and heart. Genuine conversations happen when you bring your full self into the room; be both a professional and a human being.

Slow down. It is not a race, slow down to foster more reflection.

Have fun! What if enjoying ourselves was the key to improving community health?

Reflective Questions:

Think about a particularly meaningful conversation you have had with someone; what were the important characteristics of that interchange?

What role does courage play in a good conversation?

How can you increase your listening ability?

Facilitation and the Role of the Facilitator

“People depend on groups to accomplish what individuals alone cannot. Yet, groups are often disappointing. Group facilitation helps a group improve the way it identifies and solves problems and makes decisions, in order to increase the group’s effectiveness.” (Schwarz, p.3) It is a key skill in many community engagement activities, whether you are in the formal role of ‘the facilitator’ or you wish to play a facilitative part in an initiative.

While a facilitator is sometimes a part of the group, more often, the facilitator is a neutral outside person who is trusted by the group. In either case, the facilitator’s focus is the entire group, and the processes that group uses to achieve its aims. An analogy for the role of facilitator is the midwife, who assists in the process of the birth, but is not the producer of the end result – that belongs to the group. “The facilitator’s job is to support everyone to do their best thinking and practice. To do this, the facilitator encourages full participation, promotes mutual understanding, and cultivates shared responsibility. By supporting everyone to do their best thinking, a facilitator enables group members to search for inclusive solutions and build sustainable agreements.” (Kaner, p.32)

A facilitator may be brought in for a specific substantive problem facing a group. In this case, he/she takes on primary responsibility for managing a group process and helps the group solve the problem. However, in many cases, the facilitator functions in a developmental role, addressing immediate problems but also assisting the group to develop and learn to improve its’ own group processes. This ultimately reduces the dependence on the facilitator for solving future problems.

“There are advantages to involving a third party who is not associated with the issues under consideration and whose role is to maintain the integrity of the group process.” NSW, p. 49

In the primary health context, there are a number of tasks which may benefit from facilitation including

- Identifying opportunities for and supporting the development of PHC teams including working with them to establish priorities, monitor progress and support team building activities.
- Engaging health professionals, inter-sectoral partners and community members in PHC activities through networking, education and outreach.
- Assisting community groups to clarify goals, activities and structures to accomplish tasks (See Story from Practice, p. 40).
- Encouraging evaluation and research activities as part of an improvement process. (Newfoundland and Labrador 2006)

The core values of facilitation are (i) that the group will share all valid information in making decisions, (ii) the group has free and informed choice, and (iii) they are committed to the choices they make. The processes and interventions a facilitator makes in a group must support these core values; they must 'stand in the purpose of the group'. In time, using developmental facilitation, group members will learn to identify when they have not employed these core values, and make corrections in their processes. The aim of a good facilitator is ultimately to ensure the group can function effectively on its own.

Good facilitation may look easy, but in fact utilizes a set of complex skills that can be learned and improved and improved with practice and feedback. These skills can then be applied in many encounters, even if there is no formal 'meeting' nor formal 'facilitator'. The principles of facilitation can be used in leadership, and anyone in an organization can become a facilitative leader, regardless of their position in the organization. If the definition of facilitation is to help others accomplish what they want to accomplish, practicing the core values and using facilitation approaches is not only about a way to facilitate and lead, but about "the kind of life people create for themselves and others in organizations." (Schwarz, p. 260)

As we embrace technological change, facilitation sometimes takes place across time and space, where all participants are not in the same place at the same time. Teleconferences, web links, forums and blogs allow people to have conversations across the globe as it is convenient. However, many of the same facilitation tasks are necessary – perhaps even more necessary – for these modalities to be effective.

The Facilitation Journey

When encountering a new group, how does a facilitator proceed?

(See also Appendix 1 for a formal Engagement Planning Cycle in more detail)

Consulting with the group/client/initiator: Discuss with the group member or the convenor/contractor in the group to determine the purpose and hoped-for outcome of the meeting or process. Listen to determine the stage of development of the group and the task(s) the group wishes to address; this may be done by interviews with group members individually or just the organizational leaders. Establish who needs to attend, what a possible agenda and timeline might be. Discuss with the group/client what a facilitator might offer; clarifying assumptions, role, timelines, etc.

Making arrangements for the meeting/process: Find a suitable time, date, and venue for the meeting and confirm with the participants. Create an agenda, and circulate it, including any background materials needed for participants to come to the meeting fully informed. Think about and plan for any strategies or techniques that you might employ to achieve the purpose of the group.

Establish group norms: If this is the first time the group has met, establish some agreed-upon guidelines for interaction. Clarify the discussion format and decision-making process to be used. Determine any specific roles of participants in the meeting, e.g. taking notes, keeping time, etc.

During the meeting: Restate the purpose, format, approach and timeline for the interaction and review any background material or events. Provide an opening to begin the discussion. As the meeting progresses, the facilitator should be aware of overt or covert disagreements, verbal and non-verbal behaviour, and the themes of the discussion, while ensuring the safety and full participation of all members. Assist everyone to understand different points of view and foster exploration of alternative solutions. Use facilitation techniques during the meeting as appropriate; these include paraphrasing, stacking a conversation, drawing people out, balancing participation, getting clarification, etc. (see Tools section).

Summarize and close: As agreements are reached and recorded, the facilitator should harvest them and ensure they reflect the group's wishes. Summarize the results of the meeting, the actions to be taken, the date and time of the next meeting (if appropriate). Take a few minutes to evaluate the meeting process and outcomes with the participants, noting any particularly helpful contributions, outstanding issues, new ideas generated, etc.

The simple model above will give a new facilitator a sense of competence in handling a most groups. As he/she gains more experience, this model can be built on for more sophisticated facilitation. Dale Hunter and associates believe that the most important role for the facilitator is to “Stand in the Purpose of the Group”, which means understanding and then honouring the reason they are coming together and bringing group members back to that purpose when the discussion gets off track. To do this, the facilitator needs to be able to discern the subtle behaviours that indicate the group is going awry and intervene effectively; the model reinforces the necessity of having ‘eagle vision’ while engaged with a group. Their model describes specific behaviours that might be observed and how to intervene effectively. These are the more ‘intuitive’ skills of an experienced and sensitive facilitator.

