AN EXAMINATION OF TWO MECHANISMS OF PUBLIC ENGAGEMENT IN CENTRAL NEWFOUNDLAND

by

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Abstract

This project is an examination of two types of engagement mechanisms, online and in-person focus groups, used in a large multi-sector public engagement initiative held in Central Newfoundland, between February and July 2013. Each mechanism is evaluated according to a seven point evaluative framework which was developed by the researcher and includes data collected from surveys administered to participants and key informant interviews with the organizers of the initiative. Components of the evaluative framework included resource accessibility, task definition, independence, likelihood to participate again, representativeness, fairness and expectations of the organizers. Overall, focus group participants felt much more positive about the criteria of task definition, independence, fairness and were much more likely to feel strongly about participating in a similar initiative again. While both engagement mechanisms tended to be unrepresentative of the population of Central Newfoundland, due to the low level of participation for the online component, it is difficult to conclude which mechanism better represented the demographic make-up of the population. Initially, organizers felt very positive and optimistic about the online component. After the initiative, however, they discussed ways of improving the online experience and reiterated their support for using two mechanisms of engagement for future initiatives.

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List of Abbreviations

Central Region Citizen Engagement Initiative [CRCEI]

Organization for Economic Co-operation and Development [OECD]

Citizen Advisory Panel [CAP]

College of the North Atlantic [CNA]

Canadian Institutes of Health Research [CIHR]

Canadian Agency for Drugs and Technologies in Health [CADTH]

Health Research Ethics Authority [HREA]

International Association for Public Participation [IAP2]

National Health Service [NHS]

National Institute for Health and Care Excellence [NICE]

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Chapter 1: Introduction

1.1 The issue

Decision makers in healthcare, such as senior management within a health authority or government officials with decision making responsibilities, have the difficult task of allocating resources and setting policies that impact every member of the public. Decision makers are often faced with a plethora of inputs to consider in making decisions and must decide what information is most relevant (Longest, 2012). Horizontal governance includes any attempt to reach out and reduce the gap between decision makers and stakeholders, including citizens or community organizations (Termeer, 2008). In an era where many decision makers are favouring this model of governance, mechanisms that allow participation of affected stakeholder groups in decision making are likely to garner more attention (Sheedy, 2008). Engagement with the public can help inform affected stakeholders and create support for difficult decisions in many areas of policy (Bruni, Laupacis & Martin, 2008). Meaningful engagement with the public can also be a part of an organization's mandate and can positively influence its decision making (Sher, 2008).

However, incorporating public input into all realms of public decision making may not be always advisable. For example, the potential to roll back environmental rules and regulations has been viewed as a limitation of involving an uninformed public (Irvin & Stansbury, 2004). Public engagement can also backfire and be seen as unfavourable in instances where the public perceive their input as not being used meaningfully. Public engagement processes need to be well structured and sufficiently transparent to the public if they are going to successfully incorporate public input into decision making and policy setting (Abelson, Montesanti, Li, Gauvin & Martin, 2010).

Public input must play an important role alongside other forms of evidence and inputs (Mitton, Smith, Peacock, Evoy & Abelson, 2011). This need is especially apparent in the realm of healthcare decision making, where decision makers must balance heterogeneous types of evidence, including scientific research, expert opinions, economic analyses and various lobbying efforts (Wright & O'Rourke, 2012). Even for those who recognize the value of involving the public in decision making, key questions remain, particularly pertaining to the method and scope of such participation (Renn, Webler, Rakel, Dienel & Johnson, 1993). Over the last 30 years, a wide body of research has been developed on public engagement. In particular, the work by Rowe and Frewer has contributed significantly to the field of public engagement evaluation and methodology (Rowe & Frewer, 2005; Rowe & Frewer, 2000). Abelson and colleagues have also contributed significantly to the body of literature surrounding public engagement in healthcare decision making (Abelson & Eyles, 2002; Abelson et al., 2010; Abelson et al., 2003). Nonetheless, the relative dearth of literature and reliable scientific evidence surrounding the evaluations of public engagement initiatives is well documented (Abelson & Gauvin, 2006).

1.2 The context

This project evaluated aspects of the Central Region Citizen Engagement Initiative [CRCEI]. The CRCEI is a large scale public engagement initiative organized by several public organizations in Central Newfoundland. The initiative has an explicit focus on capturing the values of the citizens in the region as they relate to resource allocation and priority setting decision making. The engagement initiative was initially envisioned as having two phases. The first phase consisted of two components: a broad online based engagement survey available to every member of the public in Central Newfoundland and 11 sub-regional focus groups held throughout the region. The second phase of the engagement initiative is planned to be a large

town-hall style, interactive engagement format, modeled after the format used by America*Speaks* (America*Speaks*, 2010). This thesis focuses solely on the first phase of the initiative. Planning for the second phase is on-going.

The initial concept for the CRCEI was developed during the *Many Voices, One Vision* conference in May of 2009. The conference was organized by the Grand Falls Windsor-Baie Verte-Harbour Breton regional council of the Provincial Government's Rural Secretariat. The ten volunteer based regional councils throughout Newfoundland and Labrador have a mandate of developing policy-advice for submission to the Provincial Government. The Grand Falls Windsor-Baie Verte-Harbour Breton regional council is composed of nine volunteer members who reside within the secretariat region (Grand Falls-Windsor-Baie Verte-Harbor Breton Regional Council of the Rural Secretariat, 2011). The goal of the *Many Voices, One Vision* conference was to discuss regional sustainability with various community stakeholders and public organizations such as the Gander-New Wes Valley regional council, Central Health, the Nova Central School District and the College of the North Atlantic (Government of Newfoundland and Labrador, 2010). As a result of this conference, and other research efforts completed by the regional councils, it was decided to initiate a dialogue with the public in order to learn more about citizens' perspective on regional healthcare and the allocation of public resources across sectors in relation to sustainability. Much of the public disdain towards decision making by these public organizations may stem from the regionalization of many diverse policy fields in Newfoundland and Labrador throughout the 1990's. While the Government touted increased regionalization as a move towards improved accountability, lower costs and ameliorated service delivery; it was also a way of unloading unpopular policy decisions onto these newly created organizations while not delegating sufficient resources or power to allow

these organizations to successfully carry out their mandate. Nowhere has regionalization been more prevalent in Newfoundland and Labrador than healthcare, where regionalization can be seen as producing successful regional bodies (Tomblin & Braun-Jackson, 2006).

Initial organizing partners of the initiative included the Rural Secretariat, the Grand Falls Windsor-Baie Verte-Harbour Breton and Gander-New Wes Valley regional councils of the Rural Secretariat, Central Health, Nova School District and the College of the North Atlantic. In the fall of 2012, the Nova School District withdrew from the initiative due to organizational restructuring.

The organizing committee established various sub-committees. The sub-committees included the steering committee responsible for setting the direction of the initiative and setting the agenda. The content design and development sub-committee was responsible for drafting a conversation guide, designing the focus group sessions and the online component. The communications and online sub-committee was responsible for increasing awareness of the initiative, inviting participants to the focus group sessions and generating the post-initiative reports. The logistics and outreach sub-committee was responsible for organizing and coordinating the logistics of the focus group sessions. The session implementation/facilitator sub-committee was responsible for recruiting and training focus group session facilitators. The evaluation sub-committee was responsible for developing and implementing evaluation tools for evaluating the initiative both during and afterwards.

1.3 Focus of the study

This study is a process evaluation of the public engagement initiative initiated by Central Health and its public partners. Rowe and Frewer (2004) define process evaluation criteria as "[the

consideration of] how components of the initiative lead to effective and fair involvement of participants, in terms of enabling appropriate and efficient two-way communication" (p. 541). Process evaluations aim to measure the effectiveness of how the public engagement initiative was conducted. In contrast, outcome evaluations tend to focus on the acceptance and uptake of the results of an engagement initiative (Rowe & Frewer, 2000). Process evaluations of public engagement initiatives do not focus on the whether the initiative produces right or wrong answers, and instead are a study of the initiative itself. Outcome evaluations, on the other hand, answer the question of whether the initiative has obtained its intended effect and focus more on the results of the initiative (Abelson & Gauvin, 2006; Weiss, 1998).

The purpose of this study is to evaluate and compare the two mechanisms of engagement, focus group and online, used by the organizers of the CRCEI. The organizers of the initiative chose to use both mechanisms of engagement to overcome the barriers of geography and logistics to ensure that everyone had an opportunity to participate. The inclusion of both mechanisms in a single public engagement initiative allowed for an excellent opportunity to compare them within a similar context. The research aims to examine the advantages and disadvantages of using each mechanism and to determine which mechanism of engagement was more appropriate within the context of the initiative. Each mechanism of engagement was evaluated according to a seven point evaluative framework developed by the researcher, based on a previous evaluative framework developed by Rowe and Frewer (2000). This framework includes the criteria of fairness, independence, resource accessibility, likelihood to participate again, task definition, representativeness and expectations of the organizers.

1.4 Knowledge gaps around public engagement

Despite an increase in interest in public engagement in recent years, there are still many knowledge gaps surrounding its use. In particular, questions remain about the implementation of evaluation criteria and the use of newer technologies, such as online based engagement mechanisms.

1.4.1 Gaps in evaluation

This project makes use of a process evaluative framework. Outcome evaluations are equally as important, but are often more difficult to study, as outcomes can be complex and framed in varying ways (Thurston et al., 2005). The use of mixed evaluation framework criteria allows a varied perspective to look at each mechanism of engagement. The use of a pre-designed set of criteria remains a contentious issue, since the idea of an *effective* public engagement initiative can be purely contextual (Rowe & Frewer, 2004). Thus, the evaluative criteria chosen for this project were created with the goals of the organizers and the context of the initiative in mind. Due to the nature of any evaluation being somewhat political and contentious when it comes to the choice of evaluator, evaluative criteria and ability to influence future practice, it is beneficial to have a third party conducting the evaluation (Abelson & Gauvin, 2006). In terms of its contribution to the wider literature on public engagement, this project proposes and presents an evaluative tool that can be employed to evaluate different types of public engagement mechanisms and can be used within a rural context.

1.4.2 Online engagement

Online engagement mechanisms represent a new frontier for public engagement. Online engagement can be a cost-efficient method of engaging citizens in policy discussions (Weber, Loumakis & Bergman, 2003). However, given the lack of nonverbal cues, it has been suggested

that online discussion is perhaps less effective than face-to-face discussion (Min, 2007). Other difficulties associated with engaging citizens online include the inaccessibility of the online survey to those without an internet connection or the necessary computer or communication skills (Van Selm & Jankowski, 2006), a poor survey design that is not user-friendly (Nair & Adams, 2009) and an inability to engage users in the online survey (Puleston, 2011).

Limited research has been completed on the comparison of electronic and traditional engagement mechanisms, especially regarding sample characteristics and representativeness (Rowe et al., 2006). In an assessment of electronic and traditional engagement mechanisms for a large scale engagement initiative in the United Kingdom; Rowe et al. (2006) found that website respondents were more likely to be younger, and from more affluent areas than paper questionnaire respondents. There were no consistent differences between the two mechanisms in terms of the extreme responses of strongly agree or strongly disagree given by participants. Despite a slight male bias, the use of the electronic mechanism in their study allowed for a sample that was more representative of the gender composition of the general population as a whole. They also suggest benefits of web-based engagement such as lower administrative costs, more complete survey responses, reduced gender bias, and reduced data recording errors. Min (2007) found that participants in an online focus group were more likely to express candid opinions than participants in face-to-face focus groups, a finding that could have an influence on engagement outcomes in which a deliberative component was used.

Online participation may also be considered more democratic due to reduced dominance by one individual and may increase contributions by those who would not normally be inclined to contribute (Min, 2007). Online engagement requires leadership that is technologically aware and a willingness to use new technologies in traditional engagement realms (Chadwick, 2011).

Unfortunately however, most of the limited research already completed on electronic engagement or public deliberation has taken place in a laboratory setting, where the generalizability of results to real world situation is not certain (Rowe & Gammack, 2004).

1.5 Research objectives

This research project is an evaluation and comparison of the two different mechanisms of engagement used in the CRCEI, online and in-person (focus group). Specifically, this research project aims to:

I. Discern the demographic differences between the focus group sessions and the online component in order to determine which mechanism was more representative of the Central Newfoundland public;
II. Uncover the differences in citizen participation between the two mechanisms in terms of perceived fairness, independence, resource accessibility, and task definition of the process as well as the likelihood of participants to participate in a similar imitative again;
III. Determine which mechanism of engagement better met the expectations of the organizers;
IV. Develop recommendations for future organizers of similar public engagement initiatives.

1.6 Organization of the dissertation

Chapter 2 provides an overview of the current academic and grey literature surrounding the issue of public engagement. Literature of public engagement in healthcare is examined in particular. The foundations, goals, benefits and mechanisms of public engagement are discussed. An

overview of similar public engagement initiatives in Canada, as well as a description of the Central Health region is provided as context for the study. Chapter 3 describes the methodologies used in this study. Chapter 4 provides an overview of the results from the evaluation of the initiative. Chapter 5 discusses the findings and compares the results from both mechanisms of engagement. Chapter 6 provides a number of conclusions from the results of the study and proposes a number of recommendations stemming from the findings, as well as identifying study limitations.

Chapter 2: Literature Review

2.1 Introduction

This literature review explores a number of issues related to the evaluation of public engagement and to the region in which the public engagement initiative was conducted: Central Newfoundland. The article databases searched included PubMed, Google Scholar, the Cochrane Library and the electronic database at Memorial University libraries. For each database, various search terms were used to identify relevant literature, including 'public engagement', 'citizen engagement', 'public participation', 'citizen participation', 'public consultation', 'public involvement', 'citizen consultation' and 'citizen involvement'. The literature surrounding public engagement covers a wide range of topics and contexts, including engagement in environment policy (Nisbet, 2009); public discussions around the use of nanotechnology (Delgado, Kjølberg, & Wickson, 2011) and the inclusion of the public on a panel examining education reform (Hunter, 1999). While these instances can help expand our understanding of public engagement in the healthcare arena (Mitton, Smith, Peacock, Evoy & Abelson, 2009), literature involving public engagement in the Canadian health care sector, rural contexts or which used electronic mechanisms was given priority during the review.

This chapter begins by examining proposed definitions of public engagement and the goals of public engagement in healthcare. The various mechanisms used to conduct public engagement initiatives are discussed. The literature surrounding the evaluation of public engagement processes is reviewed. The next section explores examples of successful public engagement in healthcare in Canada, looking particularly at examples where engagement was conducted in rural areas or used electronic mechanisms. Health care and economic issues in rural areas are

discussed in order to provide further context for the CRCEI. Finally, a description of the geography and demographics of the Central Health region is provided.

2.2 Definitions of public engagement

Public engagement can be difficult to define due to the fact that the term is used to refer to a wide range of activities, with various goals, in a number of different fields and industries. There are also a range of terms which are often used to describe the same activities, including 'public involvement', 'public participation', and 'citizen engagement'. While there may be different connotations associated with each term, collectively they all refer to a flow of information between sponsors and the public (Rowe & Frewer, 2005). For this study, the term 'public engagement' includes all attempts to reach out and engage people outside of the organization sponsoring the engagement initiative.

A number of specific definitions of public engagement have been offered by organizations and authors. In 2008, the Organization for Economic Co-Operation and Development [OECD] created a set of criteria to define public engagement so that it could be used by policy makers to engage the public in discussions on nanotechnology. The criteria include "*deliberative*- emphasising mutual learning and dialogue, *inclusive*- involving a wide range of citizens and groups whose views would not otherwise have a direct bearing on policy deliberation, *substantive*- with topics that are related to technical issues, and appropriate to exchange; and *consequential*- making a material difference to the governance of nanotechnologies." (OECD, 2012, p.11). The International Association for Public Participation, IAP2, an international association dedicated to advancing the use of public engagement, defines public participation as "[a] means to involve those who are affected by a decision in the decision-making process."

(IAP2, n.d.). The IAP2 definition comes after international consultation with many different groups and aims to be as inclusive as possible and suitable for use in any sphere of public policy.

Closer to healthcare, Health Canada developed a public engagement framework in 2000 that included a commitment to "improve knowledge and understanding of health issues through dialogue", "to [hear] the views of Canadians and [provide] timely feedback on the outcomes of dialogue", to engage through activities that "reflect the diversity of Canadians' values and needs and are transparent, accessible and coordinated" and to initiate public engagement that is "integral to decision making and providing quality service" (Health Canada, 2000). While the language used by Health Canada is vague and all-encompassing, it does reinforce some of the core tenets of public engagement, including informing the public, ensuring representativeness of the target population, and using public input meaningfully. A more succinct definition of public engagement in healthcare is described by Meetoo (2013), who refers to public engagement as a process which reflects "choosing committed and broadly representative members of the general public, providing them with all essential evidence, finding ways adequately to represent marginalised citizens, eliciting values and expectations from participants and receiving their clear guidance with regard to policy and decision-making." (p.372). Horlick-Jones, Rowe and Walls (2007) define citizen engagement as "the participation and deliberative involvement by lay publics in planning, decision-making and policy-making situations." (p. 259). Charles and DeMaio (1993) similarly describe public engagement in healthcare as a "democratic and participatory process of decision making" (p. 883) away from the usual dominance of medical professionals and others.

Definitions of public engagement in healthcare reflect the role of patients, communities and all members of the public as the most important stakeholders in the healthcare system (Born &

Laupacis, 2012). While the definitions provided by the OECD and IAP2 are useful for understanding the overall goals of public engagement, they fail to fully account for the importance of specifically engaging those disadvantaged in our society. Meetoo (2013) touches on many of the key components of public engagement - representativeness, resource accessibility, effective communication - that are necessary for healthcare.

2.3 The goals of public engagement in healthcare

There are various goals which organizations hope to achieve when using public engagement. As Chafe et al. (2007) note, the model of engagement, level of responsibility delegated to the public, and information collected from the public are all dependent upon the goal of engagement stated by the organizers. As described in this section, the goals of public engagement define the level of decision making, mode of engagement and therefore the goals and benefits derived thereof. Table 2.1 outlines many of the various models of public engagement and lays out the societal, institutional and personal benefits of such initiatives.

2.3.1 Level of decision making

One perspective used to view public engagement is the level of decision making model. Lomas (1997a) identifies that decision making in healthcare occurs at three different levels. Macro-level decisions proceed at the government level which dictates the amount of resources available to the healthcare system. Meso-level decision making proceeds at the healthcare program level and pertains to how resources are distributed across an institution's health programs. Micro-level decisions pertain to individual patients. However, it is important to note that Lomas found that the public is much more apt to provide input into decisions made at the macro and meso levels (Lomas, 1997a). Litva et al. (2002) report similar findings of a study involving random members of the public and find that the public recognize the need for information, yet also understand the

role that emotions and experiences play in decision making and therefore support the tough role that decision makers face when making decisions that impact many.

2.3.2 Reasons for public engagement

The need for citizen engagement is recognized in the face of limited resources and declining public confidence in our healthcare system (Chafe, Levinson & Hebert, 2011). The increased interest in initiating public engagement initiatives and finding new, innovative means to engage the public in healthcare has its roots in the devolution of healthcare decision making responsibility from the provincial government to regional health authorities (Lomas, 1997b). The devolution of healthcare decision making was a direct result of restructuring during the 1990's and led to the rationalization of hospital care by health authorities as the public sought greater accountability (Naylor, 1999). However, as a result of general public apathy and the profound influence of special interest groups, the regionalization of healthcare may not be the ultimate facilitator of public engagement that some had initially thought (Church & Barker, 1998). Indeed, some view the regionalization of healthcare as a façade in order to deflect blame away from the provincial government and a failure to fully include all aspects of society in decision making at the health authority level (Lomas, 1997b). This policy shift is in line with the view of public engagement as a means of re-invigorating interest in policy and government for the public. It can be viewed as a result of the shift from 'top-down' to 'horizontal' policy setting frameworks that utilize citizen and stakeholder input (Sheedy, 2008).

Abelson and Eyles (2002) propose that public engagement in healthcare is primarily concerned with improving the quality of information regarding the population's needs and preferences, encouraging public debate over the fundamental direction of the health system, ensuring public accountability for the processes within and outcomes of the system, and protecting the public

interest. Furthermore, citizen empowerment is a powerful goal of public engagement. Citizen empowerment can be taken to mean a greater sense of efficacy or belief in their personal abilities and a sense of connectedness with others (Higgins, 1999). Lasker and Weiss (2003) hypothesize that individual empowerment and bridging social ties, along with synergy, are needed for community based problem solving. Empowerment and reducing social gaps are important benefits for the participants of public engagement initiatives, while synergy is the result of working together and the development of creative solutions (Boydell & Rugkåsa, 2010).

2.3.3 Benefits of public engagement

Conklin, Morris & Nolte (2010) hold that the benefits of public engagement can be divided into three main categories: intrinsic, instrumental and development benefits.