There are excellent resources available to practitioners to sharpen their skills and vision in working with groups, including Sam Kaner, Dale Hunter, Roger Schwarz and others, all listed in the bibliography. It is also useful to observe skilled facilitators working with groups to understand the dynamics of the role.

Reflective Questions:

What was the principal role and opportunity of facilitation?

What are your personal principles that contribute to effective facilitation? (e.g. letting go of the outcome, holding the space)

What evidence is there that your contributions of facilitation have increased the capacity of the group you are working with?

Collaboration and Partnership Building

The necessity for agencies and community partners to work together more closely has grown exponentially in the last two decades. This is due to a number of factors:

- The recognition that many health issues are related to the social determinants of health. “Social determinants of health are the economic and social conditions, or living conditions, that shape our health” (Fernandez et al, 2010, p.7); indeed, up to 50% of our health status is determined by factors outside the health care system.
- Presently, these conditions include growing inequities in income distribution, degradation of the natural environment, and the affordability of housing and education.
- As a result of the fact that community issues and health determinants are beyond the scope of any one organization, intersectoral work has gained ascendancy.
- Restraints in public spending on programs that ameliorate inequities (e.g. post-secondary training, Employment Insurance)
- Recognition of the need to address intractable issues in new ways, such as First Nations educational achievement, or inner city gangs.

Primary health, by definition, often deals with clients and communities that have multi-faceted health issues that are influenced by many agencies and also by community conditions. Those who work in primary health settings, then, need to be skilled in fostering successful collaborative efforts.

The goal of community collaboration is to “bring individuals and members of communities, agencies and organizations together in an atmosphere of (mutual) support to systematically solve existing and emerging problems that could not be solved by any one group alone. While this is easily ‘said’ experience shows it is not easily ‘done’ It has been likened to ‘teaching dinosaurs to do ballet’”. (Bergstrom, p. 3) Understanding the complexities of collaboration – what it is and what it is not – increases the likelihood of achieving shared goals or outcomes.

Just as communication strategies vary by intent and intensity, collaboration is one community linkage strategy on a continuum, as in the table below:

LEVEL	PURPOSE	STRUCTURE	PROCESS
Networking	A dialogue for common understanding or clearinghouse for information	Non-hierarchical, loose and flexible roles, focused on community action among members	Low key leadership and minimal decision-making; informal communication and little conflict.
Cooperation	Attempt to match needs and provide coordination to reduce duplication of services.	A central body of people to act as a communication hub; links and roles semi-formal. Group may leverage resources.	Facilitative leaders for some decision-making; formal communications within group; potentially some conflict.
Coordination or partnership	Sharing of resources to address common issues, or manage resource base to create something new.	Central body consists of decision-makers, with defined roles and formal links. Joint budget developed.	Autonomous leadership but focus in on issue. Communication is frequent and clear. Group decision-making in central and sub-groups.
Coalition	Share ideas and be willing to pull resources from existing systems. Develop a commitment for one to three years.	All members involved in decision-making, with roles and timelines defined. Links written into a formal agreement; joint budget developed.	Shared leadership; formal decision making by all members; communication is prioritized.
Collaboration	Accomplish shared vision and impact benchmarks. Build interdependent system to address issues and opportunities.	Consensus used in shared decision-making; roles, links, timeline and evaluation written and formalized.	Leadership high, trust level high, productivity high. Ideas and decisions equally shared; highly developed communication.

(Adapted from Bergstrom, 1996)

The table shows that the purpose of each of these activities is distinct and demands a different level of commitment. While we use many of these terms (collaboration, cooperation) colloquially and rather loosely, the importance of this categorization is to remind us to be intentional about what level of interaction is most suitable for the purpose and most agreeable to all participants. Primary health staff need to be clear if a network will suffice for their current goals, or if they need to invest more social capital in other levels of community linkages such as coalition building or collaborative efforts.

What are the conditions necessary for a successful collaboration among organizations? Based on extensive research, the following six categories and specific factors are vital: (Mattesich et al, 2001, p. 8).

1. Factors Related to the Environment

- a) A positive history of collaboration or cooperation in the community.
- b) The collaborative group is seen as a legitimate leader in the community.
- c) There is a favourable political and social climate for collaboration.

2. Factors Related to Membership Characteristics

- a) There is mutual respect, understanding and trust among the members.
- b) There is an appropriate cross-section of representation.
- c) Members see collaboration as in their interest.
- d) The members have the ability to compromise.

3. Factors Related to Process and Structure

- a) Members take an interest in both process and outcome.
- b) There are multiple levels of organizational participation, including management and operations.
- c) There is flexibility in organizing and managing the work.
- d) There are clear roles and policy guidelines.
- e) The group is adaptable in the face of changes .
- f) There is an appropriate pace of development that doesn't overwhelm the group.

4. Factors Related to Communication

- a) There is open and frequent communication.
- b) There are established informal relationships and communication links.

5. Factors Related to Purpose

- a) There are concrete and attainable goals and objectives.
- b) There is a shared vision.
- c) There is a unique purpose to the collaboration.

6. Factors Related to Resources

- a) Sufficient funds, staff, materials and time exist to achieve the goals.
- b) There is skilled leadership that is legitimated by the partners.

The Collaboration Journey

While the above indicators for collaborating represent an ideal state, how do you go about building a collaborative group that is suitable for individuals or organizations who want to work together?

The first step is to bring people together. This may require an initiator who invites participation by choosing potential members, involving community members and bringing diverse interests together. Choosing a trusted convenor for the first meeting is important to ensure that everyone becomes involved in the meetings. Using facilitation techniques, collectively determine what the focus or vision of the group is, and specify the desired results of working together. Think big, think strategically, and plan to make change to the way things are (not) working.

Thinking big often starts with choosing an affirmative topic choice. An example of the Appreciative Inquiry process that illustrates the impact this has: Entering a community that has been informed that there will be a reduction in health services. The facilitators asked the community 'Think about times when you have worked in a group. What are some of the working rules that helped make that group work well?' Community members and health region employees began listing all important ways of working together, such as listening deeply, respect, acknowledging the wisdom of all people in the room, etc. These working rules then became part of how the group worked together through some very difficult conversations. From this beginning work, they created a Terms of Engagement document that outlined the principles, goals and processes for how they would work together now and into the future. Community members say it isn't about the document, it is about the process used to create it.

Make sure organizational roles, the authority to represent one's group, and commitments are in place, recorded, and communicated. **Clarify how members will work together, including how to handle conflict.** Determine how the group will make decisions – consensus, voting, etc. Provide positive feedback for participation in the collaboration.

Organize the effort to begin to do the work: lay out an action plan, form a structure, determine roles, secure resources. Ensure there are multiple communication links between members. As much as possible, build collaborative work habits utilizing teams and task groups and create accountability for the work by reporting to the whole group. If necessary, articulate joint agreements to do the work, keep records of these agreements, and make any needed organizational changes to make this happen.

Create some visibility for the collaboration through promoting membership, naming the collaboration, and discussing results, both personal and organizational. Evaluate the progress of the collaboration – use developmental evaluation to mark milestones and determine next steps.

Recognize that collaborations need to constantly renew themselves, by retiring members and attracting new members. Celebrate participation as well as accomplishments.

Partnerships

Sometimes seen as more formal than collaborations, partnerships are organizations that want to get involved in a joint venture that will produce better results than working separately, AND has financial or risk implications for those organizations. When health organizations begin to work in communities with others on health determinants, it is often a partnership model that suits best, e.g., municipal government, the health region, a First Nation and a Metis organization came together in a partnership to create an inner city health and recreation facility. Many of the same considerations, conditions, and tasks are involved in forming a partnership as in building a collaborative. However, there may be additional legal agreements and safeguards that need to be negotiated in the foundation of a partnership; these skills should be delegated to those with legal and accounting expertise.

Partnership - A formal and mutually agreed upon sharing of resources for mutual gain.
O.E.Dictionary

It is useful to understand the ‘gives’ and ‘gets’ for each stakeholder group involved in a partnership. A facilitated dialogue where each partner – including the community, the municipality, the RHA, the PHC team members (both clinical and administrative), health care employees and their associations/unions – contributes what they see as benefits and resources can uncover both the commitments and the gaps in bringing a partnership to life. Syntegrity p. 38

For both collaborations and partnerships, there are some deal-breakers that will likely result in frustration and failure. They include:

- When people can't set aside their own mandate or agenda
- When people are unwilling to change how they do things
- When there is no sharing of resources
- When there is a lack of skilled facilitation to move the process along, include everyone, and get results
- When there are side-bar conversations when not everyone is included in communication and conversations
- When there is a lack of established legitimacy of each organization
- When there are unresolved conflicts between individuals or organizations

In summary, collaborations and partnerships are complex undertakings that require respectful, open-minded, patient behaviour, visionary participation, skilled facilitation, hard work, and regular renewal to be successful.

Reflective Questions:

In some countries during the Second World War, 'collaboration' had a very different meaning, indicating working with occupying enemy forces. Do you think this still influences people's ideas of collaboration today?

A collaboration is an entity, a noun; collaborating is an action, a verb. How do we use these terms interchangeably in everyday language? How might this be confusing in communities?

For a short-term effort where two agencies are cooperating on a project, how much effort would you put into assessing and discussing all the factors for successful collaborations listed above?

Accessory Skills

Community Health Assessment

Sometimes, one of the first steps in engaging with community is to create an overview of the community's strengths and its challenges; this is often labelled a 'health needs assessment'.¹ A community health assessment is a process that systematically collects and analyzes information about the health status of a population, both assets and needs. It may include health status information, health utilization data, health resource availability, information about health determinants, including behavioural and environmental indicators, community network and belonging information, and social support indicators.

Health 'needs' assessments have evolved from three different traditions and elements of all three can be found in practice today:

- 1. A medical science approach**, which focuses on the epidemiological patterns of illness and the risk factors associated with them. This top-down approach which does not involve community members proposes solutions that lie in the application of more medical services and technology.
- 2. A health planning approach**, which focuses on improving programs and program delivery by health service agencies, including better coordination. It is often done in isolation from other community planning, and is coordinated by agency personnel.
- 3. A community development approach** where health is viewed as a resource which results from community social, economic, and environmental conditions. The focus is on community demographic, social and economic indicators and indicators of behavioural, social and environmental risk as well as community capacities and readiness for change. Data collection, planning and priority-setting is done jointly by citizens and health organizations to create sustainable community-specific solutions. (Bracht)

Utilizing the community development/asset based approach, the process of undertaking a health assessment can meet both instrumental and developmental goals. While the instrumental goal is to arrive at a prioritized list of health issues and to identify health resources, the developmental goal may be to encourage the involvement of communities by "strengthening the participation and collaboration of individuals, groups, and organizations in the community. The process provides

¹ Most authors now argue that an asset-based approach is a more balanced and empowering way to approach community health assessment. In other words, rather than focusing solely on needs, deficits, and problems, the community also looks at its resources, abilities and social capital. Hence, the choice not to use the word 'need' in describing the process.

an opportunity to facilitate civic engagement in a meaningful, inclusive, collaborative, and transparent manner." (Mang, p. 1)

There are a number of purposes for doing a community health assessment, including:

- Provide baseline information about the health status of a population (i.e., patterns of health and health resources, illness and injury, with comparisons to regional, provincial and national statistics).
- Recognize the existing community mechanisms of support, including groups, clubs, networks, sense of belonging, social opportunities in the built environment.
- Understand what services the population uses, where they access them and how they perceive the efficacy of those services.
- Identify opportunities for health promotion, health protection strategies, and disease and injury prevention.
- Incorporate evidence into planning, priority setting, decision making, and resource allocation.
- Create opportunities to work closely with community members, service providers, groups, and organizations in partnership.
- Increase community knowledge about health and empower them to take responsibility and control of their health.

Some Basic Steps in Community Health Assessment

The most important step in a community health assessment is to determine its purpose. Is it going to be a document to advocate for a specific initiative, such as a daycare? Or a bird's eye view of the whole community to see which concerns are the most urgent? Or an assessment to itemize community resources for youth? Taking time to honestly discuss what the community members and the health agency and other partners see as the potential use and outcomes of the assessment is critical. Taking time to see what information is already available is also important. The time, effort, resources, and social capital expended on a community health assessment can be immense and it is at this crucial decision stage where good decisions are needed. A clearly stated purpose will determine the scope, the objectives, the need for resources, whose involvement is important, and the uses of the information.