2.3.3.1 Intrinsic benefits

Intrinsic benefits refer to the ability of public engagement to be a good in itself (Conklin et al., 2010). Benefits include strengthening of democratic society and the inclusion of the system's ultimate funder, the tax-payer, in policy discussions (Bruni et al., 2008). While, the concept of public participation in decision making processes has its roots in the foundation of our modern democratic system of governance (Coleman & Gotze, 2001), it has only recently increased in popularity as a legitimate mechanism for decision making (Rowe et al., 2006). Wait and Nolte (2006) propose that public engagement plays a democratic role in our society based on the criteria that public participation is an important part of one's citizenship, and that a diversity of interests and views should be represented in public policy. Public engagement in healthcare decision making also aids in satisfying the ethical requirements of decision making set out in Norman Daniel's accountability for reasonableness framework (Martin, Giacomini & Singer, 2002; Daniels, 2000).

2.3.3.2 Instrumental benefits

Instrumental benefits refer to the amelioration of decision making and policy synthesis efforts through the use of public engagement (Conklin et al., 2010). Such benefits include increased accountability about decision making processes (Chafe et al., 2007), the provision of a human element to exist in conjunction with scientific evidence for evidence-based decision making (Pimbert & Wakeford, 2001), more efficient use of resources in the health system (Abelson & Eyles, 2002), the provision of quality information about community perspectives and concerns for decision makers (Bruni et al., 2008), improved quality of decisions (Bruni et al., 2008) and the promotion of the sharing of information between organizers and participants (MacFarlane, 1996).

2.3.3.3 Developmental benefits

Developmental benefits refer to the building of capacity for dialogue between the public and decision makers and an increasing awareness of issues in the public sphere (Conklin et al., 2010). Often cited developmental benefits include increased citizen responsibility and strengthened democratic values (Phillips & Orsini, 2002; Abelson & Eyles, 2002), greater trust in decision makers (Rowe et al., 2008), increased public understanding of the rigors and difficulties faced by decision makers, especially in coverage and priority setting areas, increased public empathy and appreciation (MacKinnon, Pitre & Watling, 2007), the capacity to empower citizens and increase trust in the system, and the strengthening of our democratic society (Bruni et al., 2008). However, it is important to note that not all developmental benefits may be realized in a public engagement initiative. Public engagement depends on the political and societal context, where it is being practiced and as such may not be successful or produce meaningful results where citizens do not feel the need to participate (Redden, 1999). Likewise, it is also important for

organizers to be open and transparent with participants regarding their objectives in order for developmental benefits to be fully revealed (Abelson et al., 2010).

Table 2.1 Summary of many of the goals of public engagement

Component	Description	Source
Level of decision making	Macro-level decision making: Government level decisions	Lomas (1997a)
	Meso-level decision making: Program level	
	Micro-level decision making: Individual, patient level	
Reasons of public engagement	Improving quality of information regarding the public needs/preferences	Abelson and Eyles (2002)
	Encouraging public debate about direction of system	
	Ensuring public accountability	
	Protecting public accountability	
	Public empowerment	Higgins (1999)
Benefits of public engagement	Intrinsic: Inclusion of system funders in policy formulation discussions	Conklin et al. (2010)
	Instrumental: An open dialogue between citizens and decision makers; increased accountability.	
	Developmental: Fostering public confidence in the system	

2.4 Structure of public engagement

There is much more to a public engagement initiative than choosing an arbitrary mechanism. Thought and care needs to be taken to ensure the goals of the initiative are met, the public participating in the initiative are able to participate to the best of their ability, and the organizers deem the initiative a success. The type of mechanism used in a public engagement initiative is an important factor in determining the success of the initiative. For instance, intensive, deliberative methods - such as citizen juries or small focus groups - allow for a better interaction with the

public and can enable more in-depth discussion about specific programs or services. Initiatives that seek unspecific public input may require a less intensive approach such as a town hall or public meeting style format, depending on the goal the sponsor of the initiative wants to achieve (Chafe et al., 2007). Nonetheless, the selection of an engagement mechanism must also be sensitive to external factors that may affect its outcomes, such as the political environment and the organizational context (Abelson et al., 2010); and internal considerations, including the amount of resources that are available for the initiative.

2.4.1 Who to Involve

Involving the public is not always straightforward. The idea of a general public can be a convoluted and obscure idea. Deciding who to engage can prove difficult for organizers as they must discern between various groups such as citizens, consumers, tax-payers, lay people, patient and the community (Conklin, Morris & Noble, 2010). Lomas (1997a) views the public as adopting one of at least three roles when providing input on public policy issues; taxpayer, collective community decision-maker or patient. Conversely, Charles and DeMaio (1993) view the participants of public engagement processes in healthcare as taking on one of two roles; either the role of the 'lay' public or that of a traditional healthcare decision maker, such as a provider, government official or administrator.

There is also a tension surrounding the involvement of special interest groups, as the involvement of powerful and influential interest groups is seen by some as important as the involvement of uninformed citizens in public engagement processes (Maxwell, Rosell & Forest, 2003). While, others view lay participation as an important consideration in itself to be used in healthcare decision making (Charles & DeMaio, 1993). Mitton et al. (2009) report in a review of public engagement in healthcare priority setting in Canada, that most public engagement

processes seem to involve both the lay public and special interest groups as well as patients or consumers of healthcare services.

The inclusion of all types of public can be important as all members bring their expertise or experience to the table, such as the specific legislation or policies that professionals and experts can provide and the experiences and perceptions that consumers that the lay public can describe (Church, 1996). Citizens advocate for values and policy preferences that can be integrated into decision making in the public sphere, while experts, professionals and special interest groups provide the public with necessary information to contribute to the discussion in a meaningful way (MacKinnon et al., 2007). When strong community-researcher/decision maker links are forged, the inclusion of disadvantaged and marginalized populations is also a marked feature of public engagement (Abelson et al., 2010).

2.4.2 Level of engagement

Engagement mechanisms can be distinguished along many lines including type of information flow, manner of participation, and model of engagement amongst others. A number of these models are discussed below.

2.4.2.1 Models of information flow

Arnstein (1969) typified the levels of public participation in decision making according to a *ladder of citizen participation*. Arnstein equates citizen control and input with power, and puts at the upper end of the ladder mechanisms such as partnership, delegated power and citizen control which are supposed to represent citizen power. In the middle of the ladder, Arnstein refers to mechanisms such as placation, consulting and informing as ‘tokenism’ whereby citizen’s views are heard, but there is no guarantee or power to ensure that their views will be used. Such

mechanisms may refer to engagement processes that are an end 'in their own right'. At the bottom of the ladder, therapy and manipulation are referred to as 'nonparticipation'. Arnstein argues that manipulation may occur to citizens on advisory councils who are there only to be 'educated' or 'engineered' in order to support organizer recommendations. However, much of Arnstein's ladder may overlook the knowledge and influence that the public may provide by emphasizing power. Additionally, it also disregards the intrinsic benefits that any type of public participation can provide (Tritter & McCallum, 2006).

The number of different public engagement mechanisms available to organizers of such initiatives has increased substantially in recent years (MassLBP, 2009). Rowe and Frewer (2005) outline a large variety of different mechanisms used for public engagement. They categorize public engagement processes based on an information flow model as outlined in Table 2.2.

Table 2.2 Information flow models of public engagement mechanisms as developed by Rowe and Frewer (2005)

Type of process	Flow of information
Public Communication	Organizer → Public
Public Consultation	Organizer ← Public
Public Participation	Organizer ↔ Public

Public communication is a passive, one-way process that involves the flow of information from the organizing sponsor to the public. Conversely, public consultation is a one-way process that involves the flow of information from the public to the organizing sponsor, usually in response to questions posed by the sponsor. Public participation is a two-way process that involves information exchange and debate between the sponsor and the public.

In a review of public engagement literature, Mitton et al. (2009) group each public engagement initiative reviewed into three distinct categories. Communication corresponds to mechanisms

such as newspaper ads, public meeting or hearings, or a hotline. Consultation refers to an opinion poll or survey, electronic or internet consultation, focus groups, referendum or a citizens' advisory panel. Participation refers to more involved, deliberative style mechanisms such as citizen juries, citizen meetings with voting, or a task force style event.

Similarly, Conklin et al. (2010) expand on these categories and produce a set of six different types of engagement. Consultation refers to obtaining citizen input through non-deliberative means. Participation includes more deliberative methods such as citizen representation at council meetings to produce input. Engagement initiatives include highly deliberative mechanisms such as citizen juries and citizen partnerships for topics such as priority setting. Partnership refers to collaborations with community groups or the establishment of patient advocacy groups involved in decision making. Community development refers to processes using networked representation in engagement processes, especially for marginalized populations. Representation refers to a group of mechanisms that include public or patient representation on decision making boards or conferences.

Many other conceptual models of involvement in public engagement also exist. For instance, Forbat, Hubbard and Kearney (2009) identify the patient in healthcare decisions as a consumer involved in the purchase or choice of service, the patient as a citizen participating in policy and service planning, the patient (or partner) as partner involved in care practice and the patient as researcher involved in co-research. Hanley et al. (2003) outline an engagement continuum of consultation, defined as obtaining public's input; collaboration, defined as a partnership in decision making; and, user-control, defined as public control. While the framework developed by Hanley et al. (2003) originally pertained to public involvement in scientific research; the levels of public involvement can easily be suited for use in public engagement in other areas of policy.

2.4.2.2 Type of mechanism

Deliberative style public engagement processes bring together citizens to deliberate on a certain topic, or a number of topics, with the aim of providing decision makers with distinct recommendations (Hendriks, 2006). Abelson et al. (2003a) provide a set of characteristics that define deliberative public engagement mechanisms in healthcare including; a group of citizens that represent the community, either a single or series of meetings, provision of background information about the issue, the utilisation of expert or key witness testimony to inform discussion and to answer participant questions, and the production of a set of recommendations. Deliberative approaches in particular have been increasing in popularity, perhaps due to the fact that they are more on-going than other styles of engagement and provide organizers and participants with a deeper understanding of the issues (Mitton et al., 2009).

Deliberative engagement mechanisms can have an influence on participant views, with participants forced to consider others views before making recommendations (Abelson et al., 2002). Abelson et al. (2003) found that, in a study investigating both deliberative and phone-survey methods, that opinions were more likely to be changed throughout the course of the deliberative process. However non-representativeness of the target population is an issue. Most of the respondents for both processes were female, well-educated and employed in the healthcare sector. Nonetheless, deliberative mechanisms can play an important role in healthcare decision making, even regarding tough issues such as rationing or resource allocation decisions, and allow the public a meaningful say about the issues affecting them (Lenaghan, 1999).

Some of the most prominent examples of public engagement in healthcare are the use of deliberative style citizen's panels. Citizen's panels, such as the one established by the Ontario Ministry of Health and Long Term Care, provide a forum for community members to voice their

concerns, values and opinions (Kathlene & Martin, 1991). The Ontario example, created in order to provide insight into drug policy in the province, is comprised of 25 Ontarians that reflect the many diverse needs, cultures and attitudes of the province (Ontario Ministry of Health and Long-Term Care, 2012). Internationally, the [NICE] at the National Health Service [NHS] in the United Kingdom is quite experienced with involving citizens in deliberative engagement initiatives (Abelson et al., 2003). The NICE citizen's council comprises 30 members representing the demographics characteristics of the UK. The council provides NICE with public input regarding moral and ethical issues that arise from NICE's guidance (National Institute for Health and Care Excellence [NICE], 2013).

2.4.3 Mechanisms of public engagement

Mechanisms of public engagement include many different styles and mechanisms of engagement. For instance, Rowe and Frewer (2005) identify over 100 different types of public engagement mechanisms. Nonetheless, certain mechanisms are more popular than others and, due to the ambiguous terminology used to describe certain mechanisms; it is difficult to ascertain the difference between every type of mechanism (Rowe & Frewer, 2005). Popular deliberative, participation style mechanisms include citizen's juries (Lenaghan, 1999); planning cells, deliberative polling, consensus conferences and citizen's panels (Abelson et al., 2003). Other types of engagement falling under the realm of participation that do not involve deliberative style mechanisms include involvement of members of the public on boards (Frankish, Kwan, Ratner, Higgins & Larsen, 2002), or the inclusion of community groups in decision making (Adamson & Finney, 1994). More consultative style approaches include petitions (Goyder, 1999), types of focus group sessions (Gray, James, Manthorne, Gould & Fitch, 2004), opinion polls (Rowe & Frewer, 2005), or the use of electronic mechanisms using an interactive interface and feedback

questionnaire (Rowe et al., 2006). On the other end of the spectrum, popular communicative mechanisms include hotlines and other forms of popular media (Mackinnon et al., 2007), public surveys (Whitty, 2013), types of public meetings or information posted on the internet (Rowe & Frewer, 2005).

The various conceptual models of public engagement mechanisms, as well as a listing of various examples of popular engagement mechanisms are included in Table 2.3.

Table 2.3 An overview of the considerations and mechanisms used in the planning of public engagement initiatives

Aspect	Options	Source / Example
Who to involve	Taxpayers	Lomas (1997a)
	Community partners/ Stakeholders	
	Patients	
Level of engagement	Communication	Rowe and Frewer (2005)
	Consultation	
	Participation	
Type of mechanism	Deliberative	Abelson et al. (2003)
	Non-deliberative	
Mechanism	Focus Group	Gray et al. (2004)
	Survey	Whitty (2013)
	Citizens Juries	Lenaghan (1999)
	Community Meetings	Adamson and Finney (1994)
	Representation on a board	Frankish et al. (2002)
	Hotline / Publicity	Mackinnon et al. (2007)
	Interactive online exercise	Rowe et al. (2006); Rowe and Frewer (2005)

2.5 Evaluations of public engagement: components of evaluative framework

Evaluation of public engagement is an area that is underdeveloped and lacking, primarily due to lack of rigorous evaluative frameworks and a lack of an emphasis on evaluation (Abelson & Gauvin, 2006; Mitton et al., 2009; Rowe & Frewer, 2005). Evaluations of public engagement

initiatives generally focus on either outcome or process evaluations (Rowe & Frewer, 2000). While frameworks for process evaluation of public participation frameworks have been documented in literature, it is still an area that needs work. Abelson and Gauvin (2006) note that the deficiency of outcome evaluations may be partially due to the difficulty of defining measurable outcomes of public engagement initiatives. They also note that outcome evaluations are very beneficial for organizers to ascertain whether their engagement initiative truly influences decision making processes. Similarly, Thurston et al. (2005) argue that the impact of public engagement processes may not be felt immediately, but may have a lasting impact further down the road which could be difficult to objectively measure.

However, of notable mention is Beierle's (1999) framework for evaluating the outcomes of a public engagement process. The five stated goals include: educating and informing the public, incorporating public values into decision making, improving the substantive quality of decisions, increasing trust in institutions and reducing conflict. A clear advantage of this framework is the broader definition of 'outcome' as normally used (Beierle, 1999; Abelson & Gauvin, 2006).

2.5.1 Evaluation criteria

The evaluative criteria used in this study are based on a set of evaluative criteria developed by Rowe and Frewer (2000). This section presents the literature and rationale behind the involvement of each evaluative criterion used in this study. The evaluation criteria discussed herein are summarized at the end of the section in Table 2.4.

2.5.1.1 Representativeness

For *acceptance* criteria, Rowe and Frewer (2000) argue that the participants of a public engagement initiative should comprise a representative sample of the targeted public. Since

citizens hold a range of opinions, it is important to include a diverse cross section of citizens in the engagement initiative (Webler, 1995). In particular, deliberative public engagement mechanisms should be representative of the general public since they make recommendations that could influence policy affecting everyone (Abelson et al., 2003). However, as Lomas and Veenstra (1995) demonstrated, many public engagement initiatives include a very unrepresentative sample of the public, including in terms of gender, age, income and employment in the sector being engaged.

Ensuring a cross-sample of citizens is especially important in public engagement since many public engagement initiatives can be manipulated by decision makers to 'rubber stamp' decisions already made by organizers (Middendorf & Busch, 1997). Indeed, representativeness is argued to be an integral component of any public engagement initiative as it fulfills a democratic criteria for such initiatives (Middendorf & Busch, 1997) and increases the legitimacy of any public engagement initiative (Rowe & Frewer, 2000).

Martin (2008) argues that, while many bemoan the perceived domination of such processes by only a few special interest groups and individuals, electoral or democratic means of ensuring a 'representative' sample of citizens are not always perfect. Instead he holds that there are other legitimate means of recruiting citizens that take into account unique experiences or views they may offer. He argues that the role of the 'active' citizen is important in public policy discussions, as they are knowledgeable about the needs and demands of most groups in the community. Rayner (2003) offers a differing view of representativeness in public engagement processes and proposes that any engagement initiative that seeks to represent public views should capture the emergent properties or views of society. Allowing for sufficient time and notification before the engagement is an important step to allow a representative mix of citizens to be heard (Innes &

Booher, 2004). Nonetheless, given a small number of participants, it is sometimes impossible to fully represent the population and therefore a compromise must be made (Barnes, 1999).

2.5.1.2 Independence

Also of importance in Rowe and Frewer's (2000) framework is the concept of independence. Although there is a sponsoring organization for any public engagement initiative, the engagement should be run in an unbiased way, including in the information that is provided to participants and the amount of time participants have to participate. Deliberative public consultations should especially include a wide range of expert or organizer opinions in order to establish trust with citizens and provide participants with a diversity of viewpoints (Petts, 2008). Such well-structured processes can enable meaningful discussion and aid in mitigating power imbalances (Wondolleck, Manring & Crowfoot, 1996). Minimizing intimidating power imbalances between participants and organizers should help in strengthening the legitimacy and fairness of the process (Bruni et al., 2008). As part of the independence of any public engagement initiative, legitimizing the process is also an important goal. It is known that the public will more willingly participate in an initiative that they know is 'real' and will have a substantial and tangible impact (MassLBP, 2009).

2.5.1.3 Resource accessibility

Rowe and Frewer (2000) state that any initiative should provide participants with "(1) information resources (summaries of the pertinent facts), (2) human resources (e.g., access to scientists, witnesses, decision analysts), (3) material resources (e.g., overhead projectors/whiteboards), and (4) time resources (participants should have sufficient time to make decisions)" (p.15). The onus to provide the resources lies with the organizers and is integral to ensuring the process is 'steered and structured' properly (Macfarlane, 1996). However, care must

also be taken in the presentation of resources and information to participants. Depending on how it is presented and framed for participants, information can have a powerful effect on the opinions participants form about certain issues (Price & Neijens, 1998).

2.5.1.4 Task definition

Task definition is important to ensure that the public understand what is being asked of them. The nature and the scope of the initiative can have a profound influence on who participates, the level of participation and the outcomes reached (Chafe et al., 2007). Outlining the scope and expected outcomes of the initiative as well as the mechanisms used helps reduce confusion and disputes regarding the initiative (Rowe & Frewer, 2000). An important factor of task definition is *comprehensibility*; whether participants fully understand all of the information, the mechanisms involved in the initiative and what they are being asked to contribute (Rowe & Frewer, 2005). Ensuring that participants fully understand the tasks, information, mechanisms and what is expected of them will enable an effective initiative.

2.5.1.5 Fairness

Fairness in a public engagement process may be defined as "the extent to which all the stakeholders were treated equally in their contribution to the process." (Timotijevic & Raats, 2007, p.305). Respectful and egalitarian relations between participants are an important part of good process quality and should be part of any engagement process (MassLBP, 2009). Fairness may best be evaluated by parties who represent different perspectives in the process (MassLBP, 2009). If the public is being asked to participate in a deliberative process and make recommendations surrounding potentially contentious topics such as resource allocation or priority setting, it is essential that the public have the necessary time to acquire the skills, and knowledge needed to make such decisions (Singer, 1995). Additionally, financial and social

supports need to be in place in order to fairly include disadvantaged persons in any engagement process (Boyce, 2002). Fairness of the process means, after all, that every willing member of the public should have an opportunity to participate and contribute.

2.5.1.6 Likelihood to participate again

The likelihood for participants to participate in a similar process again in the future is partly influenced by their satisfaction of the initiative (Timotijevic & Raats, 2007). Processes that participants rate highly also tend to attract participants who would likely participate again in a similar event (Gregory, Hartz-Karp & Watson, 2008). The likelihood to participate again in a similar initiative is a criterion that is usually correlated with an increased public confidence in their own ability to participate in the community (Warburton, Wilson & Rainbow, 2007). Public engagement processes organized and run at arm's length from the government may also allow the public to feel a stronger attachment to their community and increase social capital which can influence the willingness of the public to participate in a similar initiative again in the future (MacMillan, 2010).

2.5.1.7 Expectations of the organizers

The 'expectations of the organizers' is a process evaluation criterion that closely resembles an outcome evaluative criterion. For certain evaluations, it may be considered closely related to an outcome criterion, such as relevance, that examines whether the initiative is consistent with government or organizer's priorities and whether the mechanism used was the most appropriate (Motsi, 2009). However, considering Rowe and Frewer's (2004) definition of process criteria as the *effective* involvement of the public; it is only appropriate to consider organizer expectations as a process criterion. This is in consideration that the effective involvement of the public can have a profound influence on the outcome of the initiative, and therefore the expectations of the

organizers. For instance, if the initiative process is well run, then the organizers will be more likely to embrace the recommendations stemming from the engagement and will rate the process favourably (Rowe & Frewer, 2004; Warburton, 2008).

The role of the public in the engagement process as viewed by the organizer can also have a profound influence on organizer expectations or satisfaction. Organizers who view citizens as a source of raw knowledge to be used in conjunction with other factors in decision making are more likely to rate the public engagement initiative as favourable (Kathlene & Martin, 1991). Many factors can determine the influence that public engagement initiatives have on organizers and therefore the outcomes that accompany such initiatives.

Table 2.4 A list and brief description of the various components of the evaluative framework used in this study

Component of evaluative framework	Description	Section	Source
Representativeness	How representative of the general public are the participants in the initiative?	2.5.1.1	Rowe and Frewer (2000)
Task definition	Were the nature and scope of the initiative well defined?	2.5.1.4	Rowe and Frewer (2000)
Independence	Was the initiative run in an unbiased way?	2.5.1.2	Rowe and Frewer (2000)
Resource Accessibility	Were the necessary resources supplied in order to enable participants to make a meaningful contribution?	2.5.1.3	Rowe and Frewer (2000)
Fairness	How equal/fair was the initiative?	2.5.1.5	Rowe and Frewer (2000)
Likelihood to participate again	Would the general public be likely to participate in a similar initiative again?	2.5.1.6	Researcher
Expectations of the organizers	How closely did the initiative match the expectations of the	2.5.1.7	Researcher

	organizers?		

2.6 Public engagement in the Canadian healthcare sector

Public engagement in Canada has been highlighted by a number of well-known examples, particularly in the health sector. Much of this success in the health sector is the result of the devolution of decision making responsibilities from provincial governments to regional health authorities; a decision made to bring decision-makers and citizens closer together to provide increased accountability (Abelson et al., 2002). Nonetheless, this review found that there is limited empirical evidence surrounding the success of public engagement in healthcare. A number of notable examples are discussed below.

2.6.1 Northwest Local Health Integration Network

An example of engagement carried out in a rural area involving electronic engagement methods is the *Share your Story, Shape your Care* initiative by the North West Local Health Integration Network in rural Ontario. Public participation was sought by organizers to provide input for an upcoming health services report and to inform local decision making. Efforts were made to ensure a representative selection of the public participated. Citizens were made aware of the initiative through a large-scale recruitment campaign ranging from posters in local establishments to a presence on social media (Shields, 2012).

The various online tools made available enabled a broad range of citizens to participate in a rural area. A visible social media presence also enabled organizers to reach out to a variety of age groups and allowed organizers to use new methods beyond those of traditional media. Results showed a very good representation of the general population with a good turnout. Various planning information and priorities were identified and the results were made available online for

the public. This type of approach demonstrated the use of innovative technological engagement in a rural health setting; many of the lessons learned by the organizers can be used by organizers in similar contexts elsewhere. The popularity and success of this initiative shows that successful engagement can be completed in rural and remote areas using an innovative, contextualized approach (Shields, DuBois-Wing & Westwood, 2010).

2.6.2. Northumberland Hills Hospital

A more deliberative style of engagement, organized by the Northumberland Hills Hospital in Eastern Ontario, featured a citizen's panel style of engagement to provide input to an individual hospital during a time of budgetary duress.

Initially, a representative survey was commissioned in order to gain a firm understanding of how the public wished to be engaged (Born & Laupacis, 2012). Using results garnered in the survey, an outside firm was brought in to handle the logistics and create the 28 person citizens advisory panel [CAP] to be representative of the population. The panel spent a period studying and discussing hospital services. Input was received from experts, stakeholders and service providers and also included a public roundtable discussion. The citizens' panel then provided its recommendations in a report to the hospital board. Many of the recommendations made by the CAP were aligned with the decisions which were ultimately made by the board (Biron & Gillard, 2012).

The Northumberland Hills CAP model of citizen engagement has been hailed as a novel and innovative approach to decision making in healthcare (Biron & Gillard, 2012). The initiative demonstrates the willingness of citizens to participate in providing input into service delivery and is a powerful example of a successful collaboration between decision makers and the public.

2.6.3 Health Council of New Brunswick

An example of larger scale public engagement in healthcare decision making was conducted in Atlantic Canada by the Health Council of New Brunswick in 2010.

The multi-phased engagement initiative included focus groups held in communities around New Brunswick so that participants did not have to travel a large distance to attend. The engagement initiative consisted of three distinct phases over three days and allowed participants to gain a richer understanding of the issues at hand. It enabled, in the final phase, a validation of the findings from the first two phases. Both deliberative and consultative mechanisms were used, including table discussions and learning sessions (Pollack & Mackinnon, 2012). Despite a lower than expected turn-out, the public engagement initiative provided decision makers with a plethora of information from a representative sample of citizens on a variety of specific, and non-specific, issues (New Brunswick Health Council, 2010).

The Health Council of New Brunswick initiative demonstrates the importance of having a strong recruitment strategy and providing an honorarium to participants. Nonetheless, the initiative was an excellent example of including a large number of diverse participants and maintaining an open dialogue with the public (Pollack & Mackinnon, 2012).

2.6.4 Commission on the Future of Healthcare in Canada

Public engagement played an important role in the *Commission on the future of healthcare in Canada* (Mackinnon et al., 2007). The commission sought to engage Canadians on four different themes: the values Canadians find important in healthcare, the sustainability of the healthcare system, the need to develop a culture of dynamic change in healthcare, and mechanisms to improve communications and relations between various stakeholders in the system (Mackinnon

et al., 2007). As part of an extensive engagement strategy, the Commission first used televised policy forums to expose Canadians to various policy debates in healthcare. Phase II consisted of open public hearings where interested groups or individuals were able to make a submission to appear before the hearing. Care was taken to ensure that a balance of views was represented at the hearing. Over 3000 telephone or web submissions from individuals and groups were also made to the hearing. Phase II also included closed workshops involving a sample of participants from the previous day's hearing to find a consensus on certain issues. The Romanow commission included television format debates series around important issues as well as a toll-free phone number and website posting service for other submissions.

To this day, the Romanow commission is seen as facilitating the most comprehensive public engagement initiative of its kind in Canada. While the use of the recommendations formed by the engagement in formal policy development is debatable (Chafe et al., 2011; Mackinnon et al., 2007); the integration of values into healthcare decision making is an important result of the commission.

2.6.5 Eastern Health Needs Assessment

The Eastern Health Needs Assessments for the Burin Peninsula in 2006, the Southern Avalon region in 2007, the Bonavista-Clarenville region in 2010 and the Northeast Avalon in 2010 are examples of an innovative approach in Newfoundland. Interviews with key stakeholders helped identify issues in the community. Subsequent focus groups included discussions regarding community issues, health concerns, perceived gaps in service, opportunities for improvement in service and the current capacity in the community. Concurrently, a random sample telephone survey was conducted throughout the service area. The survey focused on access to health services, satisfaction with health services, perceptions of community problems and self-

assessment of personal health and wellness. Additionally, members of the public were invited to contribute oral or written submissions to Eastern Health regarding the health and community services in their area. Advertisements were put in local newspapers and on local radio and television stations. The Northeast Avalon needs assessment differed in that the telephone survey occurred first, and was followed by focus groups and key informant interviews that built on themes developed from the survey results.

Results from the needs assessment were disseminated to participants and goals were incorporated into an organizational plan. A two-year follow up report was released to determine the progress taken on each initiative (Eastern Health, 2007). Although this process contained no formal evaluative component, the approaches used by Eastern Health indicate a commitment to reaching out to the community and using public engagement as a working tool. The media profile used by Eastern Health ensured that the public was made aware of the initiative and the comprehensive approach allowed for a range of engagement options for members of the public. Although Eastern Health did not include an extensive online engagement component, the use of local media and a phone survey nonetheless allowed for a broad range of input from rural areas.

2.7 Health care issues in rural areas

Owing to their often remote and sparsely populated locales, rural areas present unique challenges for healthcare delivery and use. Rural areas are defined by Statistics Canada to include areas with a population less than 1000 inhabitants and a population density lower than 400 inhabitants per square kilometre (Statistics Canada, 2011). Generally, rural areas have more expensive care than urban areas due to a number of factors such as transportation or living costs (Herbert, 2007).

Healthcare needs in rural areas are also different owing to a number of negative health trends. Rural areas in Canada experience lower life expectancy and higher mortality rates than their urban counterparts (Pong, DesMeules, & Lagace, 2008). Rural Canadians are also more likely to participate in unhealthy behaviors, have lower educational attainment, and tend to reside in poorer socio-economic conditions (Canadian Population Health Initiative, 2006). Overall, reported health in rural populations is generally lower; suicide, motor vehicle accidents, cardiovascular disease, obesity and certain types of cancer are more prevalent in rural populations (Smith, Humphreys & Wilson, 2008). However, the phenomenon of poor health in rural areas is not only a Canadian one; worldwide health disparities between rural and urban populations are well documented (Ryan-Nicholls, 2004).

Many factors contribute to poorer health outcomes in rural areas. Some of the realities facing rural areas, including geographical location, lifestyle, socioeconomic status and race or ethnicity, seem to play a role (Smith et al., 2008). Lack of accessible services or a shortage of healthcare workers are also often cited factors (Ryan-Nicholls, 2004). In 2011, less than 10% of physicians in Canada practiced in a rural area despite rural Canada having about 20% of the general population (Canadian Medical Association, 2011). Lack of exposure to rural medicine during training, lack of financial or social incentives, lack of rural students entering medical school and lack of professional support have been cited as contributing factors to the recruitment and retention issues of healthcare workers (Laurent, 2002; Kwong et al., 2005; Pope, Grams, Whiteside & Kazanjian, 1998).

Further understanding the discrepancies in rural health requires consideration of the determinants of health facing rural areas. Determinants such as limited or reduced access to acute care services, riskier or unhealthier lifestyles due to dangerous working conditions or risky behaviors,

a higher proportion of indigenous peoples all play a role in the health situation of rural citizens (Smith et al., 2008; Hartley, 2004).

More than just health disparities, rural areas are faced with stagnant population growth, a population that is aging more rapidly than the general population and a higher unemployment rate (Statistics Canada, 2009; Laurent, 2002). Rural Canada also has lower per capita income and difficulties retaining young people and immigrants (Federation of Canadian Municipalities, n.d.).

A number of innovative approaches have been introduced to improve access and care for rural citizens including financial incentives, rural training programs and the admission of more rural students to medical schools (Kirby & LeBreton, 2002; Romanow, 2002; Kwong et al., 2005). Additionally, Telehealth approaches have been increasing in popularity. Telehealth uses videoconferencing technology to connect healthcare professionals with patients in rural or remote locales. It allows the local healthcare worker to refine or supplement their skills and allows patients the opportunity to interact with a specialist without travelling long distances. Telehealth approaches have been outlined and advocated for in both the Romanow Commission and the Kirby report (Romanow, 2002; Kirby & LeBreton, 2003). It is generally recognized that a number of different public health approaches may be needed in order to correct many of the disadvantages currently facing rural citizens (Canadian Population Health Initiative, 2006).

2.8 Description of the Central Health region

Central Health is one of four regional health authorities in Newfoundland and Labrador. Central Health services the health needs of 91 709 Newfoundlanders, making it the second most populated health authority in the province (Statistics Canada, 2013b). It administers a broad range of services in ten different defined health services areas, spread over a large geographical

region. Health services areas include Baie Verte, Buchans, Green Bay, Exploits, the Grand Falls-Windsor area, the Coast of Bays, Lewisporte, the Isles of Notre Dame, the Gander area and the Kittiwake Coast area (Central Health, 2008).

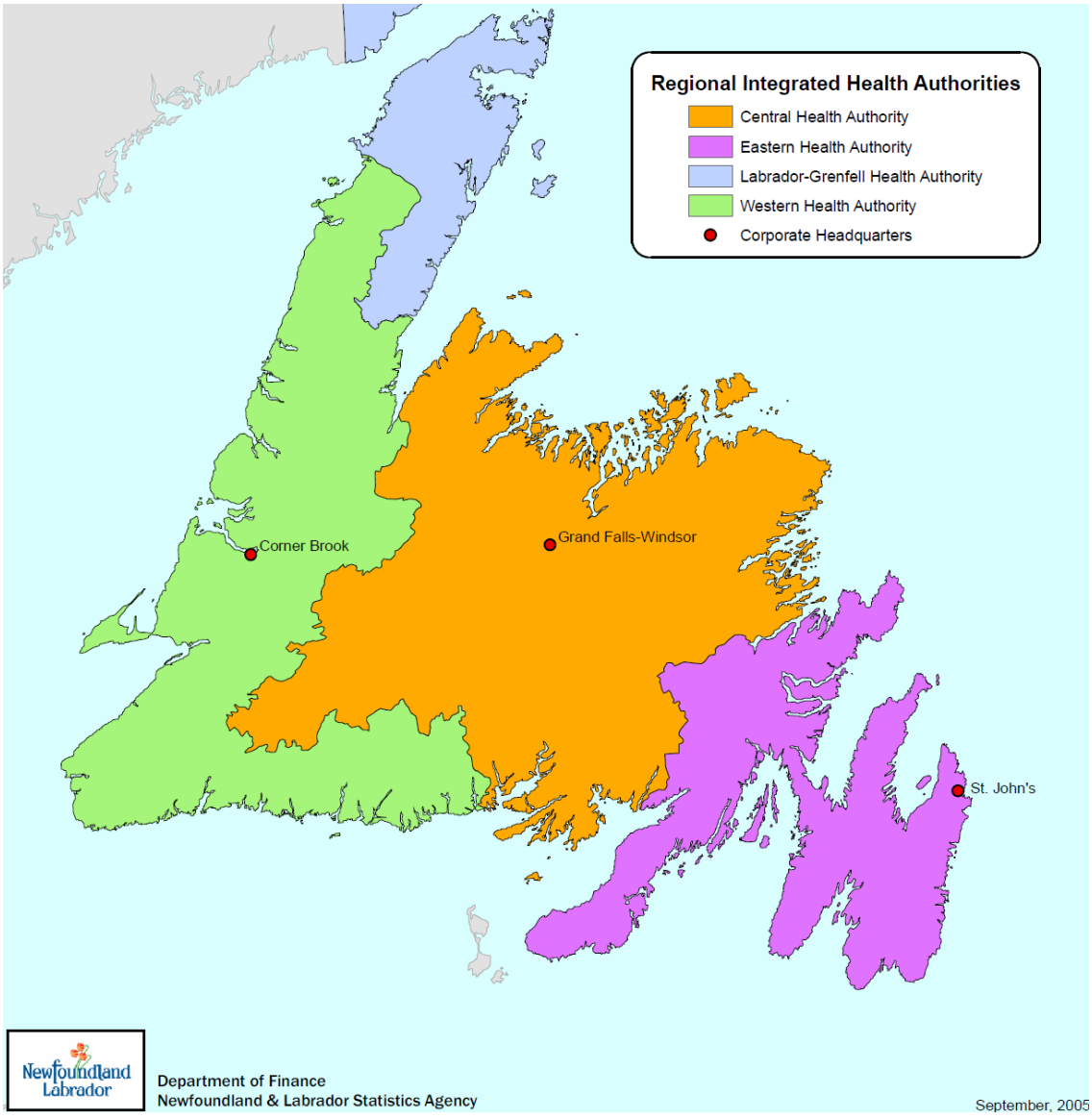


Figure 2.1 Map showing Central Health and the other Regional Health Authorities in Newfoundland and Labrador (Department of Finance, Government of Newfoundland and Labrador, 2005)

2.8.1 Health of Central Health residents

In 2011, 63.1% of Central Health residents 12 years and over rated their health status as 'Very Good' or 'Excellent', while only 12.6% of residents rated their health as 'Fair' or 'Poor', similar to the provincial figures of 60.9% and 13% (Statistics Canada, 2012). As well, 2006 census data indicates that over 77% of Central Health residents between the ages of 25 to 29 had achieved a high school diploma; lower than the provincial and national averages of 84.5% and 86.7% respectively. Less than half (48%) of residents aged 25- 54 were graduates of post-secondary, again lower than the provincial average of 58.1% and much lower than the national average of 62.6%. Unemployment in the Central Health area in 2011 stood at 17%; substantially higher than the national rate at 7.5% (Statistics Canada, 2013a).

2.8.2 Rural citizens in Central Health

The majority of residents in the Central Health region, over 60%, reside in rural areas, defined as communities containing less than 1000 residents and a density of 400 or more people per square kilometre. Nationally, the percentage of citizens residing in census rural areas is over three fold lower at 19.9% (Statistics Canada, 2013a). Over 47% of Central Health residents are at least 50 years old, while less than 25% of residents are 24 years or younger. Nationally, about 36% of citizens are 50 years or older while over 29% of citizens are aged 24 years or younger, indicating an aging demographic in the Central health region (Statistics Canada, 2013b).

2.8.3 Main stakeholder groups

The public organizations involved in the CRCEI are described below.

2.8.3.1 Central Health

Central Health is the second largest regional health authority in Newfoundland and Labrador by area, encompassing over half the land mass of the island of Newfoundland. It is an organization with 3 115 employees and over 800 hospital and long-term care beds. Central Health states its organizational mandate includes five major areas, including: promoting health and well-being, preventing illness and injury, providing supportive care, treating illness and injury, and providing rehabilitative services (Central Health, 2013a).

The senior leadership team at Central Health is composed of several vice-presidents and chief operating officers responsible for overseeing the various business units of Central Health and who report to the chief executive officer (Central Health, 2013b). While Regional Health Authorities in Newfoundland and Labrador are responsible for healthcare delivery, the provincial Ministry of Health and Community Services maintains control over policy formulation (Tomblin & Braun-Jackson, 2006).

2.8.3.2 College of the North Atlantic

With more than 20 000 students and 17 campuses throughout the province; the College of the North Atlantic [CNA] is the largest public college in the province of Newfoundland and Labrador. According to the CNA's *Strategic Plan for 2011-2014*, the primary lines of business for the college include administering full and part time post-secondary programs, learner support, contract training, continuing and community education programs, applied research, community outreach, and institutional research and planning (CNA, 2011).

2.8.3.3 The Rural Secretariat

The Rural Secretariat is a department of the Office of Public Engagement; a Ministry in the province of Newfoundland and Labrador that also oversees the Voluntary and Non-Profit Secretariat, the Strategic Partnership and the Access to Information and Protection of Privacy Office. The Rural Secretariat's mandate includes advancing the sustainability of rural communities throughout the province. The rural secretariat fulfills its mandate through a number of means including, facilitating public engagement, supporting collaboration amongst rural stakeholders, promoting research that helps inform decision making and policy setting, and assisting the ten volunteer run regional councils to develop policy advice for decision makers (Government of Newfoundland and Labrador, 2013).

Chapter 3: Methodology

This chapter describes the methodological choices made to achieve the project's objectives of evaluating online and in-person engagement. The topics covered in this chapter include the selection of the study topic, developing an evaluative framework, the methods of data collection, the use of key informant interviews and the development of questions used, the use of survey data and the development of the questions used, considerations using a mixed methods approach and a review of ethical considerations for this project.

3.1 Study Topic

The goal of this study is to evaluate two different types of public engagement mechanisms and evaluate the advantages and disadvantages of each from the perspective of the CRCEI.

I first became involved in this initiative in the summer of 2012 after being approached by Dr. Doreen Neville, a member of the steering committee and evaluation subcommittee. The organizers recognized the need for an evaluative component to be included in the initiative. I subsequently attended meetings of the organizing committee, starting in October 2012 and shortly thereafter identified a thesis project and possible methods of data collection for the project.

Abelson and Gauvin (2006) note the need for more high quality evaluations of public engagement initiatives, particularly in regards to the role context plays in the initiative. Research into electronic and internet-based engagement mechanisms is relatively uncommon (Rowe & Gammack, 2004). The CRCEI provided a unique opportunity to study the use of two different mechanisms of engagement in a rural context.

3.2 Developing an Evaluative Framework

In order to evaluate these two mechanisms of public engagement, an evaluative framework was developed based on the process evaluative criteria proposed by Rowe and Frewer (2000). Selected criteria from Rowe and Frewer (2000) include fairness, independence, task definition, representativeness, and resource accessibility. These criteria were selected based on an extensive search of literature about public engagement (see Abelson & Gauvin, 2006; Rowe et al., 2005; Rowe et al., 2008).

Considering the unique contexts of this project, including the use of an online component, the lack of experience for the organizers in public engagement and the rural setting, and the scope of information to be collected, additional criteria were incorporated into the evaluative criteria. The exact evaluative criteria used to evaluate the initiative are included in Table 2.4.