The next steps involve making decisions about how to proceed:

Who is going to undertake the assessment and how are community members going to be involved? There are many ways to proceed – a volunteer community committee, a partnership of agency representatives, a single researcher reporting to a health assessment committee, etc. Those hired or designated to do the assessment should be trained in a variety of research approaches; if community members are going to be collecting data, there needs to be a consistency of approach and an overall agreed-to plan. If the assessment will result in recommendations, those responsible for making decisions should be apprised of the purpose, design, and progress of the report.

What information is needed? Based on your purpose, what kinds of data are needed? Do you need to do original research through interviews, surveys, chart reviews, or is the information available in data bases from a variety of sources? How current does the information need to be? How wide does the scope need to be – many communities, just a neighbourhood, or a particular group of participants? Kinds of information include:

- Demographics – current and projected
- Social, environmental, and economic issues and trends
- Population health indicators – life expectancy, low birth weight, PYLL from all causes
- Behaviours, values, lifestyles
- Self-reported health
- Community profile, including community service utilization information
- Opportunities and issues from a variety of perspectives – community members, community leaders, health authority
- Macro trends outside of the community that have or will have an impact on the community

How will the data be analyzed? Once the data have been collected, the next task is to analyze it to make it meaningful. Identifying trends, patterns, outliers, etc. can be done by the researcher and or the community research team. Assistance can be sought from research units of universities or colleges. If it is within the mandate of the research group, they can prioritize the issues identified.

How will the information be communicated? Will it be presented to the larger community, and if so, how? Will a report be prepared for funders, the health authority, the mayor and council, or business groups? Will it become a part of a theatre production or a community charette? Will it be put up on a website? Deciding how the information will be used will assist in determining what levels of data to collect, and what kind of communication vehicles to use to disseminate it.

How will the assessment be used? Throughout the process community members, community leaders and the health organization should be regularly updated on the progress of the assessment. By the time the information is communicated, they should be ready to show how it will be used – whether integrated into the organizational action plan, allocated funding, result in a new organization, etc. In addition, a plan for monitoring implementation should be established to evaluate the effect of the assessment effort.

A community development approach to health assessment is the People Assessing Their Health (PATH) process. It is a health promotion process that helps people increase control over and improve their health through facilitating the community to develop and use its own community health impact assessment tool (CHIAT). The tool reflects the community's priorities and can then be used to undertake a community-led health assessment to look at the potential positive and negative impacts that any policy, program, or service could have on the health of the community. The process used to create the CHIAT involves a story-telling approach based on adult education principles.

Keys to Ensure Success

The following can help ensure success in planning and conducting health assessments:

- Inform the community about what is involved in assessing health. Conduct orientation and education sessions with staff, community representatives and stakeholders to increase their understanding and involvement with the purpose and process. The scope, objectives, and use of the information needs to be defined and communicated.
- Allocate sufficient resources to get the job done. The assessment plan should include estimates of the time and resources needed to complete the tasks. If the assessment is seen as a long-term, on-going process, can the assessment take place in a modified form over time?
- Determine the expertise needed. Many agencies designate a person or a team to plan and implement an assessment. Determine who is best suited to do the job, whether inside or outside of the health agency, or if certain parts of the assessment should use outside expertise.
- Look for partners in collecting and sharing health assessment information. In every region, there are many organizations that are interested in collecting and analyzing information for planning purposes. Coordination of assessments and possibly sharing information may be mutually beneficial. Good communication with partners, communities and planning teams is essential in this case.
- Build on what has already been done. If there has been a comprehensive assessment of seniors or youth, build on that to begin to establish a comprehensive base of population health over time.
- Be realistic about the information/data required. There is a lot of data that could be collected, but it takes time and resources. It is critical to be clear about what information is required, when, for what specific population, issue and time period. Investing time in careful planning for data collection, analysis and determining the use of the results will pay off in a clearly focused, resource-efficient and meaningful assessment.
- Separate health assessment from program performance measurement. Health assessment is complementary to determining the effectiveness of programs, but they are fundamentally different processes. Make this clear in the planning stages to all participants. (Adapted from Mang, 2010)

Developmental Evaluation

How do we know that community engagement in the primary health context is having an impact? How do we know that things have changed, or better yet, improved? We evaluate. Primary health facilitators should be knowledgeable about and skilled in a variety of evaluative techniques, including one that is particularly well-suited to emergent initiatives, developmental evaluation.

In traditional evaluation, a program, with suitable goals, is established and at the end of the program, a summative evaluation is done to determine the overall merit, worth, or impact of the program. Formative evaluations can be conducted along the way to improve a program, identify strengths and weaknesses, and ready the program for the more rigorous summative evaluation.

But what if the community engagement participants are unable to articulate their goals at the outset? Developmental evaluation emerged in response to the need to support real-time learning in complex and emergent situations such as community engagement processes. Traditional forms of evaluation work well in situations where the progression from problem to solution can be laid out in a relatively clear sequence of steps. However, initiatives with multiple stakeholders, high levels of innovation, on-the spot decision-making and areas of uncertainty require more flexible approaches. (Patton 2011, Dozois et al 2010)

Developmental evaluation (DE) is a newer methodology and a work-in-progress, and differs from more traditional approaches in several key ways:

- The primary focus is on learning rather than accountability to an external authority.
- The evaluator may be embedded in the initiative as a member of or consultant to the team.
- The DE role includes actively intervening to shape the course of the initiative, helping to inform decisions and facilitate learning.
- DE is looking for innovations and new ideas, and to capture the dynamics of what is happening.
- Flexible processes are used to monitor and measure progress.

Developmental evaluation may or may not be appropriate for any given situation; an assessment of the readiness of the group is necessary. Assessing readiness for DE takes into account such factors as:

- Is there buy-in or a champion for developmental evaluation?
- Does the culture of the group support and have the time to invest in learning? Is there mutual trust and an interest in feedback?
- Does the leadership understand the need for participatory processes? How are decisions made in the group?
- Is there a willingness to adapt to accommodate new ways of doing things?
- What are the organizational values and practices? Are they in line with such an approach?

In order to be an effective developmental evaluator, a practitioner needs to:

- Be a strategic thinker.
- Be able to recognize patterns in the systems' interactions.
- Build relationships that are grounded, sensitive and trustworthy.
- Adopt the role of a servant leader.

The actual 'how' of doing a developmental evaluation is beyond the scope of this framework. Many excellent resources are now available, including work from Michael Quinn Patton, and further information might be obtained from an Evaluation Society or by talking with experienced developmental evaluators.

Reflective Questions:

Michael Quinn Patton emphasizes that 'the personal factor', or the presence of someone who personally cares about the evaluation and the findings it generates affects the use and impact of the results. How does this contradict our ideas of 'objective' evaluation?

What role do stories have in creating knowledge in community engagement?

Supportive Structures and Practices

Reflective Practice

Reflective practice is a tool used by health providers and others to integrate what is learned in day-to-day work experiences into improved ways of responding to situations. Some practitioners, despite years of work and many experiences, never seem to learn from those experiences, while others analyze novel situations and apply new theories and actions to solve problems as they encounter them. The term 'reflective practice' has been developed to describe this ability to develop practice expertise. Practitioners need specific and deliberate strategies to facilitate learning through practice. This ability is especially critical in engaging communities in primary health, because each community and each situation presents a novel challenge. Only by learning in action will facilitators of these processes become adept at applying new insights and creating ever better outcomes.

Reflective practice is at the heart of many strategies: the story-dialogue method (Labonte and Feather 1996), the action group learning mechanism (Graham 1995), and story telling traditions that go back to indigenous cultures.

The process of reflection (see diagram below) usually begins with an awareness that the knowledge you were applying in a situation was not sufficient to explain what was happening in that unique situation. There may be feelings of dissatisfaction or uncertainty, a poor outcome, or even a great success. A thorough description of the events, key features, thoughts and feelings is useful at this stage. Labonte calls this descriptive stage the "What" stage of reflection.

The second stage involves a critical analysis of the situation, including examining both feelings and knowledge of how the situation has affected oneself and others. You may draw on previous empirical, experiential, moral, or personal sources of knowledge. You may also challenge some of your assumptions and imagine and explore alternative ways of thinking about the situation. The analysis can also include examination of any new knowledge gained through the experience. This is Labonte's "Why" stage of explaining.

Through this critical examination, a new perspective on the situation emerges – the third stage of reflection. "The outcome of reflection, therefore, is learning. Perhaps that involves the clarification of an issue, the development of a new attitude or a new way of thinking about something, the resolution of a problem, a change of behaviour or a decision." (Atkins and Murphy 1995 p. 33) This is the synthesis stage, or "So What" step.

In order for reflection to make a real difference to practice however, it is important that the outcome includes a commitment to action. This is the final stage of the reflective cycle, and, in Labonte's model, the action stage of "Now What?"

While reflective practice may seem self-evident, in fact if it is done rigorously, it is an extremely powerful tool. By posing a set of questions to yourself, or with a community of practice, a great deal of relevant learning can take place.

What - Describe

*New experience/information
or situation; describe thoughts,
feelings, salient events,
key features*

Why - Explain

*Analyze feelings and
relevant knowledge and
challenge assumptions*

So What - Synthesize

*Evaluate relevance
of what learned*

Now What - Act

*Take action based on
new learning*

A Community of Practice

An important aspect of community engagement in primary health is the value of teamwork. The dynamic complexity of the work makes it very important to have other practitioners who understand the challenges and rewards of the work. An ideal is to create a community of practice with others in the field.

According to Etienne Wenger, a community of practice differs from a community of interest or a project team; it is a group of practitioners who work together on an on-going basis and whose association has in common three characteristics:

1. **Domain** – a domain of knowledge creates common ground, inspires members to participate, guides their learning and gives meaning to their actions. In the case of community engagement, the domain may be ‘effective strategies to engage communities in determining and creating a healthy future.’
2. **Community** – the group, through mutual agreements, creates a social fabric for learning, fosters interactions, and encourages a willingness to share ideas. The community engagement community may agree on regular meetings, planned discussion topics, and formal and informal mechanisms for communication, or book discussions.
3. **Practice** – a community of practice is distinguished from an interest group by being committed to utilizing the knowledge from the group in its’ practice. The group is used to develop, share and maintain its core of knowledge. This may be achieved through mentoring, a shared library of resources, being connected to outside professional or interest groups, planning sessions or developing educational opportunities.

A well-functioning community of practice can increase organizational performance by:

- decreasing the learning curve of new employees,
- responding more rapidly to communities’ needs,
- preventing ‘reinvention of the wheel’,
- spawning new ideas.

*The Primary Health Development Team of Saskatoon Health Region created a document on their community of practice in 2007 which stated their **domain** as “improving health through creating equitable conditions for health, including equitable access to primary health services, equitable opportunities to participate in and influence community decisions, and equitable access to material resources for healthy living.” Their **community** included primary health facilitators, community developers, community facilitators and the manager of Primary Health working together in a collegial unit. The community committed themselves to the growth of the team through a number of mechanisms, including sharing resources that had been developed, regular meetings, asking for and providing each other with consultation advice and assistance on projects, and having fun together. Their **practice** consists of “engaging, supporting, and facilitating groups of people to achieve their aims for health improvement.” using a shared library of resources, maintaining connections to local, provincial and national organizations, looking for opportunities to integrate work horizontally, scheduling learning events, a book club, and team evaluation and planning. They also articulated criteria for becoming involved, staying involved, and withdrawing involvement with specific initiatives.*

Failing the ability to establish a community of practice, those doing community engagement work should look for opportunities to cultivate allies within or outside of the organization, to act as neutral sounding boards, idea generators, and for support. Using Paul Born’s technique of Peer to Peer Conversations with local or non-local colleagues may be useful. ^(Born, p.109) There are also opportunities to develop support relationships through community development societies or facilitation networks. And don’t forget the opportunities that on-line communities can offer!

SCALING UP COMMUNITY ENGAGEMENT ACTIVITIES: THE NEXT CHALLENGE

Community engagement is a dialogue around a particular issue that establishes parameters for a shared sense of meaning, direction, resources, and responsibilities. Throughout this document (and in Appendix 1), there are suggestions about evaluation and accountability for community engagement. On the part of the practitioner, these include adherence to a set of values and principles; employing a skill set that includes facilitation, communication, and relationship-building; utilization of learning tools such as reflective and collaborative practice; and a commitment to continued professional development.