A question regarding the participant's likelihood to participate in a similar initiative was added to gauge whether participants enjoyed their experience enough to participate in a similar initiative again. This is an important criterion because citizens are unlikely to participate in a similar initiative in the future if they are not satisfied with the way the initiative was run (Timotijevic & Raats, 2007).

The expectations of the organizing committee is another evaluative criterion that was not originally included in Rowe and Frewer's (2000) framework, but is included in the evaluative framework of this study. This criterion was assessed by qualitative interviews with members of the organizing committee. The criterion was chosen as it provides an in-depth examination of how the organizers viewed the initiative and therefore provides an indication of the organizational impact of the initiative and whether the organization is likely to continue to use public engagement exercises (Kathlene & Martin, 1991; Rowe & Frewer, 2004). These interviews provide valuable insights and multiple perspectives into the context of the initiative (Abelson & Gauvin, 2006). Completing the interviews pre and post initiative facilitates a measurement of change in attitudes or behavior regarding the initiative and an examination of changes in the political context (MassLBP, 2009).

The representativeness criterion was modified from the criterion that Rowe, Marsh and Frewer (2004) used. Instead of measuring participant perceptions of representativeness, participants were asked to complete a demographic information questionnaire which was then compared to the demographic information from the Central region as a whole. Since representativeness is such an important criterion in public engagement initiatives, it was comprehensively covered to measure whether a representative population participated, in terms of health status, education, age, gender and community (Middendorf & Busch, 1997). Although it is desirable to fully recruit

a representative sample of the population, practical considerations made this difficult for the organizers of the initiative (Rowe & Frewer, 2000). Therefore, after consultation with Dr. Rick Audas, demographic categories that correlate with Statistics Canada data were selected.

3.3 Methods of data collection

In determining the data collection strategy to be used, we considered what was the most appropriate for the different aims and for the nature of the engagement initiative. I began by reviewing the possible sources of relevant data that could be collected. For the surveys and focus groups, I discussed with Central Health the possibility of including a survey instrument in the focus group and online sessions. Initially, the idea of evaluating initiative outcomes and cost-effectiveness was also considered, however, was subsequently decided against due to the lack of rigorous outcome evaluation criteria, the substantial time before the data would be made available and the organizational hurdles faced for such evaluation (Abelson & Gauvin, 2006; Rowe and Frewer, 2000).

3.3.1 Surveys

Quantitative surveys were administered to both focus group and online participants. Survey instruments were similar, next to wording changings to make them appropriate for the context in which they were administered (Appendices B and C). Both survey instruments had two distinct components: a participant experience component, and a demographic information component.

For participants of focus group sessions, surveys were administered via the TurningPoint 5.0 polling technology (Turning Technologies, 2013). It enables direct polling into PowerPoint software and each participant is able to anonymously register their survey responses via a wireless transmitter. TurningPoint software is often used by the Rural Secretariat in public

engagement initiatives. The questionnaires were administered by the facilitator of the focus groups.

Online participants completed a survey instrument created using the Fluid Survey™ website (FluidSurveys, n.d.). The free FluidSurvey™ online software allowed the use of open and closed ended survey questions and the custom design of the survey. FluidSurvey™ was chosen as it is a Canadian based online company and does not store its data internationally, thus circumventing privacy concerns (FluidSurveys, n.d.).

Online surveying can offer several unique advantages as discussed in Section 1.4.2, such as reduced cost, reduced bias, increased representativeness, and increased participation. However, online surveys are a relatively new class of survey instrument and as such pose several methodological concerns including issues with sampling concerns such as multiple responses from the same individual, access issues for some members of the population, difficulty in establishing a sampling frame and no guarantee of accuracy of information provided (Wright, 2005). Nonetheless, a clear potential advantage of online surveying is that it can attract a large sample of participants, whether by advertising or by word of mouth (Norman & Russell, 2006).

Conventional surveying can also suffer from several limitations including low response rates, low reliability for close ended questions and an overabundance of survey questions (Krosnick, 1999; Punch, 2003). Although the use of audience response systems, or 'clicker' technology is becoming more popular in research (Solecki, Cornelius, Draper & Fisher, 2010), the anonymity afforded by the technology may lead respondents to be more critical than if they had to justify their responses in person. As well, current audience response systems do not allow for the

provision of in-depth feedback and are mostly restricted to multiple choice style questions (Lantz, 2010).

Survey questions were based on the evaluative framework developed for this project. Responses from the participant experience questionnaire for both groups were compiled and combined for Chi Squared analysis. A two way chi squared analysis is best used when there is an interest in determining whether there is an association, rather than difference, between two variables (Scott & Mazhindu, 2005). The chi square test is also a good categorical test that uses nominal data, appropriate for this study (Ugoni & Walker, 1995). The chi square test was completed on SPSS Statistics 21 (IBM, n.d.).

Results from the demographic questionnaire from both groups were compared with Statistics Canada data using z-tests in order to ascertain whether the differences were statistically significant. A z-test is a statistical test used to make inferences about unknown population parameters (Sun, 2010). In the case of the demographic data, z-tests were run for each demographic data category: age, gender, health status, education level, and gender. Z-test results from the online and focus groups were compared in order to ascertain which mechanism was more statistically similar to Statistics Canada for the area. The z-score provides a measure of how many standard deviations above or below the mean an observation is (Sun, 2010). Z-scores, however, may not be valid when distributions are unequal (Traq, 2010).

3.3.2 Key Informant Interviews

In addition to the use of the two surveys, pre and post engagement initiative key informant interviews were also conducted with members of the organizing committee in order to gain a better in-depth understanding of the organizational nuances at play, including a measurement of

whether the expectations of the organizers were met. While selection of members of the organizing committee of the CRCEI only for interviewing may seem to indicate a qualitative bias in selection (Daly & Lumley, 2007), the purposeful sampling of committee members allowed for an information rich, in-depth look at this particular case, and the use of quantitative methodology to answer similar research objectives, allows for a minimization of the bias. Additionally, the selection of members of the organizing committee only was essential in ascertaining whether internal expectations of the CRCEI were met. Nonetheless, caution should be heeded when generalizing the results of these findings to other contexts (Patton, 1999).

Whiting (2008) identifies three qualities of a good informant including; knowledge about the topic, the ability to reflect and provide detailed information about the topic and a willingness to talk. Based on these criteria, a purposive sampling approach was undertaken to ensure that the interviewees were chosen based on a representative sample of the different organizations involved in the initiative, as well as a representative sample of the different sub-committees involved in the organization of the initiative (Bowling, 1997). Key informant interviews were held with five different members of the steering committee. Initially, all ten members of the organizing committee were approached after a meeting of the steering committee and asked to participate. Then, interested participants, including at least one member of each sub-committee, were sent a formal letter outlining the research and asking for their cooperation. Finally, a phone call or in-person follow-up with each potential participant was made and consent was sought from willing participants.

An interview question guide was developed (Appendix A). Interviews were semi-structured, so that the researcher could probe certain questions further and participants could be able to go slightly off topic or more in depth regarding a certain topic. Semi-structured interviews allow for

a more ‘natural way’ of collecting data and do not require any innate statistical knowledge (Griffee, 2005). Semi-structured interviews were held in order to bring out into the open the “perceptions, connotations to meanings, implicit consensus and intentionalities” (Hannabuss, 1996, p. 22) inherent in the research. This type of interviewing also allows the participant to take the interview in another, but related, direction, or elaborate on a topic (Cook, 2008).

There are a number of issues that researchers need to be aware of when conducting qualitative interviews. Interviews can be complicated by further factors such as (a) the often obfuscated researcher-participant relationship, (b) the subjective interpretation of the qualitative data by the researcher and (c) the loose, dynamic design of a qualitative experiment (Ramos, 1989). Qualitative interviewing can also yield data that is cumbersome and time consuming to analyze and may not be completely representative of the studied population (Bowling, 1997). Quality is also an issue for qualitative research and can be strengthened through the use of relevant and validated research methods (Mays & Pope, 2000). Despite the popularity of phone interviews, there remains a dearth of literature on how to effectively use this approach. However, it has been suggested that in-person interviews do a better job of enriching responses due to the use of non-verbal data as well (Knox & Burkard, 2009).

The different subcommittees of the steering committee included: the content and design development committee, the communications and online committee, the logistics and outreach committee, the session implementation/facilitator committee, and the evaluation committee. The different organizations included Central Health, the Rural Secretariat, and the Grand Falls - Windsor - Baie Verte - Harbour Breton regional council. For a further discussion of the sub-committees and the partners involved in the project, refer to Section 2.8.3.

Interview questions for key informants were developed based on the expectations of the organizers for the initiative. The expectations of the organizers was an important criterion to include because how the organizers felt about the initiative directly impacts how the information from the initiative will be used and if they will hold such an event again (Rowe & Frewer, 2004; Warburton, 2008). Other questions were included so that the subject could be cued into discussing other relevant topics about the research and to develop rapport with the participant (DiCicco-Bloom & Crabtree, 2006). Additionally, due to the longitudinal nature of the interviews, i.e., that interviews occurred before and after the engagement initiative, questions around the same themes asked in the first round of interviews were asked in the second round of interviews. This allowed for an examination of the change of answers between interviews (Hermanowicz, 2013).

Interviews were then analyzed using a coding strategy. Coding, as defined by Bowling (1997), includes "relating sections of the data to the categories which the researcher has either previously developed or is developing on an ongoing basis as the data are being collected."(p. 345). The researcher initially had categories developed pertaining to the purpose of the interview. Relevant codes were organized into themes which were then expanded upon or sub-coded. Initially, the interview transcripts were reviewed and notes and general codes were developed. Then, the codes were further refined and sub-categories were developed to represent the various themes present in the interviews. This type of coding, referred to as coding-up, involves deriving theory and categories from the data (Bowling, 1997).

3.4 Interpreting mixed methods results

This research project used a mixed methods approach involving qualitative and quantitative measures in order to achieve its objectives. In fact, the project employs two different surveys,

two different sets of key informant interviews, and data from the Central Region's Citizen Engagement Initiative. Mixed methods research can result in a type of research *pluralism*, which can result in superior research (Johnson & Onwuegbuzie, 2004). Indeed, mixed methods research can help each method `compliment` the weaknesses of the other method, resulting in an additive outcome for the researcher (Sale, Lohfeld & Brazil, 2002). This sequential type of data collection is termed parallel mixed design, where qualitative and quantitative data are collected simultaneously (Aaron, 2011). Furthermore, this type of research project is a type of 'bottom-up' mixed-methods research project where the research question has driven the use of research methods, as opposed to a 'top-down' approach where the use of mixed methods is driven by the researchers desire to conduct 'participatory' style research (Johnson, Onwuegbuzie & Turner, 2007). Nonetheless, many issues with mixed methods research remain. Many argue that mixed methods must come from a dominant, either qualitative or quantitative, paradigm. Additionally, the credibility and trustworthiness of mixed methods research can be called into question due to the lack of validation and standards (Johnson et al., 2007). These concerns were rectified in this research through the equal consideration of both types of data and the use of some validated questionnaire components from Rowe and Frewer (2000).

3.5 Ethical and organizational approval

All appropriate ethical and organizational approvals were sought before the start of this research project. An application with the Newfoundland and Labrador Health Research Ethics Authority (HREA) allowed research to be completed with human subjects using the surveys and interviews (see Appendix F). Organizational approval from Central Health was also obtained before the start of the project.

Chapter 4: Results

This chapter presents the results of the evaluation of online and focus group engagement for the CRCEI. The details of the initiative are presented first including the general organization of the initiative, dates of the focus groups, structure of the online engagement, and structure of the key stakeholder interviews. The results from the initiative are then divided into results according to each component of the evaluative framework. Results are further divided into the mechanism of engagement used. Results from the interviews with the organizing committee are then presented and organized into dominant themes from the interviews.

4.1 Central region citizen engagement initiative

The CRCEI consists of two phases. The first phase of the initiative involved 11 focus groups held throughout the Central Health area and an online engagement component. As mentioned in Section 1.2, phase two is a town hall style engagement initiative to be held at a date not yet determined. This initiative sought to influence decision making at a meso-level (Lomas, 1997a) and used a participatory style of engagement mechanism to elicit public input into decision making. The initiative also aimed to realize intrinsic, instrumental and developmental benefits whilst encouraging debate about the direction of the system, increasing public accountability and providing decision makers with quality information about the values and opinions of the public.

Recruitment for the focus groups was left to focus group facilitators, who were a primary health care provider in each area. The method of invitation varied depending on the primary care giver. Facilitators predominantly mailed out invitations to community leaders and those actively involved in the community. Others mailed out invitations to a variety of different citizens in an attempt to capture a representative sample of the population. Facilitators attended an orientation

session run by the organizing committee before the start of the focus groups in early January, 2013. Focus groups were held in a convenient community location easily accessible to all, such as a church community room, community centre or school.

Participants were provided in advance with a conversation guide, included in Appendix D, which includes various facts about health and education services in the Central region, information about general infrastructure and services offered in the Central region and an overview of the demographics of the region. The guide also includes information about the various organizational values used in decision making and provides participants with two different scenarios, one in education and one in health, in order to enable participants to think and act deliberatively in a small group about what choices they would make and why. Participants were asked individually to list what values they considered most important in decision making; participants were then polled and the top results were tabulated. Additionally, participants were asked what perspectives or concerns they think should be used in decision making. The questions asked of participants are included in Table 4.1.

Table 4.1 Questions asked to participants in the conversation guide

Question number	Question
1	We have listed some values that people often use in determining what is important to them. What values are missing from this list?
2	What three values are most important to you when making decisions as to what services should be available in your local area and why?
3	Values are important in creating the basis for a decision making model that allows for different perspectives and concerns to be heard and considered. What perspectives or concerns do you think should be considered when making decisions?

A list of focus groups dates and locations is included in Table 4.2. In total, there were 111 participants in 11 focus groups. Participation in focus groups was influenced by a number of factors including travel and/or location. Since the focus groups were held in the middle of winter, weather played a significant role. For instance, during the night of the Botwood focus group, blizzard like conditions may have impacted the overall turnout. Survey response rates for the focus group sessions varied and are reported for each survey measure. Response rates varied depending on the evaluative criteria from 87.4% to 97.3%.

Table 4.2 Focus group sites and participants

Community	Date	Number of participants
Baie Verte	February 5th, 2013	10
Botwood	February 7th, 2013	5
Eastport	February 26th, 2013	10
Fogo Island	February 20th, 2013	13
Gander	March 28th, 2013	5
Grand Falls	March 12th, 2013	10
Lewisporte	March 13th, 2013	20
New-Wes-Valley	February 25th, 2013	8
Springdale	February 6th, 2013	11
St. Alban's	March 13th, 2013	12
Twillingate	February 19th, 2013	7

The online engagement opened to members of the public on May 1st, 2013 and closed on July 4th, 2013. It was carefully designed to resemble the focus group sessions in a number of ways. The online component was available to residents of the Central Health area through the Central Health website and consisted of a downloadable conversation guide, as well as a link to a FluidSurveys™ based survey which included the same questions about values and perspectives/concerns as those in the focus group sessions included in Table 4.1. The online component was less deliberative in nature than the focus groups. In total, there were 26 online

survey respondents, with 23 respondents completing every item of the demographic and participant experience questionnaires, indicating an 88.5% response rate.

4.2 Demographic Results

Focus group and online participants were asked about their age, gender, health status and education. Results were compiled and compared to Statistics Canada census data. Statistical analyses using z-scores were completed on the demographic information from each mechanism in order to determine which mechanism was statistically more similar to the Statistics Canada data. Z-scores for each demographic category are reported with a note about the confidence interval used. Confidence intervals provide an estimate of how good the sample mean differs from the true mean and are often used when reporting z-scores (Plichta & Garzon, 2009). Z-scores within the 95% confidence interval indicate that the population proportion is statistically similar to Statistics Canada for the Central Region; however z-scores outside of the 95% confidence interval indicate a significant difference.

4.2.1 Age

As can be seen in Figure 4.1 and Table 4.3, the focus group participants ranged from 15 to 75+, with the largest percentage of participants in the 55-64 age category. However, the 15-24 age category was possibly overrepresented due to a large turn-out of local high school students during the Lewsiporte focus group session. Also an overrepresentation in the 55-64 and 65-74 age categories may be due to the nature of the invitations to the focus groups, which included a large number of community leaders and stakeholders. The structure of the focus groups may have also influenced their representativeness, since each session was designed to be relatively small and not necessarily representative of cross-section of society. The survey response rate for the focus group sessions for this criterion was 97.3%.

The online component attracted a range of participants aged 25-64. This is a narrower range when compared with the focus group sessions and is less representative of the region as a whole when compared with Statistics Canada data (Statistics Canada, 2013b). As seen in Figure 4.1, the 25-34 age category was also overrepresented. Considering the use of the online technology, the overrepresentation of the 25-34 category was not surprising. What was unexpected, however, was the absence of participants in the 15-24 category. It was expected that the use of internet and electronic technologies would warrant participation from members of this age cohort. The lack of participants 65+ may be a reflection of the unfamiliarity with internet based technologies or problems with marketing of the survey.

As demonstrated in Figure 4.1 and Table 4.3, the largest demographic for both the focus group sessions and online engagement was the 55-64 age group. This group is also the largest demographic for the area according to Statistics Canada data. However, as most of the other categories are either overrepresented or underrepresented according to the questionnaire data. The online data seems generally much more over representative of age groups 55-64 and younger, except for the 15-24 year old category, while the focus group data is more generally spread out and represents a wider and more representative sample of ages. However, a notable exception to the focus group data is the 75+ age category, which was more underrepresented than any other category.

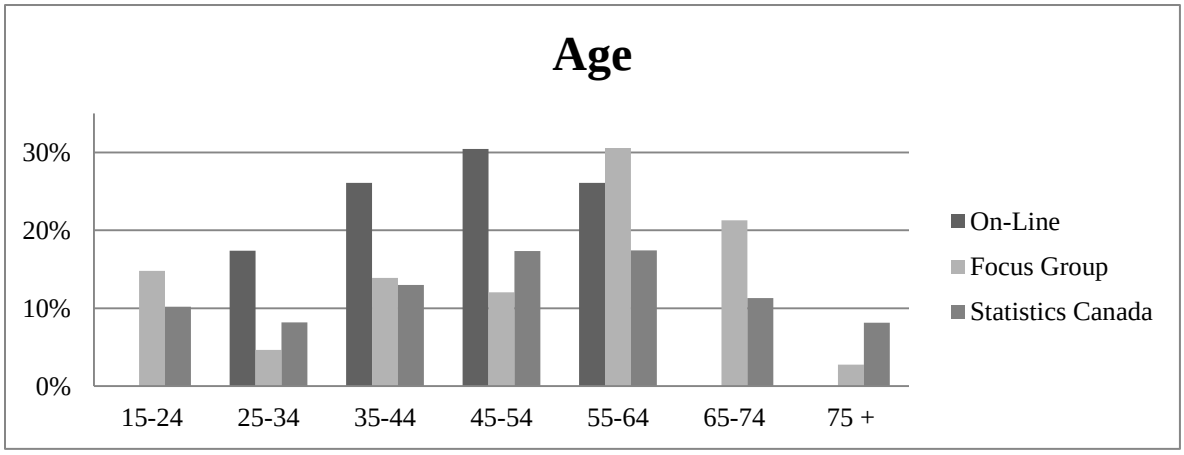


Figure 4.1 A comparison of age data from the online and focus group demographic questionnaires with Statistics Canada data for the central area.

Table 4.3 Proportions of age from participants online and the focus group sessions

	Age category						
Mechanism	15-24	25-34	35-44	45-54	55-64	65-74	75+
Focus group	14.8%	4.6%	13.9%	12.0%	30.6%	21.3%	2.8%
Online	0%	17.4%	26.1%	30.4%	26.1%	0%	0%
Statistics Canada data	10.2%	8.2%	13.0%	17.4%	17.4%	11.3%	8.1%

The z-score results for the age of participants are listed in Appendix D. As can be seen, all results lie within a 95% confidence interval [-1.96,1.96], except for the 55-64, 65-74 and 75+ age categories from the focus group sessions. These results indicate that the 55-64, 65-74 and 75+ age categories from the focus group were the only categories statistically dissimilar from the Statistics Canada data.

4.2.2 Health Status

The health status question was based on a similar question used by Statistics Canada in their Community Health Survey. The survey response rate for the focus group sessions for this question was 97.3%.The results from the focus groups show that they closely resemble Statistics Canada data listed in Figure 4.2 and Table 4.4 (Community Accounts, 2013). Again, the overrepresentation of participants who listed their health status as ‘good’ or the underrepresentation of participants who listed their health status as ‘poor’ may be due to the inclusion of participants who are more involved in the community and are thus likely to be in better health. It may be also due to the lack of 75+ participants.

About 26% of online respondents listed their health status as ‘excellent’, compared to the Statistics Canada figure of 15.1%. According to Statistics Canada data, only 4.1% of Central residents report being in ‘poor’ health, while no online participants reported being so.