The organization also needs to be committed to supporting staff in genuine engagement activities through resource allocation, leadership, and supervision (see Organizational Capacities in Essential Elements). More importantly, though, **the organization as a whole needs to set the context for engagement activities by establishing an organization-wide community engagement strategy that includes a statement of purpose, specific goals, and performance indicators for engagement.** Some health organizations believe that the only way to ensure on-going engagement is to have organization-wide, on-going requirements, processes and outcome measures for engagement.

:

“Engagement must be thought of as a process that evolves over time and the organization needs to be clear of the intended outcomes of each initiative.”
Fraser Health p. 4

A statement of purpose could be adapted from the definition in this framework. Engagement goals for the organization as a whole or for a unit such as primary health should be broadly-based on the three particular goals found in the literature on public participation, namely:

1. Instrumental goals, such as improving the quality of decision-making
2. Democratic goals, such as transparency, accountability, and building trust and confidence
3. Developmental goals, such as capacity-building and education (Abelson and Li, 2011)

Performance indicators for the organization or its units involved in CE could include:

1. The development of an annual plan consistent with the organization’s community engagement purpose and that uses CE guidelines to support project planning and implementation.
2. Participant/stakeholder evaluation is integrated into every CE plan and informs future engagement planning.

3. Each unit will submit its annual CE plan to the larger organization for review annually.
4. Each unit will demonstrate how community engagement results have been communicated to decision-makers and the impact of such results on planning, funding, and decision-making processes.

Within the broad goals and using the performance indicators, the annual community engagement strategy or plan can be developed for the whole organization (e.g., SHR) as well as for any unit (e.g., primary health, home care, public health etc.) or sub-unit (e.g., West Winds Primary Health Centre, the Primary Health Development Team) of the organization. All of these plans could be 'rolled up' for a comprehensive analysis of community engagement in the organization (See also Section 5 of the Engagement Planning Cycle in Appendix 1).

While not all engagement activities are as formal as these guidelines may indicate; keep in mind the goals, indicators and guidelines can assist practitioners and the organizations to thoughtfully approach their work. Using checklists or worksheets utilizing the headings such as the ones below can also assist in this task:

- The particular stakeholders or communities targeted for engagement
- Proposed dates/timeline/location of the engagement (logistics)
- A description of the engagement, including setting it in context of the organizational CE plan
- The purpose and objectives of the engagement
- The engagement approach (inform, consult, involve, collaborate, empower)
- The particular outputs (products such as reports, committees established, etc.)
- The expected outcomes or end results (community taking actions on own)
- Evaluation measures of success (outcomes, processes and impacts)

In summary, carefully planned and skilfully executed engagement plans and processes, with tangible outcomes, can be defined and measured. It is up to the organization and primary health to establish clear goals for engagement initiatives, make a commitment to follow through on commitments, and provide feedback to those involved on the results of the engagement, including the organization. This 'best practice' can then become the basis on which long-term dialogues and relationships are built and the practices of engagement are reinforced.

Appendix 1: An Engagement Planning Cycle

While we have said that community engagement is not a one-off process, sometimes there is a specific event that is planned with the community to create a plan or undertake an engagement or assessment initiative together. The use of a cycle model for planning reflects the on-going nature of community work, but also organizes the tasks in the particular undertaking. It will give community members and primary health facilitators a logical framework and checklist to ensure excellent results.

The model presented is a five-step plan adapted from New South Wales Planning ^{NSW p. 33}: It is most appropriate for a large-scale consultative process, but can be adapted for any engagement undertaking.

Step 1. Design and Plan

- 1.1 Set objectives for the engagement, including indicators of success
- 1.2 Do stakeholder and community analysis
- 1.3. Assess constraints, opportunities, resources
- 1.4 Decide on approaches and techniques

Step 2. Prepare and Organize

- 2.1 Prepare an action plan
- 2.2 Venue, publicity, information sharing
- 2.3 Privacy and information management
- 2.4 Who will run the events?
- 2.5 What are the measurements of success?

Step 3. Implementation

- 3.1 Confirming arrangements
- 3.2 Planning for the unexpected and potential difficulties
- 3.3 Strategies to deal with difficulties
- 3.4 Ideas to maximize success

Step 4. Feedback and follow up

- 4.1 Rationale
- 4.2 When and how to give feedback

Step 5. Developing and implementing an effective evaluation strategy

- 5.1 Benefits of evaluation and what to evaluate
- 5.2 Selecting methods of evaluation
- 5.3 Reporting on evaluation results

Step 1: Design and Plan

1.1 Set Objectives

“Clear objectives are essential to an effective community engagement process.”
NSW p. 34 It is enormously important to spend time developing objectives and to get them right, because it will help determine the approach to take, because the community’s and the agency’s expectations will be built on these objectives, and because their measurement will ultimately determine success or failure.

Some potential objectives for an engagement might be:

- Determine community and agency health priorities
- Evaluate the performance of existing services
- Find solutions to health gaps and needs
- Set performance standards and targets
- Strengthen local democracy by showing people they can make a difference
- Build capacity of individuals, organizations and communities

Once the objectives are determined, generate some indicators for outcomes that would measure success. So, if the objective is ‘to determine community and agency health priorities’, the success indicator would be that ‘a list of community and agency health priorities is created’.

1.2 Stakeholder and community analysis

Depending on what the nature of the engagement is, a number of factors need to be considered in whom to include in the consultation, including the scope of the change, who is likely to be affected and/or interested, whose involvement is important to the matter, the resources available, and the overall complexity of the issue or process.

In general, aim to be inclusive not only of the ‘usual suspects’- those with a vested interest who are knowledgeable, articulate and organized – but also of those who do not usually participate in public processes. While you may need to clarify whom they represent (are they speaking on behalf of all seniors, or as one senior citizen?) and support their involvement differently, their perspectives from lived experience may be invaluable. “Inclusive engagement means ensuring that everyone who may have an interest in the outcome has an opportunity to participate.” NSW, p.36 Look for people who have previously been involved, as well as those who are often excluded. Possibilities include:

- Local council members and council community committees (recreation boards etc.)
- Local businesses and industry/agricultural representatives
- First Nations and Metis leadership or staff

- Community organizations – environmental groups, school committees, community service organizations
- Community activists and volunteers, including seniors, disability support groups, child development groups, etc.
- Local media

Community analysis is another essential aspect in this process of being representative and inclusive; data provides a starting point for deciding who has or may have an interest in the issue. Try to access relevant demographic and other available data to build an accurate picture of the relevant communities, including the history of the community, and their history of engagement. Sources of information may include:

- Population health data bases
- Census information
- Local councils' planning documents
- Research reports, other survey results
- Community, business and government directories
- Workforce or industry statistics
- First Nation and Metis population information
- Local libraries/genealogical and local history groups
- Community members

While data is important, it is imperative to weigh its relevance to the issues at hand - it is easy to get lost in the numbers of reports and databases! Be selective as to the recency of the material, as well as its' quality. And remember that just as important to the community analysis are the observations and informal conversations you may have with community members and others.