The data collected from the online and focus group questionnaires suggests a fairly representative sample of participants in terms of health status. The largest grouping is for the 'very good' health category which mirrors the online and focus group data. Keeping in line with this trend, the 'good', 'excellent', and 'fair' categories, which represent the second, third and fourth largest categories respectively according to Statistics Canada data, also represent the second, third and fourth largest categories of data reported from the focus groups and online. Nonetheless, a notable exception is the 'poor' category which is underrepresented both in the focus groups and online data.

Figure 4.2 A comparison of health status data from the online and focus group demographic questionnaires with Statistics Canada data for the central area

Table 4.4 Proportion of health status results from demographic information questionnaire

	Health status				
Mechanism	Poor	Fair	Good	Very Good	Excellent
Focus group	0.9%	9.3%	33.3%	38.9%	17.6%
Online	0%	13.0%	26.1%	34.8%	26.1%
Statistics Canada data	4.1%	9.2%	26.4%	45.2%	15.1%

The z-score results for the health status of participants are listed in Appendix D. As can be seen, all results lie within a 95% confidence interval [-1.96, 1.96] indicating a statistically similar relationship with the Statistics Canada data.

4.2.3 Education

Results of the education question reveal a much more educated sample of participants in the focus group sessions than in the general population according to Statistics Canada information (Community Accounts, 2008). The survey response rate for this question for the focus group sessions was 87.4%.The number of participants with post-secondary education far out-numbered the percentage of the population with such an education according to Statistics Canada data as seen in Figure 4.3 and Table 4.5. The percentage of participants without a high school certificate, or with a high school certificate only, are most likely from the students that attended during the Lewisporte session and do not represent an older demographic without, or with only, a high school level education.

Online participants were overall much more educated than the general public. Figure 4.3 and Table 4.5 demonstrate that 91% of online participants report a university education, whilst according to Statistics Canada data only 8.9% of Central residents are university educated. There was no representation amongst the online participants from apprenticeship/trades graduates, high school only graduates or members of the public without a high school certificate while according to Statistics Canada data, 76.6% of the Central residents belong to one of these categories.

Focus group and online participant data reveals a very unrepresentative sample of participants in terms of education. For both the online component and the focus group sessions, participants selected university education more than any other type of education. This is different from the data for the area from Statistics Canada which indicates that the biggest group of citizens in the central area are without a high school education, a group which is underrepresented in the focus group data and not at all seen in the online component. In fact, the online data is very out of line with the Statistics Canada data with representation in only the 'university' and 'college' educated categories, indicating a very educated sample of the general population.

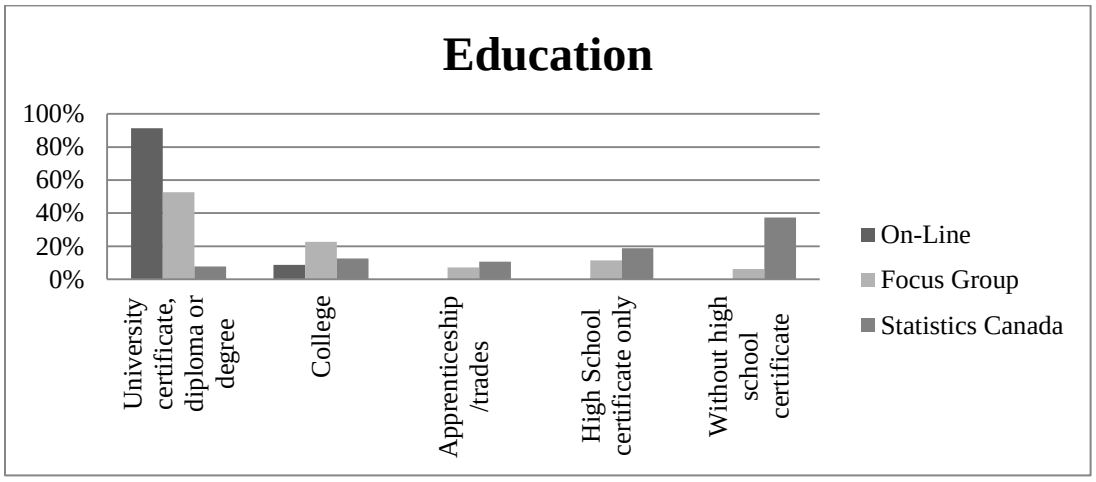


Figure 4.3 A comparison of education data from the online and focus group demographic questionnaires with Statistics Canada data for the central area

Table 4.5 Proportion of education results from demographic information questionnaire

	Highest level of education achieved				
Mechanism	University certificate, diploma or degree	College	Apprenticeship/ trades	High School Certificate only	Without high school certificate
Focus group	52.6%	22.7%	7.2%	11.3%	6.2%
Online	91.3%	8.7%	0%	0%	0%
Statistics Canada	8.9%	14.5%	12.2%	21.6%	42.8%

The z-score results for the education of participants are listed in Appendix D. As can be seen, the only results lying within a 95 % confidence interval [-1.96,1.96] are those from the apprenticeship level for both the focus group sessions and online, and from the college level for the online component. These results indicate that the only results statistically similar to the Statistics Canada data are those from apprenticeship level for both the focus group sessions and online, and from the college level for the online component.

4.2.4 Gender

As seen in Figure 4.4 and Table 4.6, Statistics Canada data indicates about an equal split in the percentage of the population that identifies as male or female (Statistics Canada, 2013b). The survey response rate for the focus groups for this question was 91.9%. According to the focus group data, this proportion is slightly skewed in favour of the female demographic. Online data suggests a much higher proportion, 78%, of female respondents. Nonetheless, both engagement mechanisms display a heavy female bias.

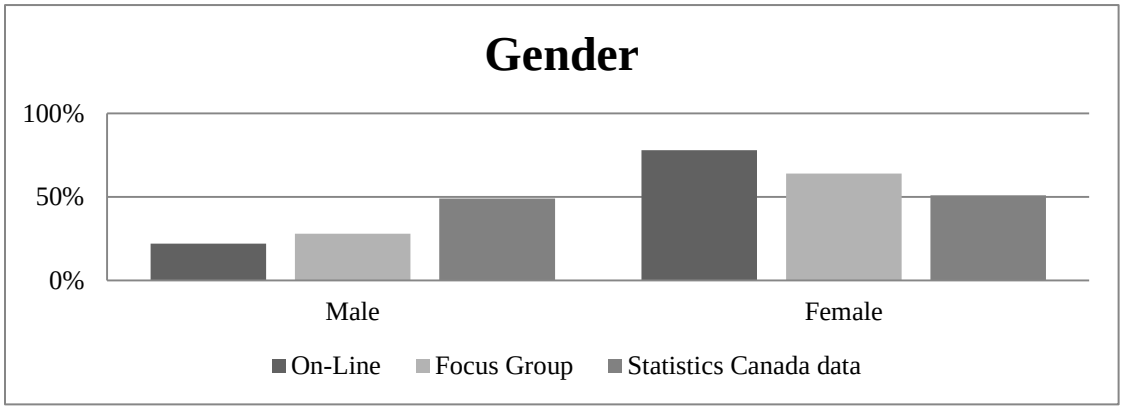


Figure 4.4 A comparison of gender data from the online and focus group demographic questionnaires with Statistics Canada data for the central area

Table 4.6 Proportion of gender results from demographic information questionnaire

	Gender	
Mechanism	Male	Female
Focus group	30.4%	69.6%
Online	21.7%	78.3%
Statistics Canada	49.0%	51.0%

The z-score results for the gender of participants are listed in Appendix D. As can be seen, no results lie within a 95% confidence interval [-1.96, 1.96] indicating that all results are statistically dissimilar to the Statistics Canada data for the region.

4.3 Participant experience results

Participants of the focus group and online sessions were asked to complete a participant experience questionnaire, see Appendices B and C, which asked participants questions regarding fairness, resource accessibility, independence, task-definition and likelihood to participate again.

Using SPSS (IBM, n.d.) software for analysis, the results from both surveys were compared using chi-square test for association. Expected values are listed with each chi-square statistic as they are an important consideration when interpreting the statistic. Generally, expected values should be greater than 5 and the lower the expected values are the less valid are the results of the chi-square test. There are remedies to correct this, however in order to preserve the integrity of the data, these were not used (Connor-Linton, 2010). Therefore, results should be interpreted with this in mind.

4.3.1 Fairness

Regarding the ability for every participant to provide equal input, focus group participants overwhelmingly felt strongly that the engagement initiative was fair and allowed them to have an equal say. Over 80% of participants 'Strongly Agreed' that the focus group sessions allowed them an opportunity to provide equal input. The survey response rate for this question for the focus group sessions was 92.8%.

Overall, participants had mixed views about the fairness of the online engagement process. 39.1% of participants felt 'neutral' about the fairness of the initiative in providing them an equal opportunity to provide input. The next most popular response was 'agree', which 30.4% of respondents selected.

Focus group responses to the question of fairness seem to indicate a much more positive view (see Figure 4.5 and Table 4.7). The most frequent response from online participants was 'neutral', while focus group participants most often selected 'strongly agree' indicating a level of apathy surrounding the issue of fairness.

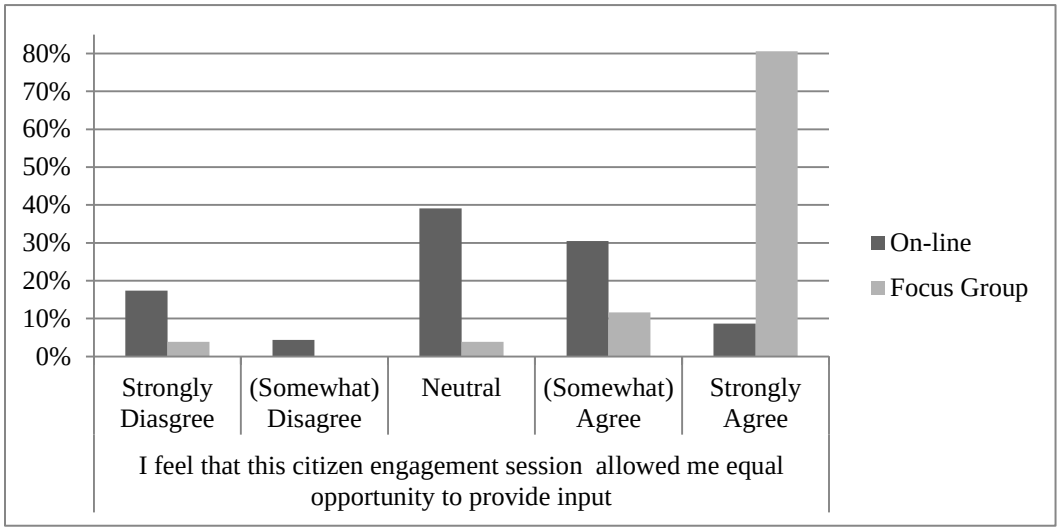


Figure 4.5 A comparison of the criterion of fairness from the focus group sessions and online

Table 4.7 Results of the criterion of fairness from the focus group and online components

Question		Responses				
I feel that this citizen engagement session allowed me equal opportunity to provide input	Mechanism	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	Focus group	3.9%	0%	3.9%	11.7%	80.6%
	Online	17.4%	4.4%	39.1%	30.4%	8.7%

A chi-squared test for association was conducted between the online and focus group mechanisms for the criteria of fairness. There were three cells with an expected less than five; the minimum expected value was 1.83. There was a statistical significant difference between the online and the focus group mechanism with respect to the criterion of fairness, $\chi^2(4)=49.783$, $p=0.000$.

4.3.2 Resource Accessibility

Resource accessibility refers to providing participants with the necessary information and resources so that they can participate in the engagement initiative successfully and intelligently. Of focus group participants, 92% either strongly agreed (59.6%) or agreed (32.7%) that the information provided in the conversation guide was sufficient to enable them to take part in the discussion, while less than 1% of respondents disagreed. 47.8% of online participants strongly disagreed or disagreed that the organizers provided them with sufficient resources in order to enable them to take part in the discussion meaningfully. This is a drastic contrast to the 30.5% of online participants who strongly agreed or agreed that they felt they had sufficient resource accessibility.

As seen in Figure 4.6 and Table 4.8, resource accessibility is a criterion where focus group participants felt very positively, but online participants voted quite neutrally or negatively. Focus group participants most often strongly agreed that the resources provided by the committee were sufficient to take part in sessions, while online participants most often strongly disagreed with the statement. This reveals a discrepancy between the focus group sessions and the online component in terms of readiness and resource availability. The survey response rate for this question for the focus group sessions was 93.7%.

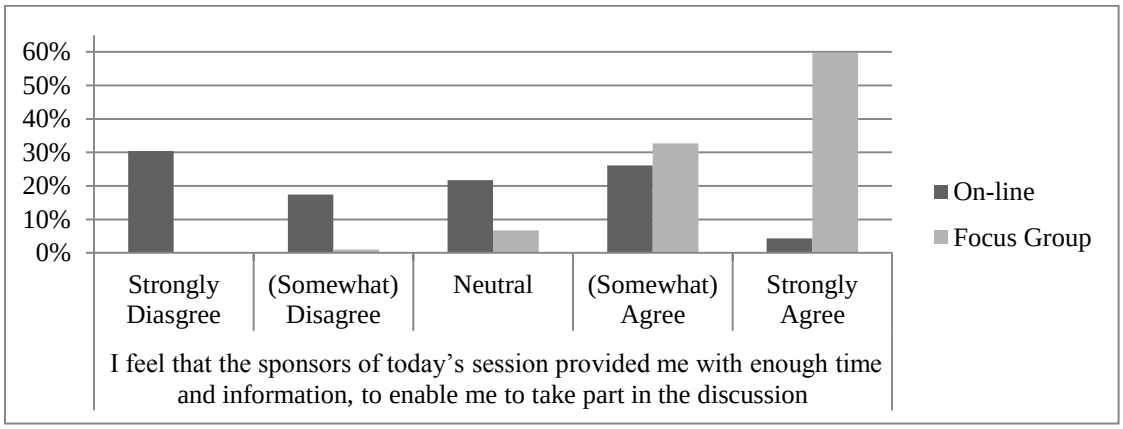


Figure 4.6 A comparison of the criterion of resource accessibility from the focus group sessions and online

Table 4.8 Results of the criterion of resource accessibility from the focus group and online components

Question		Responses				
I feel that the sponsors of today's session provided me with enough time and information, to enable me to take part in the discussion	Mechanism	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	Focus group	0%	0.96%	6.7%	32.7%	59.6%
	Online	30.4%	17.4%	21.7%	26.1%	4.4%

There was no statistical significant difference between the online and the focus group mechanism with respect to the criterion of resource accessibility, $\chi^2(4)=7.850$, $p=0.097$. There were three cells with an expected less than five; the minimum expected value was 1.99.

4.3.3 Independence

Almost 78% of focus group participants strongly agreed that the focus group session was run in a neutral way and was not biased. This is a very positive response, considering less than one percent of respondents disagreed with that statement and no one strongly disagreed. The survey response rate for this question for the focus group sessions was 93.7%. For online respondents, the largest responses to the question of independence and bias belonged to the 'neutral' and 'agree' categories indicating respondents did not feel too negatively about the initiative. They did, however, more 'strongly disagree', at 17.4%, than 'strongly agree', at 13%, about the issue of biasedness.

As seen in Figure 4.7 and Table 4.9, focus group participants overwhelmingly responded very positively to the question of biasedness, while online participants felt somewhat less positive. The top two responses for online participants were divided along the lines of 'somewhat agree' and 'neutral', whilst focus group participants by and large selected 'strongly agree'.

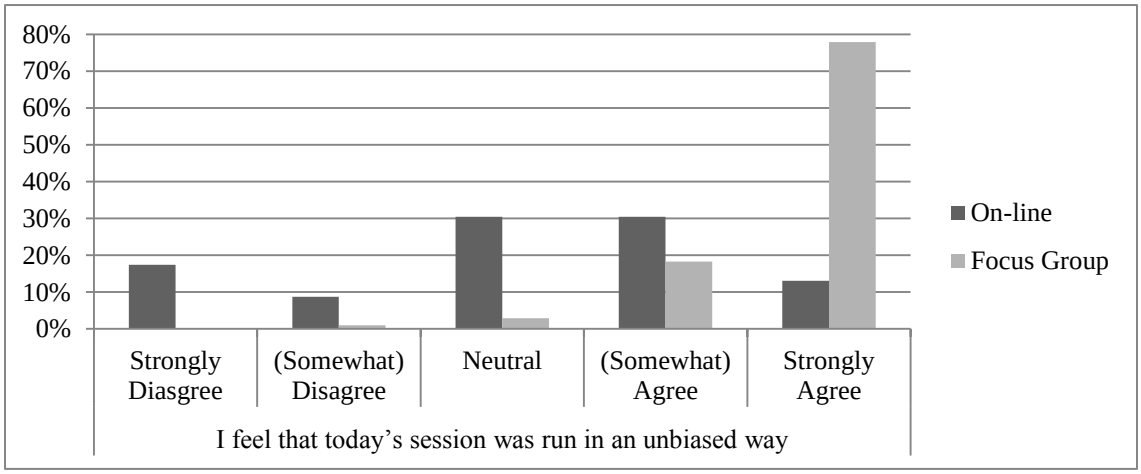


Figure 4.7 A comparison of the criterion of independence from the focus group sessions and online

Table 4.9 Results of the criterion of independence from the focus group and online components

Question		Responses				
I feel that today's session was run in an unbiased way	Mechanism	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	Focus group	0%	0.96%	2.9%	18.3%	77.9%
	Online	17.4%	8.70%	30.4%	30.4%	13.0%

A chi-squared test for association was conducted between the online and focus group mechanisms. There were three cells with an expected value less than five; the minimum expected value was 1.63. There was a statistical significant difference between the online and the focus group mechanism with respect to the criterion of independence, $\chi^2(4)=29.418$, $p=0.000$.

4.3.4 Task Definition

Task definition refers to the nature of the initiative and whether participants felt that the nature and scope of initiative was well defined. Figure 4.8 and Table 4.10 show that participants of the focus group sessions did not feel strongly that the scope and nature of the initiative was well defined with only 32% of participants 'strongly' agreeing with that statement. This question elicited the largest number of 'neutral' responses (14%) of the questions in this section. The survey response rate for this question for the focus group sessions was 93.7%.

Overall, 52.2% of online participants strongly disagreed or disagreed that they felt they understood what was being asked of them in the initiative. This number compares to only 30.5% of respondents who agree or strongly agree that they understood the task of the initiative.

Participants from both the focus group sessions and the online component rated the task definition of the engagement initiative less negative than most of the other evaluative criteria. Nonetheless, as seen in Figure 4.8 and Table 4.10, focus group participants mostly selected 'somewhat agree' or strongly agree' as a response to the question, indicating a positive response but one that was slightly less positive than most of the other criteria. Online participants tended to either 'somewhat agree', feel 'neutral', 'somewhat disagree' or 'strongly disagree' with the statement indicating a more negative weighted response.

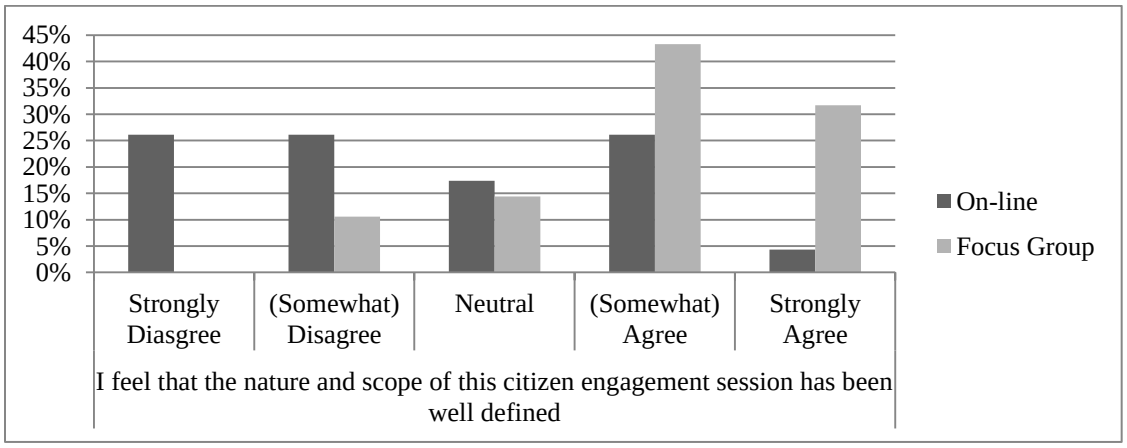


Figure 4.8 A comparison of the criterion of task definition from the focus group sessions and online

Table 4.10 Results of the criterion of task definition from the focus group and online components

Question		Responses				
I feel that the nature and scope of this citizen engagement session has been well defined	Mechanism	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	Focus group	0%	10.6%	14.4%	43.3%	31.7%
	Online	26.1%	26.1%	17.4%	26.1%	4.4%

A chi-squared test for association was conducted between the online and focus group mechanisms for the criteria of task definition. There were three cells with an expected less than five; the minimum expected value was 2.54. There was no statistical significant difference between the online and the focus group mechanism with respect to the criterion of task differentiation, $\chi^2(4)=2.526$, $p=0.640$.

4.3.5 Likelihood to participate again

The majority of focus group participants 'strongly agree' (57.3%) that they would participate in a similar initiative again. However, this question also elicited the largest number of 'strongly disagree', 3.9%, and 'disagree', 1.9%, responses perhaps demonstrating that participants were conflicted about the time they spent at the session. 39.1% of online participants felt 'neutral' about their likelihood to participate in a similar initiative again. Similarly, 26.1% of online participants agreed that they would participate in a similar initiative again, indicating a level of hesitancy. The survey response rate for this question for the focus group sessions is 92.8%.

As seen in Figure 4.9 and Table 4.11, regarding the likelihood to participate in a similar initiative again, focus group participants felt very positive with most respondents either agreeing somewhat or strongly agreeing with the statement. Online participants responded more hesitantly, with the majority of respondents either selecting ‘somewhat agree’ or ‘neutral’.

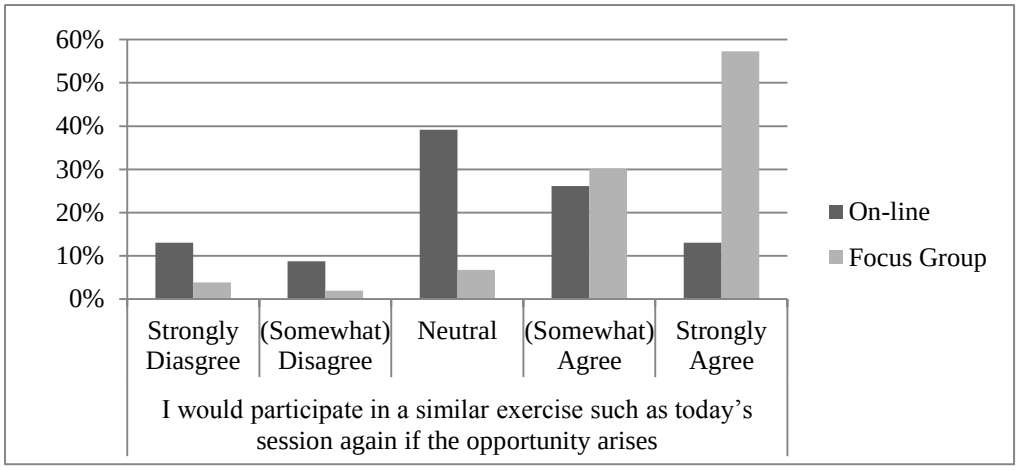


Figure 4.9 A comparison of the criterion of likelihood to participate again from the focus group sessions and online

Table 4.11 Results of the criterion of likelihood to participate again from the focus group and online components

Question		Responses				
I would participate in a similar initiative such as today’s session again if the opportunity arises	Mechanism	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	Focus group	3.9%	1.9%	6.7%	30.1%	57.3%
	Online	13.0%	8.7%	39.1%	26.1%	13.0%

A chi-squared test for association was conducted between the online and focus group mechanisms for the criteria of likelihood to participate again. There were three cells with an expected less than five; the minimum expected value was 2.74. There was a statistical significant

difference between the online and the focus group mechanism with respect to the likelihood to participate again, $\chi^2(4)=20.645$, $p=0.000$.

4.4 Key informant interviews

A first round of interviews was held to determine the key informants' expectations regarding the engagement initiative and a post-initiative round of interviews was held in order to determine whether those expectations were met. A list of interview dates and locations is included in Table 4.12.

Table 4.12 Dates and methods of interviews with steering committee members

Interview	First Interview		Second interview	
	Date	Location	Date	Location
Key informant #1	February 5th, 2013	Baie Verte	October 11th, 2013	Telephone
Key informant #2	February 7th, 2013	Gander	August 2nd, 2013	Telephone
Key informant #3	February 7th, 2013	Grand Falls	September 27th, 2013	Grand Falls
Key informant #4	February 26th, 2013	Telephone	October 10th, 2013	Telephone
Key informant #5	March 4th, 2013	Telephone	August 22nd, 2013	Telephone

4.4.1 Pre initiative interviews

4.4.1.1 Organizer expectations

Key informants felt that members of the public participating in the focus group or online sessions would come away feeling empowered or that their time was well spent. As one key informant said, "I would like to see those people become empowered to become part of the process somehow." Another key informant also discussed the hope that participants would feel their time was well spent: "my expectations would be… participants would come and that they would get a good experience, they felt like their time was well spent."

4.4.1.2 Process

Key informants had different expectations about the process of the focus group and online sessions. One key informant said regarding resource availability for participants, “we have provided them with the appropriate information and materials to allow them to have that comfortable feeling.” Other informants discussed making the process meaningful for both citizens and the decision makers who will use the information from the initiative, “make that process meaningful for both parties-citizens as well as the users, end users of that.”

The online engagement initiative was expected to be an education in engagement for the organizers; one key informant voiced the importance of the learning process, “we’re not quite there yet. We’re using some tools and techniques, but I mean ….we had to start somewhere to kinda get better at it so, I’m really interested with this group.” Similarly, another key informant acknowledged the limitations of online surveying, “I think that’s true for most, like survey things. You know, you get the nuts and bolts but not the details.” Nonetheless, there was still a hope that both the online and in-person engagement mechanisms would produce similar results, “I hope it’s going to be paralleled.” Other informants expressed the expectation that the two mechanisms would complement each other: “I think, having the balance between both approaches will be, will be, ah, useful in short term.” This was a comment similarly voiced by other key informants. As one key informant noted regarding the ability of the focus groups to garner in-depth information from a select group of individuals while the online component would cover a wider sample of the population, “I am hoping that the online piece will give us that rare insight into how the average population base is gonna look at things when they are making decisions about what’s going to happen in their communities. And that’s why I think the online piece is so important and will complement the focus groups.”

There was an opinion that the focus group sessions would have a more resonating impact with the public due to the nature of their set-up. One key informant stated this may be due to the deliberative nature of the focus groups, "I'm thinking, in my head, that you would get more of that from that dialogue between people, than you would get when an individual is just thinking about their own…their own thoughts on the issue." This was similarly voiced by another key informant who praised the facilitator and further recognized the importance of the deliberativeness apparent in the focus groups, "I think it will be, because they have more time to discuss the issues, and the other facilitator there is gonna guide the discussion and you have some, you know, some round tables where people will talk to each other, so yes, I think you'll get a …you know, you'll get more detail…" Conversely, another key informant voiced the opinion that the focus groups would produce unrepresentative, concerted data from only a few participants, "I mean, the data we collect, I think, is gonna be very, like, it's more focused when it comes from the focus groups because it's a, you know, select group of people who've been invited to come."

4.4.1.3 Representativeness

Most key informants voiced an expectation that the online engagement component would be more representative than the focus group sessions. One key informant voiced this point quite succinctly, "Well, from an online perspective, my expectation is that we'll get a broad overview of public…public input." There was also an expectation that a younger demographic would participate in the online engagement and therefore may represent a new opportunity to engage this demographic, "the online component, for myself, um, is very exciting. I think there is an age class group that we find very difficult to...like there's a voice that we don't often get at public meetings." Another expectation was that the online component would draw residents of remote

towns or of towns without a focus group session, “that people will travel from their own town to an adjacent to attend a public session…um, that’s just not happening.” However, concern was raised that not everyone would have access to a computer for the online component, “Or those people who are, are much more secure in providing online information and those types of things versus an older population who might not necessarily…especially in rural Newfoundland, have access to online participation.”

4.4.1.4 Learning to engage the public

One of the stated objectives of the CRCEI has been to learn how to engage the public. This expectation was voiced by several key informants during interviews, “I wanted to have some knowledge of public engagement because I felt that, you know, I think a lot of our work has been in consultation and not really engagement and I felt we needed to engage the citizens of our region in the decision making process.” Another key informant voiced the hope that this engagement process will be the start of a more open relationship with the public and will help foster future dialogue, “…lots of opportunities to develop that further but to be actually talking to people about how do ya think decisions are made and how do you think decisions should be made? I think that’s where we need to go for sure.”

4.4.1.5 Improving the relationship with the public

Another stated objective of the citizen engagement initiative was to build trust and understanding with members of the public, this was an expectation shared by a key informant, “try to continue to build that ongoing relationship with individuals and citizens.” This was also voiced directly by another key informant who touted the benefits of informing the public, “one of our, um, objectives, was to do somewhat of education or awareness to the public about decision making and the difficulty and how decisions are made.” Others stressed the importance of maintaining an

open dialogue between citizens and decision makers, “So we need to keep those lines of communication open.” Specifically relating to the focus groups, one key informant expected that the sessions would open a dialogue amongst citizens by noting, “We’ve already seen with some of the reports that people have been interacting with each other.”

4.4.1.6 Information gained and used in decision making

Every key informant voiced an expectation that the information gained through the focus groups and online engagement would be insightful and helpful. Regarding the values component of the initiative in particular, one key informant hoped that they would gain valuable insight, “my expectations with respect to going into this particular project is to, ah, I guess sincerely get a sense of what the true substantive values that people hold with respect to decision making.” There was also an expectation that the information collected would be of great use to decision makers, “I think the information compiled is going to be very important, but it’s only going to be as good as the people on the end who are going to use it.”

Furthermore, there was an expectation that the information collected from the focus groups would be different from that collected from the online engagement. While predicting that the online component would provide a wide variety of public opinions; a key informant admitted the possibility that the information collected from the focus groups will “be more concentrated in terms of the region and various things of that nature.” Another key informant voiced a similar opinion, “I suspect, my impression would be that the online version is going to be very much dictated and the feedback you get back is generated by personal opinions and, a true reflection of their values. Whereas, I think in a group, or in a focus group situation, depending on how the nature of the conversation progresses, people can provide feedback on their values, depending on the conversation and how that progresses.”

4.4.1.7 Involvement with public engagement initiatives

Most key informants did not have prior experience with public engagement initiatives, "This is learning by fire." While some expressed previous experience in some sort of engagement process, although not necessarily a two-way dialogue with the public, "…we've certainly done lots of.. of more of the information sharing sort of stuff…"

4.4.1.8 Interdisciplinary collaboration

An important aspect of this engagement initiative was the successful collaboration of different public organizations. Among the representatives from education, health, and rural development, there was a consensus that it was important to work together on many of the issues facing rural areas. As one key informant said, "I remember being in a meeting in Grand Falls where I, I posed this question and I still pose the question, 'who is going to make the difficult decisions that need to be made?' Relative to health and education and in any other area that will, you know, be important to rural sustainability." This was similarly voiced by another key informant who stated that different experiences are important to bring to the table, "And to be honest with you, I don't think any of this would ever [have] come to fruition unless it was a partnership…because, at different times, different partners were sort of driving or steering the bus on different occasions." Another key informant voiced the concern that the current political climate in the province is responsible for the need for interdisciplinary collaboration between public organizations, "I think it's too because of the political climate that we're in right now…I think because of some of the things that have happened in health care in other regions have made the public a little shy of sharing information with [the] health authority, because of, you know, a lot of these breaches of privacy and a lot of things that have been happening in other parts of the province." Nonetheless, there was a sense that, whatever the reason the partners came together, it was done out of

motivation for citizen engagement without any extra resources, "…nobody had any extra dollars to go do this but we kinda had the ah, either the staff, the resources and stuff in house, kinda shared out and divvy it up." This opinion was shared by another key informant who felt that, although no extra resources were committed to this project, there was still an ability to complete it in house, "I think relatively speaking, ah, we've got some capacity built within our organization with respect to public engagement."

4.4.2 Post initiative key informant interviews

4.4.2.1 Strengths

Organizers were quick to point out the successes of the focus group sessions. In particular, organizers felt that the focus group sessions were able to better foster more in-depth conversation, similar to what was voiced in the preliminary interviews. One key informant voiced a similar opinion about the deliberative nature of the focus groups, "when you have a situation where you can sit one on one in person with people, and have a round of discussions around things that you know, sort of occur to them as they are listening to others speak, you end up getting richer and deeper insights into, you know, what may be happening." This concept of learning and deeper understanding was voiced by other key informants as well, "…the participants um, really found it valuable and a learning experience, um, with respect to the face to face sessions." Nonetheless, some key informants also recognized that the benefits derived from the focus group sessions were not necessarily extendable to the online component, "I think sometimes with the online as a negative is that I just read it and I just do my own perception, whereas in a focus group, and I heard this from some of the commentary that came back, there were opportunities for the facilitators to clarify things and to, ah, monitor [the discussion]."

Similarly, the success of drawing on existing networks for recruitment purposes was also seen as a success by key informants, one of whom touted this as a major strength of the initiative, "I think one of the key strengths is that we drew down on an existing network within each of the local service areas. And by drawing down on that network, were able to recruit and solicit participation in the focus groups successfully." This kind of targeted recruitment strategy was also seen to be successful by another key informant who voiced the opinion that it made invitees feel wanted, "And I think that's one of the main things in terms of focus groups with public engagement, you make the people feel that this is necessary, it's important and we'd really like to have your ideas."

Key informants also noted advantages associated with the online component. In particular, key informants voiced the opinion that the online component was convenient for participants and overcomes some limitations of other mechanisms of engagement, "The strength of the online component was um, that it was easily accessible to people.. um, that they were able to do that on their own time, um, and review that".

Overall, some key informants viewed the entire initiative as a success. The success of the multi-organizational partnership was particularly noteworthy for key informants, "the strength I think of the entire initiative was that um, it was a partnership approach. Um…we had multi partners throughout this process." Another key informant had a similar view; admiring the success of the project despite the lack of dedicated resources and organizational mandates from the organizing partners, "I think it has been a successful collaboration, recognizing that it was not a key mandate of any one person or any one partner." Another key informant also recognized the importance of the experience that the partners bring to the table in the success of the initiative, "with our partners, the Rural secretariat and the College of the North Atlantic, we had loads of

experience and I think we did that really, really well and it did meet our expectations of the number of people you could get out."

4.4.2.2 Weaknesses

Not many limitations of the focus groups were discussed by key informants. However, two key informants did cite the weather as interfering with the success of the focus groups. As one key informant said, "at the time the focus group sessions were being completed and we were asking, probably 25 to 30% of our participants…to drive from out of town to their local service… health area, so therefore, when you're asking people to drive out of town, in the winter, when it is pitch black, you're gonna run into some limitations." Another key informant speculated that some participants could have had their views or opinions influenced by the facilitator, "you know, you have the danger that the facilitator may be leading you in the direction they want you to go in rather than the direction that…" Another constraint of the focus groups mentioned by key informants was the cost. Some thought that, due to the cost associated with running a focus group, it was impractical to hold larger sessions, "Because, we can't afford um, to do focus groups any larger than what we did."

Conversely, one key informant expressed the view that the nature of the online component itself made it a more convoluted experience than the focus groups, "Um, a computer, online situation, often provides a very sterile, um, environment, so you don't have that interaction of being able to hear what other people are saying so that it triggers something in you that says, oh yes, okay, this relates to this experience that I've had and you know, this relates to a 'what if' situation that I could, that I think of and relate to." This view was supported by another key informant who lamented the lack of clarity in the online survey saying, "and sometimes, because you do not have someone there, um, to give you that, sort of guidance and directions, you're kind of saying,

well maybe I won't bother to put that in, when in fact perhaps, just putting it in to say would this apply to this, would cause, you know, the people who are reading your responses to capture that, okay, this meant that this might be a little bit confusing and maybe we should put a little more clarification there." With regard to the low numbers, another key informant raised the possibility that the targeted population in Central Newfoundland may not be ready for such an approach to public engagement, "Is it just at this point in time a reflection of our population and readiness for this sort of activity?"

Key informants also touched on the usability of the information collected during the focus groups and online. One key informant cited the lack of representativeness as rationale behind their scepticism of the usability of the values information collected from the focus groups and online, "The actual deliverable, in terms of what were the true values that citizens have and all those types of things that were of interest questions to the partners, ah… I`m reserving judgement yet on whether or we could or probably should utilize that information because I don`t personally feel it is representative of the population…" Similarly, another key informant voiced similar concerns about the usability of information collected from the online component in particular. Similarly, they also felt uncomfortable about the usability of the information due to the lack of representativeness, "I think we got some good engagement, some good feedback, some themes. I'm really happy about that, but I really know we'd have been a lot richer if we could have gotten more online [participants] to have a more representative sample and more input, to add to the data."

Political interference was also voiced by key informants as a limitation of the exercise. This interference was noted in the use of communication strategies, in particular regarding the use of social media, "while we still have to be in line with what Government is doing, you know, and

what Government is supporting, we also have to make sure that we are in line with what the people need out in the community…"

4.4.2.3 Other considerations

As a stated goal, educating the organizers about engaging the public was equally as important as learning the values that the public find important. In particular, organizers felt that there was much to learn from the failures of the online component, "I would say to you…yes, don't throw it out, look at it, learn from what we did wrong and let's try to figure it out, but I still would say that the focus group piece, you know, still works." Generally, organizers felt that there was something to learn from the poor turnout for the online component, "we gotta figure out how we are gonna do recruitment to the online components." Suggestions for improving the uptake of the online component include increasing publicity, "We could have put it on the community channels, we could have put, you know…gotten a hold of the community correspondents that are out there in our rural areas." Other ideas for improvement of the online component include better emulating the experience of the focus groups, "…so there`s lots of ways to improve, like I said, we can make it more interactive, we could have had our own um…ah…website."

Nonetheless, there were other areas were organizers thought they could improve as well. Organizers seemed to view this engagement initiative as a missed opportunity to engage a younger demographic not typically involved, "And I will tell ya, that it's really, really difficult to engage youth…and at that age, like, they just need a lot…a lot of massaging and support to actually be a part and not feel intimidated by adults and that sort of thing…" A possible remedy to the lack of younger participants suggested by several key informants was the use of social media to increase awareness amongst youth, "Oh well, I think you'd need to use more of a social media things like Twitter and Facebook and tweets and all this different kinda stuff that kids are

into, because um, you know, there's a lot of people out there that, you know, we're not reaching and we know that."

Chapter 5: Discussion

The discussion focuses on the main components of the evaluative framework, i.e., representativeness, fairness, independence, resource accessibility, likelihood to participate again, task definition and expectations of the organizers. Each mechanism of engagement is then discussed in terms of its appropriateness for the CRCEI.

5.1 Representativeness

Overall, both mechanisms of engagement were unrepresentative of the residents of Central Newfoundland. The initiative tended to attract participants who were mostly female, well-educated and in good health. The z-score results in Appendix D demonstrate how many standard deviations away the results from each mechanism are from the Statistics Canada data. As can be seen from every one of the z-score results, there is evidence that the results from the focus group sessions and online differ from the reported Statistics Canada data. Nonetheless, z-score results from the health status results in Appendix D, demonstrate that, although the good and excellent categories were overrepresented, the results are statistically similar to Statistics Canada data and therefore representative of the Central region. The z-score results in Appendix D also demonstrate that the 15-24, 25-34, and 35-44 age categories are statistically similar to those results from Statistics Canada, demonstrating that despite the overrepresentation of older age categories, the focus group sessions did contain a relatively representative sample of younger participants. Since these results are significant within the 95% confidence interval, we cannot reject the null hypothesis that the results are similar to those from the Statistics Canada data (Osborn, 2006). However, as can be seen in the case of the age results for the online component, some of these categories were deemed significant, when in fact there were no participants. Due to the lower number of participants the research does not have sufficient statistical power to

correctly reject the null hypothesis and therefore the statistical results presented should be interpreted in light of the small sample size, n=23, of the online questionnaire (Sullivan, 2009).

The higher proportion of older and female respondents in the online component is also in stark contrast with results reported in a similar online based initiative by Rowe et al. (2006). However, the results from the online survey resembles other online surveys in that there was an overrepresentation of college/university educated participants, indicating an affluent and well educated sample (Rowe et al., 2006).

The unrepresentativeness seen in the online component has its roots in a lack of preparation. Minimal advertising was completed for the survey, and networks, including younger adults, were not notified. Another compounding factor may have been the overrepresentation of healthcare workers in the online survey due to the advertisement of the survey link on the front page of the Central Health website. As noted by a participant in the research interviews, organizers did not think they carried out a sufficient recruitment strategy. A remedy to the low turnout suggested by organizers included using a social media outreach to attract more diverse participants to the online engagement and/or using a more targeted recruitment effort, much like the focus groups. A similar online style engagement that involved a social media component was able to reach out to over 800 participants in an initiative in Northern Ontario (Shields, Dubois-Wing & Westwood, 2010).