1.3 Assess Constraints, Opportunities, and Resources

These factors may, in fact, be a first consideration in undertaking community engagement. Inadequate resourcing can undermine the engagement process. While there are significant costs associated with the process of community engagement (money, expertise, staff time, equipment, travel), these must be considered in the context of the possible costs of proceeding WITHOUT community involvement. Limits on budget and/or time may constrain community engagement.

By choosing the engagement techniques carefully, and working closely with community members to look for natural opportunities, costs can be minimized. Some costs may be reduced by partnering with other organizations to do parts of the community analysis or co-host the engagement. As well, local community networks can be employed to gather or disseminate information; seek opportunities to engage community groups by going to their meetings as a way of including their information.

Inadequate support from the sponsoring agency can also undermine engagement. There must be high-level buy-in for the process as well as the products. If the agency is not prepared for an open discussion in the community, differences of opinion, and/or the possibility of changes in direction or plans, they should reconsider their commitment to engagement. Community engagement should not be a strategy to influence public opinion on an issue that may have already been decided under the pretence of consultation. This just adds to the cynicism and apathy that is toxic to citizenship and future engagement activities.

The sponsoring agency needs to examine carefully what staff time and skills will be needed for the engagement process. Saskatchewan health regions have staff positions that have been dedicated to working on primary health with communities. The availability of these facilitators will influence the decision to run the process in-house, in partnership with other agencies or with consultants. If the facilitator is an employee of the sponsoring agency (the health region) they must remember that their role is to honour the process itself, to “stand in the purpose of the group”, and to maintain a neutral stance in the choices the community makes.^(Hunter et al, 1995)

These staff persons should have skill sets that include:

- Relationship building through intentional conversations and listening
- Presenting using a variety of media and approaches
- Planning and facilitating meetings and larger processes
- Interviewing
- Negotiating to create common purpose
- Surfacing and resolving conflict
- Accessing and utilizing data
- Handling local media
- Recording activities, preparing reports

1.4 Decide on Approaches and Techniques

Most people think of the public meeting as the sine qua non of community engagement. In fact, this technique is rarely the best tool for the job. There are a range of other techniques or tools that can be utilized more effectively to create and sustain community action.

In choosing your tool, ask yourself the following questions:

- Does it match the objectives of our engagement and contribute to our desired outcomes?
- Does it take account of the history of this community? Does it suit the political, social and cultural environment in the present?
- Can we use this technique with the resources, staff, and time we have?
- Is it the best way to involve the community?
- Does it contribute to long-term engagement?

- Is it suitable for our stage in the process?
(see Appendix 2 on types of engagement and techniques to use)

Step 2: Prepare and Organize

2.1 Prepare an Action Plan

Once the planning and design step has been completed, it is useful to have a practical action plan and timetable for the engagement event to keep it on track (an Excel Gantt timeline chart may be useful). However, there are always changing circumstances and unexpected outcomes; keep the plan flexible.

Think about:

- Developing a realistic timetable that takes into account the objectives, techniques, staff, and resources.
- Ensuring that the community will have enough time to become informed and involved.
- Finding additional resources to ensure broadly representative participation by providing translation services, transportation, child care, food, etc.
- Establishing or confirming who is coordinating the engagement process.
- Taking time to reflect on the process and evaluate at the end.

2.2 Venue, Publicity, Information Sharing

For events designed to bring people together in one location, e.g. forum, workshop, focus group, meeting, or display, consider the suitable size, location, accessibility, and layout of the venue. Sometimes it is important to be on 'neutral' territory if there is community sensitivity to entrenched interests. There may also be a need for access to technology for the engagement. Think about where people naturally congregate to help ensure representative participation – it could 'outside the box' and be a community recreation centre, or a mall.

Different types of community engagement activities need different kinds of publicity strategies. A large community-wide meeting could be advertised in the local papers, radio stations, and by putting up posters at community venues. A small group of key informants could be contacted by phone or email. Think about how much lead time people need and how critical their participation is in the overall design. Consider how different styles of publicity might appeal to different groups, e.g., young people, ethnic and cultural communities; also consider languages, large text etc.. Think about how to use social media and new technologies. Ensure the timing of the publicity will elicit the best response, and give people time to read and /or prepare. Designate one team member or a group to be responsible for publicity.

“Effective engagement is informed engagement.”^{NSW, p. 48} Information that is provided to participants should be accurate, accessible and timely. It should both create an understanding of the issues and be clear about the engagement process. Think about what information is needed before, during and after an engagement. Decide what formats are most appropriate to provide it in.

Options include:

- Information packages – paper, electronic, CD or audiotape
- Discussion paper – web based or paper
- Graphic exhibition material – pictures, videos, models, marquette, etc.
- Other hand-outs such as surveys, speakers notes, feedback forms, attendance sheets, name tags, and worksheets

2.3 Privacy and Information Management

Privacy legislation imposes limitations on the way general information is collected, used, shared and published. Any community engagement should therefore strictly adhere to the privacy policy of the sponsoring agency. Participants should be aware of how the information will be used, and if and how it will be shared with third parties. Personal information, if collected, needs to be stored in a locked filing cabinet or electronically secure server.

2.4 Who will Run the Events?

Whether the event is run by consultant facilitators or staff, or a combination of both, all need to be aware of the purpose of the community engagement, their role in it, and be prepared with suitable skills to fulfill their role.