The focus group sessions were particularly overrepresented in the 55-64 and 65-74 age categories. This distribution may be partially explained by the nature of the invitations to the focus group sessions. Facilitators who were responsible for recruitment predominantly mailed them to leading members of the community. Petts (2008) argues for the role of 'gatekeepers' of

disadvantaged groups in public engagement initiatives. Because income data was not collected, it is impossible to definitively ascertain the extent to which certain disadvantaged groups were represented in this engagement initiative. Still, it is shown that higher educational attainment is associated with higher income status (Statistics Canada, 2013c). Thus it can be ascertained that due to the high proportion of participants reporting higher than average education and self-reported health statuses, there was an underrepresentation of disadvantaged groups in both the focus groups and online. Still, despite the unrepresentativeness of the focus groups, it is clear that they are more representative of the Central region than the online component. This is reflected in the interviews with the key stakeholders, as well as in the demographic data which shows a greater participation across every demographic category as the online component. As discussed in the key informant interviews in Section 4.4.2.2, this is an important point as organizers of the initiative felt more favourably about the focus group sessions than the online component due to the issue of representativeness.

5.2 Fairness

Renn (1992) states that in order for an engagement initiative to be fair and open, it needs to be a forum where all parties are able to make their views known equally. This is an accurate description of the focus groups, which were formatted in a way to allow everyone to have an opportunity to 'take the floor', and the facilitator, whom actively encouraged participation from every participant in some instances. Respondents to the focus group questionnaire felt very positive about fairness of the initiative, with 92.3% of participants agreeing or strongly agreeing that the session was fair and provided everyone an equal opportunity to participate. Online respondents rated the process much more negatively, with only 39.1% of respondents agreeing or strongly agreeing with the statement. These results agree with prior results from Garau (2012)

who found that citizens may be more willing to participate face-to-face rather than online, even with the anonymity offered by online technologies. This finding may be a direct result of the effort put into the focus groups by participants who read the conversation guide before the sessions and engaged in a more interactive debate than the online participants. Such a finding demonstrates that participants 'got out' what they 'put in' to the engagement initiative.

Nonetheless, despite the negative answers, this evaluative criterion contained the second highest proportion of 'agree' or 'strongly agree' answers on the online questionnaire. The negative answers are surprising due to the nature of the online technology which allows for citizens to participate anonymously (Min, 2007). Online participants may have felt that the process was not sufficiently transparent, and as such may not have felt that their opinion was respected as much as focus group participants who were exposed to a wide variety of opinions and viewpoints (Bryson, Quick, Slotterback & Crosby, 2012). While the online component was open to members of the public after the focus group sessions had ended, participants were made aware of the focus group sessions through information provided online and therefore may have felt that the online process was less fair. This is a point discussed by one of the key informants during the preliminary round of interviews who acknowledged the insularity of the online component in Section 4.4.1.3, "Um, a computer, online situation, often provides a very sterile, um, environment, so you don't have that interaction of being able to hear what other people are saying so that it triggers something in you that says, oh yes, okay, this relates to this experience that I've had and you know, this relates to a 'what if' situation that I could, that I think of and relate to…" As well, as Coleman and Gotze (2001) note, technology on its own does not facilitate deliberative style discourse but rather allows connections to be made. A direct facilitator is required for such a role.

Judging by the Timotijevic and Raats (2007) definition of fairness as "the extent to which all the stakeholders were treated equally in their contribution to the process" (p.305), the lack of a facilitator or additional instructions for the online participants may have resulted in online participants being treated unequally. However, this difference was unintentional on part of the organizers and is more a reflection of the inherent nature of the online component. This was similarly reported in the interviews with organizers who viewed the focus groups as a place where participants would 'get more' out of the deliberative style of dialogue. This sentiment is also reflected by organizers who reported that the online component would not garner the same type of in-depth information as the focus group sessions. These results from the interviews confirm the results of the online survey, that perhaps the online component does not carry the same weight and relevance as the focus group sessions, particularly given its low turnout.

5.3 Independence

In the evaluative framework developed for this research project, independence is measured by asking participants whether they felt the process was run in an unbiased way. Focus group participants overwhelmingly felt that the initiative was run independently with 96.2% of participants agreeing or strongly agreeing that the process was run in an unbiased way. Focus group participants strongly agreed that the focus groups were well structured processes that minimized power imbalances (Wondolleck, Manring & Crowfoot, 1996) through small group discussion, an open atmosphere, the use of a moderator and the inclusion of mostly involved people in the community.

Online participants felt overall very negative about the issue of independence; with only 43.4% of participants agreeing or strongly agreeing with the statement that they felt the initiative was unbiased. While online participants may have felt negatively about the independence of the

mechanism for several reasons, perceived government interference may have accounted for some of this disapproval. In Sections 4.4.1.8 and 4.4.2.3, key informants cited the current political climate as a possible hindrance for engaging the public, whom may feel distrustful of such a partnership. This finding is surprising in light of the anonymity offered to online participants. Nonetheless, the lack of instruction received by online participants as a result of not having a facilitator present may help explain this finding. Such belief that decision makers neither care nor listen to the voice of the public may be enshrined in the public's psyche however can be corrected through the use of meaningful engagement measures with direct interaction with decision makers (Coleman & Gotze, 2001). Thus, the online engagement mechanism studied here may have reinforced the 'hidden agenda' idea that some members of the public believe to be reality.

It was anticipated that the online technology should allow for the reduced dominance that can be seen in focus group sessions and allow citizens to anonymously submit their opinion, as opposed to a room full of fellow citizens. This was an idea voiced by key informants in the second round of interviews who expressed the possibility that the facilitators may lead the discussion in a certain direction and that the selection of facilitators familiar to participants may have an inadvertent influence on participants.

As detailed in Section 4.4, there was a degree of hesitation surrounding the online component as some participants agreed that it was a learning experience for them. Section 4.4.6, in particular, highlights that organizers were generally optimistic about the information to be gained, however were more apprehensive regarding the usability of information from both mechanisms. As suggested by Rowe and Frewer (2004) and Warburton (2008), due to being unsure about the process, organizers may not use the information the same way as they would use the information

and recommendations stemming from the focus group sessions. This finding may help validate the finding that online participants felt more negatively about the online component; organizers may have been biased towards the focus group sessions before the initiative even began.

As noted by Rowe and Frewer (2000), an important part of independence can also be the incorporation of various partners into the organization of the initiative. This initiative was the product of cooperation between partners from health, education and rural development. This model is often touted by organizing committee members as very successful and a distinguishing feature of the initiative. The partnerships established between the partners were essential to allow successful collaboration within the community (Labonte,1993). Organizing committee members felt that involving several different facets of the community was an important part of the project as it provided people an opportunity to provide their input on a number of issues facing rural areas, without the negativity surrounding healthcare acting as a deterrent.

5.4 Resource Accessibility

According to Rowe and Frewer (2000), resources for a public engagement initiative can include information, material, time and human resources. As the results in Section 4.3.2 show, 92.3% of focus group participants agreed or strongly agreed with the statement that they were provided with the necessary time and resources to enable them to actively participate. In contrast, only 30.5% of online participants agreed or strongly agreed with that statement. While the focus group participants felt very strongly about this criterion, it garnered the least positive response from online participants. Focus group participants were provided with a copy of the conversation guides (Appendix E) before the session in order to prepare. They also had a facilitator who was able to explain the material and answer any questions. This is in contrast with the online participants who, while able to access the conversation guide beforehand, were much less likely

to be queued to read through the material, and were not provided with any form of 'human resources'. Key informants initially thought they had provided online participants with sufficient resources to meaningfully participate and get something out of the initiative.

However, as has also been noted by multiple key informants, there was no budget allocated by the partners to complete this project and other work projects and commitments sometimes took precedence over the engagement initiative. Therefore, while focus group participants felt for the most part that they had sufficient resources, the lack of allocated resources and directions that ensured that participants read the conversation guide for the project may have had a negative impact on the online component. The online component could have been enhanced to include more interactive tools and better usability, a point addressed by the key informants in Sections 4.4.2.2 and 4.4.2.3. Moreover, additional financial resources could have been used for recruitment of online participants.

5.5 Task Definition

As Sheedy (2008) notes, public engagement initiatives are much more effective when the purpose and the issue of such initiatives are framed in a manner easy for the public to understand. Furthermore, as Lomas (1997a) demonstrates, framing the initiative can be important for involvement of the public, as the public may not be comfortable providing input for certain types of decisions. Despite 75% of focus group participants agreeing or strongly agreeing with the statement that the scope and nature of the initiative was well defined, this was the least positive response from the focus group participants about any of the evaluative criteria. Online participants also felt negative about the criteria with only 30.5% of participants agreeing or strongly agreeing with the statement, consistent with the negative responses from the other evaluative criteria.

Focus group participants may have misunderstood the nature of the project as they were invited by a healthcare provider yet were tasked with answering questions relating to rural development and education as well. Participants may have also been unsure about the output of the initiative (Rowe & Frewer, 2000) as there is no explanation in the conversation guide as to what will become of their submitted information. Nonetheless, key informants felt that the focus group sessions did a good job of fostering dialogue and understanding between participants and organizers. Some decision maker participants felt this was in contrast with the online component where participants were not provided with the same level of clarity or given the same opportunities to ask questions for clarification. Comprehensibility, as noted by Rowe and Frewer (2005), was lacking in the online component as participants had no one to fully explain the information and mechanisms involved in the initiative. This was a possible limitation of the online component as discussed by key informants in Section 4.4.2.3, as they felt that the facilitator provided a level of comprehensibility not seen in the online component.

5.6 Likelihood to participate again

The majority of participants from the focus group sessions (57.3%) very positively agreed with the statement that they would participate in a similar initiative again in the future, while online participants were much less enthusiastic with only 13% strongly agreeing with the statement. The focus group sessions could have left participants feeling much more satisfied regarding their engagement experience (Timotijevic & Raats, 2007). Using Warburton, Wilson and Rainbow's (2007) assertion that the likelihood to participate again in a similar initiative again is usually correlated with an increased public confidence in their ability to participate in the community, it can be seen that, due to the nature of the sessions, focus group participants may have felt more of an ability to participate because they were selected based on their position in the community.

Online respondents, many of whom may not be the same type of community leaders who were recruited for the focus group sessions, may have felt disconnected from the initiative and unconfident in their ability to participate in the community. It is also possible that online participants did not view the initiative as operating arm's length from the government (MacMillan, 2010). Nonetheless, many key informants voiced the opinion that the online component was a necessary part of the initiative and would be repeated if the initiative were run again. They thought that by learning from their mistakes in recruitment and advertising, they would be able to attract an even larger number to the online component. There was also a belief that by enhancing the online component, there would be a better uptake and perception; a finding certainly supported in literature (Nair & Adams, 2009). Participants also expressed the belief that the focus groups would have been better attended were it not for the weather and the need to limit the cost of the groups due to cost and logistics restraints.

As discussed by key informants in Section 4.4.1.1, it was hoped that the online component would recruit members of the public from areas not serviced by a focus group. This was a perceived advantage of the online component; that participants could participate without travel and other constraints as mentioned in Section 4.4.2.1. Nonetheless, despite the perceived advantages and conveniences afforded by the online component, the results in Section 4.3.5 show that participants are still not likely to participate in a similar initiative again.

However, as was mentioned in the interviews with the organizers, it is important to note that a large component of this initiative was learning about engaging the public. With the knowledge and skills gained through this initiative, many of the organizing partners hope to continue to build and support a dialogue with the public in Central Newfoundland.

5.7 Suitability of online public engagement for the initiative

While online engagement holds many potential benefits for a rural public engagement initiative including lower transportation times and costs, accessibility to anyone with an internet connection, improved safety for participants who do not have to travel to a focus group site, cost-effectiveness, flexibility, amongst others, it still presents many challenges. Nonetheless, as expressed by interviewees, the geography of the region presented an insurmountable barrier to access, as it would have been very difficult to give every area access to a focus group. This is a similar limitation experienced by the New Brunswick Health Council in 2010 as their diverse geography may have prohibited some willing participants from attending (New Brunswick Health Council, 2010).

Thus, an online component holds potential as being one of the best and most pragmatic mechanisms of providing everyone in the area an equal and fair way of providing input. However, shortcomings in the recruitment and advertisement of the online component may have led to the low turn-out. Additionally, the negative perception of the online component may have led to participants dissuading others to participate. Therefore, to better attract participants and increase awareness of the initiative, organizers need to employ more creative and direct methods to increase exposure. The online experience plays an important role in the uptake of such a survey. By creating a more interactive experience for participants where they feel their input is being meaningfully and strategically used, the reception is likely to be much more positive. This can be established, in part, by also ensuring participants that their results have a demonstrated impact on decision making, and enacting a mechanism to provide accountability to participants. An outcome evaluation detailing the impact of such an initiative on decision making and participants' views would accomplish this task (Abelson & Gauvin, 2006).

While the use of online based public engagement mechanisms offer numerous advantages, they must be executed correctly and efficiently. The limitations faced by the online component of the CRCEI may have more to do with the implementation of the process rather than the nature of the mechanism itself.

5.8 Suitability of in-person public engagement for the initiative

While electronic communication is increasing in popularity, traditional in-person meetings have often been the choice of organizers of public engagement initiatives (Ryan et al., 2001). This is a sentiment echoed by members of the organizing committee, who expressed unfamiliarity with using an online format and expected that the focus groups would be a greater experience for participants. Focus group sessions can be powerful tools and can yield a wealth of knowledge if used correctly, however also the ability to affect participants' opinions and views (Stewart, Shamdasani & Rook, 2007). This potential was acknowledged by organizing committee members who noted the nature of the deliberative process, and also the facilitators themselves, as ways of possibly influencing conversation and deliberation.

Due to their deliberative and comprehensive nature, depending on the available resources and the direct goals of the initiative, focus groups may remain the preferred mechanism when direct input into decision making is desired (Chafe et al., 2007). This was demonstrated by the very favorable ratings given by focus group participants and the strong turn-out by residents. However, such sessions can also be logistically challenging, and expanding upon the existing framework of focus groups would have posed challenging financial and logistical hurdles for the organizers of this initiative. Thus, in order to successfully engage a broader public, other engagement mechanisms and styles should be considered. The financial impact of focus groups is an important point to consider, as it was mentioned by key informants who stated that the cost

of providing refreshments, materials and transportation was more expensive than providing an online component.

Chapter 6: Conclusions and future directions

This project is an examination of two different mechanisms of engagement used in a public engagement initiative in Central Newfoundland. It aims to discover the differences between the two mechanisms for the context of the CRCEI and determine the pros and cons of each mechanism within the context of the wider initiative. The project used the same evaluative framework of representativeness, fairness, independence, task definition, resource accessibility, likelihood to participate again and organizer expectations across both mechanisms of engagement. Using the same evaluative framework on both mechanisms of engagement allowed for a direct comparison of the two mechanisms. It also allowed for the same survey tools to be employed in the evaluation of each mechanism.

As seen in the results from both mechanisms, the participants varied markedly in terms of representativeness and participant experience. As well, organizers expressed diverse opinions about their expectations of the initiative. After the initiative finished, key informants voiced their diverse opinions on the success of the initiative, as well as various limitations and learnings that they learned from both mechanisms of engagement.

The focus groups and the online component differed significantly in many areas. Focus group participants were generally unrepresentative of the demographic characteristics of Central Newfoundland. They tended to be better educated, in better health and female compared to the general population of Central according to Statistics Canada data. Online participants were even less representative of the statistical population of the region than the focus group participants. Online participants were generally much better educated, in better health and comprised a larger proportion of female participants. Online participants also consistently rated their experience

much more unfavourably than focus group participants. Initially, key informants discussed how they hoped that the online component would attract a wide range of representative participants, in particular a younger demographic. They also expressed the hope that participants would come away from the initiative feeling better informed and with more understanding of the issues of health, education and rural sustainability facing decision makers. During the follow-up interviews, key informants extolled the benefits of the focus groups, while discussing the many limitations of the online component, in particular pertaining to the issue of recruitment and experience. During both rounds of interviews, key informants emphasized the importance of learning about engagement and which mechanism suits their purpose. Key informants also praised the success of the atmosphere of collaboration and cooperation amongst organizing partners.

6.1 Recommendations

A number of issues are apparent after looking at the questionnaire results from the focus groups and online. Key informants also voiced a number of strengths and limitations associated with the project. The following section outlines challenges and presents recommendations to address them.

R1. The use of a concerted and direct approach to recruitment for any use of online engagement

The data from the online component tells a compelling story. A low turn-out factored with dissatisfaction with the online mechanism led to some soul-searching from key informants during the second round of interviews. Key informants initially had high hopes for the online mechanism, and while holding some reservations about the overall experience for the participant, they hoped it would be a successful venture with a high turn-out. Thus, during the second round

of interviews, key informants suggested a number of ways of increasing turn-out. Some of the tools recommended, in particular approaches using social media or a non-probabalistic recruitment effort, have shown past success. The Northwest Local Health Integration Network *Share your story, Shape your care* example discussed in Section 2.6.1 provides particularly useful insight into the effective use of social media in online engagement. As was also alluded to in the second round of interviews, involving the use of multiple organizing partners means different organizational rules that must be adhered to. For the engagement initiative used in this project, a social media recruitment effort may not have been as feasible. Nonetheless, an intensive recruitment effort is needed to attract participants to such an online survey. Such a strategy could also be tailored to try and address of the issues around the representativeness of the population who participated in the current initiative.

R2. Create an interactive online experience for engagement participants, similar to the focus group deliberative style of engagement

Despite the small sample size of online participants, it was evident that there was a significant dissatisfaction with the perceived fairness, independence, availability of resources, definition of the task at hand, and likelihood to participate in a similar initiative again. These findings are in stark contrast with the focus group participants who generally reported a much more favourable overall experience. Many reasons for this disparity may exist. Organizing committee members emphasized the sense of disconnection when using online survey technology and of the inability to fully replicate the focus group experience. Online participants themselves may have had differing expectations of the engagement experience than focus group participants due to the use of the online technology. Therefore, to better improve the participant experience outcomes with online participants, it is beneficial to create a more interactive approach, similar to the focus

group sessions. Emulating the more favourable focus group experience online may also assist in boosting recruitment through word of mouth connections.

R3. The use of a neutral facilitator at focus group sessions in order to foster an open, neutral environment

Key informants also reported problems with the structure of the focus groups. Despite a large positive response to the participant experience criteria of fairness, key informants expressed some reservation about the use of local Central Health employees to facilitate the focus group sessions. Some interviewees felt that the use of a facilitator known to participants may lead the direction in a certain direction or influence the ability for citizens to express themselves. Conversely, the use of an in-house facilitator reduced overhead costs for the focus groups, and potentially led to the focus groups being well attended due to the personal nature of the invitations. It is also demonstrated that having a facilitator with the same background and characteristics of participants may be a benefit to the focus group and may make the session more relatable (Fern, 2001). Still, these benefits could have still been realized had the sessions been facilitated by a Central Health employee unfamiliar to the participants.

R4. The contextualization of the organizing process of the initiative

One of the major successes of this initiative was the collaboration between different public organizations. Key informants often touted the impressive task of assembling and working with partners from different organizations. The cooperation was seen as a model of organization and invited the equal input of each member. It was also a result of the need to involve multiple partners due to resource constraints and political reasons. Despite the loss of one organizing partner in the fall of 2012, the project forged on with the remaining partners each devoting their own expertise and limited resources to the project. One key informant also touted the multi-

disciplinary approach as a success since it was able to attract participants who would have normally not attended a health or education only event due to a perceived negativity associated with these sectors.

The use of several different partners also may aid in mitigating the limitations associated with the lack of experience in engagement. Using various partners in the planning and implementation process allows for a wide range of experiences and opinions to be brought to the table.

Moreover, contextualizing the engagement process is also of benefit for organizers. Another major success of the CRCEI was the use of both online and in-person engagement mechanisms in an effort to include as many citizens as possible in the initiative. Overcoming challenges associated with cost, geography or demographics are important for organizers to consider during the planning process.

R5. The development of a clear framework early in the planning process to include information gained from the initiative in decision making

Key informants were unsure of the benefit of the information gained from the engagement initiative. Some felt that it would be used and would be beneficial for future decision makers; others felt that the information from the focus groups would be particularly important, while another key informant doubted the use of the information at all. Using the information obtained is important so that the engagement process can be seen as more than just an 'end' in its own right and is not seen as purely a means of 'rubberstamping' decisions (Middendorf & Busch, 1997). Creating a clear framework and having a mechanism to include such information into decision making is important during the initial planning stages (Chafe et al., 2007). While the key informants were divided whether the information would be used or not, it is important to

such issues resolved early in the planning process. While the information gained during the CRCEI may be of use to the senior management team at any of the organizing partners, policy formulation is the responsibility of the government of Newfoundland and Labrador and as such may not be informed by the information obtained during the CRCEI.