Some roles in an engagement that need to be assigned:

- Welcoming participants – be attuned to cultural practices!
- Chairing and consensus building
- Presenting and explaining
- Translation
- Recording proceedings and writing reports
- Answering questions during the engagement
- Liaising with the media
- Evaluation and implementation

2.5 Measurements of success

At this stage, an interim evaluation process can be useful. Look back over the planning you have done and try and answer the following questions:

- Is there a record of the rationale for engaging participants?
- Did the process enable everyone involved to have their say?
- Will accurate, timely information be provided to the participants and will it obviously inform the process?

- Will accurate, comprehensive and timely feedback be provided to the participants after their involvement?
- Have adequate steps been taken to make the records and outcomes of the process available to the public?
- Are the next stages of the process being communicated?

Step 3 Implementation

Implementation is the culmination of sound planning and design, through preparation and good organization. Even with the best preparation, unforeseen circumstances may arise and may need to be dealt with during implementation. Be flexible here and prepared to modify the plan during the implementation process.

3.1 Confirming arrangements

A checklist such as the one below can be useful:

- Venue booking, including access times for preparation/clean up, adequate numbers of chairs, layout, directional signs, parking arrangements
- Refreshments
- Audio-visual equipment/staff
- Welcomer, notetaker, presenter, facilitator all have confirmed date, time, place and equipment needs

It is useful for some types of community engagements to do a rehearsal to ensure all technical systems are operational, as well as all staff are knowledgeable and prepared. If interviews or telephone surveys are involved, role playing is useful to iron out any ambiguous or difficult to understand questions.

3.2 Planning for the unexpected and potential difficulties

No community engagement process unfolds exactly as planned, no matter how prepared you are. While some problems can be prevented in advance by selection of participants and techniques, there is always human nature to deal with.

Some common problems include:

- Participants with unrealistic expectations or inaccurate information
- Participants who are aggressive or dominant and don't allow others to speak
- Participants who digress widely from the issue at hand
- Assessing the needs of the silent: Participants who do not speak up/contribute, even though you know their opinions ought to be heard

- Participants who challenge the constraints of the process, i.e., wanting to have more influence on decision-making than can be accommodated, extend the timeframes beyond that budgeted
- Distrust and cynicism being voiced about the process
- Managing large numbers of responses in the timeframe available
- Managing negative or inaccurate media coverage
- Technical difficulties
- Poor participation due to conflicting commitments for participants
- Inappropriate venue

3.3 Strategies to deal with difficulties

The facilitator or team should discuss how to deal with potential conflict before the engagement. If decisions are required, this could include how to make decisions (e.g., consensus, majority vote), limiting the items that need agreement, or writing of minority reports.

If a conflict arises, try to respond to it on the spot by adopting a non-combative, respectful stance. Utilizing the “Getting to Yes”^{Fisher and Ury} framework may be helpful:

1. Separate the people from the problem
2. Focus on interests, not positions
3. Invent options for mutual gain
4. Insist on objective criteria for deciding

If the conflict continues to escalate or seems irresolvable in the moment, ask for permission of the group to address it at a later time, with a one-on-one conversation or through a more formal mechanism, such as mediation.

3.4 Ideas to Maximize Success

Some ideas to maximize success:

- Build trust with as many participants as possible before the event.
- Keep the event as informal as possible.
- Don't rush to judgement or try and force consensus – it is about listening and being heard.
- Allow enough time.
- Maintain a non-judgemental, non-defensive attitude – an open mind, heart and will.
- Remember that conflict can be healthy and creative.
- The design and the technique should encourage ownership of the project by all parties, avoiding an ‘us’ versus ‘them’ approach.

Step 4. Give Feedback and Follow Up

4.1 Rationale

Timely and informative feedback to participants reassures them that their views and concerns have been heard and considered. The level of trust and cooperation between the organization and community is likely to increase. One of the most common complaints about community consultation and engagement is that people don't get feedback on outcomes or decisions, which can harm future processes by creating cynicism. At each stage of the process, let participants know what the next step is, and when and how they will be advised of the outcomes of any activity or event; if outcomes are delayed, keep participants informed of progress.

4.2 When and How to Give Feedback

Consider a range of feedback mechanisms to address the needs of the participants, language issues, etc.:

- Letters
- Summary reports which include acknowledging participants' contributions and a record of the consultation process
- Provide telephone hotlines
- Hold meetings to relay results
- Establish an interactive website
- Use informal discussions
- Use community newsletters

Step 5: Developing and Implementing an Effective Evaluation Strategy

5.1 Benefits of Evaluation and What to Evaluate

Evaluation is a useful learning and organizational development tool to determine whether a community engagement process has achieved its objectives, and whether the most suitable techniques were used. At its simplest, "evaluation is about finding out if the community process, strategy, or event was a useful thing to do, what it achieved, how it could have been done better and what might be done next." ^{NSW p. 56} There are different perspectives and stakeholders involved in any community engagement strategy, and these individual audiences' opinions need to be rolled together into a comprehensive evaluation. Evaluation of one-off events should examine all these different perspectives, perhaps using different questions and methods. Some aspects of the engagement that should be evaluated include:

- participation level and characteristics of the participation – whether it was diverse, inclusive, representative
- quality of communication – clearly indicated purpose, provision of needed information, skilled impartial facilitation, thorough reporting-back processes

- the influence of the engagement – to what extent participants expressed their views and how influential they were in determining the outcomes; how the views differed across different audiences
- equity and cost-effectiveness – participants were provided with adequate support to contribute, timing was adequate, resources were used cost effectively etc.

5.2 Selecting Methods of Evaluation

An effective evaluation strategy will be one that is tailored to the planned engagement process, and is an integral part of the community engagement plan. There are a variety of mechanisms to evaluate consultation processes, including:

- informal discussions
- questionnaires and surveys (pre-post)
- qualitative observations to assess the qualities of participation
- content and qualitative reviews of process and outcomes documentation
- comparisons of participation to demographic characteristics of the population
- budget commitments and expenditures

(See also: Skills for Community Engagement, Developmental Evaluation)

5.3 Reporting on Evaluation Results

A careful analysis of the evaluation results should be completed and compared to the objectives established for the process. This evaluation should be available to participants and to the community so people understand how their input has been understood and used. A variety of reporting mechanisms can and should be used, including web pages and interactive methods. Documenting the issues or problems encountered and how they were addressed in the reports can give confidence to the community about the transparency of the process and can also be useful in future engagements.

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