6.3 Limitations

This project had a number of limitations. First, data from a part of one key informant interview was lost due to having the digital recording partially deleted. This section of the interview was approximately five to ten minutes in length and its loss should not have substantially impacted the findings of the overall study. Second, the qualitative data management program NVivo 10 (QSR International, 2013) was unavailable due to an issue of purchasing by the university. The inability to use such software may have resulted in a less substantial analysis of the interview data manually. Nonetheless, the qualitative coding was completed by hand and should not affect quality or content of the dissemination of the interviews.

Despite the statistical work presented in the results section, the low number of online participants hindered the possibility for a comprehensive statistical analysis and did not allow for a representative sample of Central residents. As this was an initiative organized by Central Health and its partners, it was not the role of the researcher to recruit participants. Had the recruitment effort been the responsibility of the researcher, particular groups could have been targeted in an effort to garner a representative sample (Martin, 1995).

6.4 Knowledge translation strategy

The Canadian Institutes of Health Research [CIHR] define knowledge translation as a “dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound

application of knowledge" that takes place within a complex system of interactions between researchers and knowledge users which may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge user" (CIHR, 2013). Using this definition, knowledge translation for this project includes the publication of peer-reviewed academic journals, dissemination of results at academic and institutional conferences, and the use of project results in public reports.

Results from this project have already been presented at the Aldrich interdisciplinary conference held at Memorial University in April 2013, the annual Ethics Education Day organized by Eastern Health in September 2013, the PriFor primary healthcare research held in St. John's, NL in November 2013, and the Canadian Agency for Drugs and Technology in Health [CADTH] 2014 symposium in Ottawa, ON. Plans for future conference presentations and publications are on-going. The data from this project will also help inform the report by the organizers of this initiative for the public and other interested parties in terms of participant experience and representativeness.

6.5 Concluding remarks

Deciding to engage the public, especially in a public policy discussion, is a decision that should be taken after careful and thorough consideration of all the parameters involved. A successful engagement initiatives hinges on a number of factors (Chafe et al., 2007). Of particular interest, the choice of an engagement mechanism is a decision that can have dramatic implications on the outcome of the initiative.

The CRCEI employed a dual mechanism style of public engagement to elicit the values of the public in Central Newfoundland. The use of the two mechanisms allowed the organizers to

employ focus groups to reach citizens near larger centres, while the online component was designed partly so that residents in hard to reach locales, or those who were not invited to the focus groups, would also have an opportunity to provide input.

Both mechanisms offer unique advantages, however used separately they do not provide the same kind of opportunities for citizens as when used concurrently. Used independently, an online mechanism has the ability to reach across barriers of age and gender. However, as was seen in this study, such initiatives require a concentrated effort and are not as seemingly straightforward to organize. Focus groups used on their own offer a great deal of interactivity amongst citizens and are a good forum for citizens to dialogue with decision makers. However, focus groups can be rather exclusive and are not always accessible to every member of the public the same way an online survey may be. Faced with these difficulties, the use of these two mechanisms of public engagement in concert affords organizers the ability to offer a comprehensive and encompassing medium for anyone to provide input.

The evaluation of public engagement initiatives is a growing field. However, examples of evaluations and evaluative tools remain relatively scarce. This research project was an unprecedented example of an evaluation of a Canadian public engagement initiative in healthcare that occurred in a rural setting. The lessons learned from this initiative, however, have wider implications and may help inform other public engagement initiatives in other contexts in the future.

Bibliography

Aaron, L. (2011). Mixed methods research. *Radiologic Technology, 82*(3), 274-275.

Abelson, J., & Eyles, J. (2002). *Discussion Paper No. 7: Public Participation and Citizen Governance in the Canadian Healthcare System. Commission on the Future of Healthcare in Canada*. Retrieved from http://publications.gc.ca/collections/Collection/CP32-79-7-2002E.pdf

Abelson, J., Forest, PG., Eyles, J., Smith, P., Martin, E., Gauvin, FP. (2002). Obtaining public input for health-systems decision making: Past experiences and future prospects. *Canadian Public Administration, 45*(1), 70-97.

Abelson, J., Forest, PG., Eyles, J., Smith, P., Martin, E. & Gauvin, FP. (2003). Deliberations about deliberative methods: issues in the design and evaluation of public participation processes. *Social Science & Medicine,* 57, 239-251.

Abelson, J. & Gauvin, FP. (2006). *Assessing the impacts of public participation: Concepts, evidence, and policy implications*. Canadian Policy Research Networks. Retrieved from http://skat.ihmc.us/rid=1JGD4CQS2-16X32NW-1KMD/SEMINAL%20Assessing%20the%20Impacts%20%20OF%20PUBLIC%20PARTICIPATION%20Concepts,%20Evidence,%20and.pdf

Abelson, J., Montesanti, S., Li, K., Gauvin, FP. & Martin, E. (2010). *Effective strategies for interactive public engagement in the development of healthcare policies and programs*. Canadian Health Services Research Foundation. Retrieved from http://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/Abelson_EN_FINAL.sflb.ashx

Abelson, J. & Lomas, J. (1996). In search of informed input: A systematic approach to involving the public in community decision making. *Healthcare Management Forum, 9*(4), 48-52.

Adamson, B., & Finney, J. (1994). Victoria Hospital listens to the community. *Leadership in Health Services*, *3*, (6), 46-7.

America*Speaks*. (2010). *About Us*. Retrieved from http://americaspeaks.org/about/

Aronson, J. (1994). Old people having a say? Public consultation on long term care reform in Ontario. *Women and Environments*, *14*, 11-13.

Arnstein, SR. (1969). A Ladder of Citizen Participation. *Journal of the American Institute of Planners*, *35*(4), 216-224.

Barnes, M. (1999). *An evaluation of two citizens' juries.* London, UK: Institute for Public Policy Research

Beierle, TC. (1999). Using social goals to evaluate public participation in environmental decisions. *Policy Studies Review,* 16(3/4), 75-103.

Besley, JC. (2010). Imagining public engagement. *Public Understanding of Science, 21*(5), 590-605.

Biron, R. & Gillard, J. (2012). Shared Challenge, Shared Solution: Northumberland Hills Hospital's Collaborative Budget Strategy. In Chafe, R., Levinson, W., Laupacis, A., Born, K. & Lukensmeyer, C. (Eds.), *CIHR's Citizen Engagement in Health Casebook* (pp. 37-43). Ottawa: Canadian Institutes of Health Research.

Born, K. & Laupacis, A. (2012). Public Engagement in Ontario's hospitals-Opportunities and Challenges. *Healthcare Quarterly*, *15*, 16-20.

Bowling, A. (1997). Research methods in health: Investigating health and health services. Philadelphia, PA: Open University Press.

Boyce, WF. (2002). Influence of health promotion bureaucracy on community participation: a Canadian case study. *Health Promotion International, 17*(1), 61-68.

Boydell, LR. & Rugkåsa, J. (2007). Benefits of working in partnership: A model. *Critical Public Health, 17*(3), 217-228.

Bruni, RA., Laupacis, A., & Martin, DK. (2008). Public engagement in setting priorities in health care. *Canadian Medical Association Journal,* 179(1), 15-18.

Bryson, JM., Quick, KS., Slotterback, CS. & Crosby, BC. (2013). Designing public participation processes. *Public Administration Review, 73*(1), 23-34.

Canadian Institutes of Health Research [CIHR]. (2012). *CIHR's Citizen Engagement in Health Casebook*. Ottawa: Canadian Institutes of Health Research.

CIHR. (2013). *More about knowledge translation at CIHR.* Retrieved from http://www.cihr-irsc.gc.ca/e/39033.html#Definition

Canadian Medical Association. (2011). *Canadian Physician Resources: 2011 Basic Facts*. Retrieved from http://www.amc.ca/multimedia/CMA/Content_Images/Policy_Advocacy/Policy_Research/19-PhysFacts2011-E.pdf

Canadian Population Health Initiative. (2006). *How Healthy are Rural Canadians? An assessment of their health status and health determinants.* Ottawa, Ontario: Public Health Agency of Canada. Retrieved from http://www.phac-aspc.gc.ca/publicat/rural06/pdf/rural_canadians_2006_report_e.pdf

Carpini, MXD., Cook, FL., & Jacobs, LR. (2004). Public deliberation, discursive participation, and citizen engagement: A review of the empirical literature. *Annual Review of Political Science,* 7, 315-344.

Charles, C. & DeMaio, S. (1993). Lay participation in healthcare decision making: a conceptual framework. *Journal of Health Politics, Policy and Law, 18*(4), 927-935.

Church, J. & Barker, P. (1998). Regionalization of health services in Canada: a critical perspective. *International Journal of Health Services, 28*(3), 467-486.

Church, K. (1996).Beyond "bad manners": the power relations of "consumer participation" in Ontario's community mental health system. *Canadian Journal of Community Mental Health, 15*(2), 27-44.

Central Health. (2008). *Health Services Areas.* Retrieved from http://www.centralhealth.nl.ca/health-services-areas/

Central Health. (2013a). *Annual performance report 2012-2013*. Retrieved from http://www.centralhealth.nl.ca/assets/Publications/Annual-Performance-Reports/Central-Health-2012-13-Annual-Report-web-ver.pdf

Central Health. (2013b). *Central Region Health Authority: Organization Chart.* Retrieved from http://www.centralhealth.nl.ca/assets/Uploads/Organizational-Charts/Organizational-Chart-April-2013.pdf

Chadwick, A. (2011). Explaining the failure of an online citizen engagement initiative: The role of internal institutional variables. *Journal of Information Technology & Politics, 8*(21), 21-40.

Chafe, R., Neville, D., Rathwell, T., Deber, R., Kenny, N., Nestman, L., Joffres, C., Chappell, H., Conrad, P. & Batema, M. (2007). *A framework for involving the public in healthcare coverage and resource allocation decisions.* Halifax: Dalhousie University

Chafe, R., Levinson, W. & Hebert, PC. (2011). The need for public engagement in choosing health priorities. *Canadian Medical Association Journal*, 183(2), 165.

College of the North Atlantic. [CNA] (2011). *Strategic Plan: April 1, 2011-March 31, 2014.* Retrieved from http://www.cna.nl.ca/about/publications/sp2011web.pdf

Community Accounts. (2008). *Central Health authority: Census 2006: Highest level of schooling*. Retrieved from http://nl.communityaccounts.ca/table.asp?_=vb7En4WVgaSzyHNYnJvJwKCus6SfY8W4q5OruZKoh4yDXGeAyb2atJ7Skb2Iz8Kf

Community Accounts. (2013). *Central Health authority: Canadian Community Health Survey, 2009-2010: Health status of individuals.* Retrieved from http://nl.communityaccounts.ca/table.asp?_=vb7En4WVgaSzyHNYnJvJwKCus6SfY8W4q5OruZCnkM2Ei2OKiZM_

Connor-Linton, J. (2010). Chi-Square Test. In Salkind, NJ. (Eds.), *Encyclopedia of Research Design* (145-150). Thousand Oaks, CA: SAGE.

Cook, KE. (2008). In-Depth Interview. In Given, LM. (Eds.), *The SAGE Encyclopedia of Qualitative Research Methods* (423-424). Thousand Oaks, CA: SAGE.

Coleman, S. & Gotze, J. (2001) Bowling Together: Online Public Engagement in Policy Deliberation. London, UK: Hansard Society.

Conklin, A., Morris, ZS. & Nolte, E. (2010). *Involving the public in healthcare policy: An update of the research evidence and proposed evaluation framework.* RAND Technical Report. Retrieved from http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR850.pdf

Daly, J. and Lumley, J. (2007). Bias in qualitative research designs. *Australian and New Zealand Journal of Public Health, 26*(4), 299-300.

Daniels, M. (2000). Accountability for reasonableness. *British Medical Journal*, 321, 1300-1301.

Department of Finance, Government of Newfoundland and Labrador. (2005). *Map of Regional Health Authorities.* Retrieved from http://www.stats.gov.nl.ca/Maps/PDFs/HA_N.pdf

Delgado, A., Kjølberg, KL., & Wickson, F. (2011). Public engagement coming of age: From theory to practice in STS encounters with nanotechnology. *Public Understanding of Science, 20*(6), 826-845.

Denscombe, M. (2009). Item non-response rates: a comparison of online and paper questionnaires. *International Journal of Social Research Methodology,* 12(4), 281-291.

DiCiccio-Bloom, B. & Crabtree, BF. (2006). The qualitative research interview. *Medical Education, 40,* 314-321.

Eastern Health. (2007). *On the Path to Health & Wellness: Southern Avalon Community Health Needs Assessment.* Retrieved from http://www.easternhealth.ca/OurCommunity.aspx?d=1&id=400&p=379

Federation of Canadian Municipalities. (n.d.*). Rural Canada by the Numbers*. Retrieved from http://www.fcm.ca/Documents/backgrounders/Rural_Canada_by_the_Number_EN.pdf

Fern, EF. (2001). *Advanced focus group research*. Thousand Oaks, CA: SAGE.

FluidSurvey. (n.d.). *About FluidSurveys.* Retrieved from http://fluidsurveys.com/about/

Forbat, L., Hubbard, G. & Kearney, N. (2009). Patient and public involvement: models and muddles. *Journal of Clinical Nursing,* 18, 2547-2554. doi: 10.1111/j.1365-2702.2008.02519.x

Frankish, C., Kwan, B., Ratner, P., Higgins, J., & Larsen, C. 2002. Social and political factors influencing the functioning of regional health boards in British Columbia (Canada). *Health Policy, 61,* (2), 125 -151.

Griffee, DT. (2005). Research tips: Interview data collection. *Journal of Developmental Education, 28*(3), 36-37.

Garau, C. (2012). Focus on Citizens: Public engagement with online and face-to-face participation—A case study. *Future Internet, 4,* 592-606.

Government of Newfoundland and Labrador. (2013). *Rural secretariat*. Retrieved from http://www.exec.gov.nl.ca/rural/

Goyder, J. (1999). Petitions, public opinion and hospital restructuring in Kitchener-Waterloo. *Healthcare Management Forum, 12,* (1), 14-26.

Grand Falls-Windsor-Baie Verte-Harbor Breton Regional Council of the Rural Sectretariat. (2011). *Executive council activity report 2010-11.* Retrieved from http://www.exec.gov.nl.ca/rural/publications/pdf/gfw_201011_report.pdf

Gray, RE., James, P., Manthorne, J., Gould, J. & Fitch, MI. (2004). A consultation with Canadian rural women with breast cancer. *Health Expectations, 7*(1), 40-50.

Gregory, J., Hartz-Karp, J. & Watson, R. (2008). Using deliberative techniques to engage the community in policy development. *Australia and New Zealand Health Policy, 5*(16). doi:10.1186/1743-8462-5-16

Hagendijk, R. & Irwin, A. (2006). Public deliberation and governance: Engaging with science and technology in contemporary Europe. *Minerva, 44*(2), 167-184.

Hanley, B. Bradburn, J., Barnes, M., Evans, C., Goodare, H., Kelson, M., Kent, A., Oliver, S., Thomas, S. & Wallcraft, J. (2003). Involving the public in NHS, public health and social care research: Briefing notes for researchers' (second edition). *INVOLVE.* Retrieved from http://www.twocanassociates.co.uk/perch/resources/files/Briefing%20Note%20Final_dat (2).pdf

Hannabuss, S. (1996). Research interviews. *New Library World, 97*(1129), 22-30.

Hartley, D. (2004). Rural health disparities, population health, and rural culture. *American Journal of Public Health, 94*(10), 1675-1678.

Health Canada. (2000). *The Health Canada policy toolkit for public involvement in decision making.* Retrieved from http://www.hc-sc.gc.ca/ahc-asc/pubs/_public-consult/2000decision/index-eng.php

Hendriks, CM. (2006). When the forum meets interest politics: Strategic uses of public deliberation. *Politics & Society, 34*(4), 571-602.

Herbert, R. (2007). Canada's Health Care Challenge: Recognizing and Addressing the Health Needs of Rural Canadians. *Lethbridge Undergraduate Research Journal, 2*(1). Retrieved from https://www.uleth.ca/dspace/bitstream/handle/10133/495/Herbert.pdf

Hermanowicz, JC. (2013). The longitudinal qualitative interview. *Qualitative Sociology, 36,* 189-208.

Higgins, JW. (1999). Citizenship and empowerment: a remedy for citizen participation in health reform. *Community Development Journal, 34*(4), 287-307.

Horlick-Jones, T., Rowe, G. & Walls, J. (2007). Citizen engagement processes as information systems: the role of knowledge and the concept of translation quality. *Public Understanding of Science, 16*(3), 259-278.

Hunter, MA. (1999). All eyes forward: Public engagement and educational reform in Kentucky. *Journal of Law and Education, 28*(4), 485-516.

International Association for Public Participation [IAP2]. (n.d.). *IAP2: Good public participation results in better decisions.* Retrieved from http://www.iap2.org/

IBM. (n.d.). SPSS Software. Retrieved from http://www-01.ibm.com/software/analytics/spss/

Innes, JE. & Booher, DE. (2004). Reframing public participation: Strategies for the 21st century. *Planning Theory & Practice, 5*(4), 419-436.

Irvin, RA. & Stansbury, J. (2004). Citizen participation in decision making: Is it worth the effort? *Public Administration Review, 64*(1), 55-65.

Johnson, RB. & Onwuegbuzie, AJ. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33*(7), 14-26.

Johnson, RB., Onwuegbuzie, AJ. & Turner, LA. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research, 1*(2), 112-133.

Kathlene, L. & Martin JA. (1991). Enhancing citizen participation: Panel designs, perspectives, and policy formation. *Journal of Policy Analysis and Management, 10*(1), 46-63.

Kelson, M. (2005). The NICE Patient Involvement Unit. *Evidence-based Healthcare and Public Health, 9*(4). doi: 10.1016/j.ehbc.2005.05.013

Kirby, MJL. & LeBreton, M. (2002). *The Health of Canadians- The Federal Role. Volume Two: Current Challenges and Future Challenges.* Ottawa, Ontario: The Standing Senate Committee on Social Affairs, Science and Technology, Parliament of Canada. Retrieved from http://www.parl.gc.ca/Content/SEN/Committee/371/SOCI/rep/repjan01vol2-e.pdf

Knox, S. & Burkard, AW. (2009). Qualitative research interviews. *Psychotherapy Research, 19*(4-5), 566-575.

Krosnick, JA. (1999). Survey research. *Annual Review of Psychology, 50*, 537-567.

Kwong, JC., Dhalla, IA., Streiner, DL., Baddour, RE., Waddell, AE. & Johnson, IL. (2005). A comparison of Canadian medical students from rural and non-rural backgrounds. *Canadian Journal of Rural Medicine, 10*(1), 36-41.

Labonte, R. (1993). Community development and partnerships. *Canadian Journal of Public Health, 84*(4), 237-240.

Lantz, ME. (2010). The use of 'Clickers' in the classroom: Teaching innovation or merely an amusing novelty? *Computers in Human Behavior, 26*(4), 556-561.

Laurent, S. (2002). *Rural Canada: Access to Health Care.* Retrieved from http://publications.gc.ca/Collection-R/LoPBdP/BP/prb0245-e.htm

Lasker, RD. & Weiss, ES. (2003). Broadening participation in community problem solving: a multidisciplinary model to support collaborative practice and research. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 80*(1), 14-47.

Lehoux, P., Daudelin, G. & Abelson, J. (2012). The unbearable lightness of citizens within public deliberation processes. *Social Science & Medicine, 74*(12), 1843-1850.

Lenaghan, J. (1999). Involving the public in rationing decisions. The experience of citizens juries. *Health Policy, 49*(1-2), 45-61. doi: 10.1016/S0168-8510(99)00042-1

Litva, A., Coast, J., Donovan, J., Eyles, J., Shepherd, M., Tacchi, J., Abelson, J. & Morgan, K. (2002). 'The public is too subjective': public involvement at different levels of health-care decision making. *Social Science & Medicine, 54*, 1825-1837.

Lomas, J. (1997a). Reluctant rationers: Public input to health care priorities. *Journal of Health Services Research & Policy, 2*(2), 103-111.

Lomas, J. (1997b). Devolving authority for healthcare in Canada's provinces: 4. Emerging issues and prospects. *CMAJ, 156*(6), 817-23.

Lomas, J., & Veenstra, G. (1995). If you build it, who will come? *Policy Opinions, November*, 37-40.

Longest, BB. (2012). Management challenges at the intersection of public policy environments and strategic decision making in public hospitals. *Journal of Health & Human Services Administration, 35*(2), 207-230.

Lukensmeyer, CJ. & Torres, LH. (2006). *Public deliberation: A manager's guide to citizen engagement. Collaboration Series, IBM Center for The Business of Government.* Retrieved from http://www.businessofgovernment.org/sites/default/files/LukensmeyerReport.pdf

Mays, N. & Pope, C. (2000).Assessing quality in qualitative research. *British Medical Journal, 320*(7226), 50-52.

Macfarlane, D. (1996). Citizen participation in the reform of healthcare policy: a case example. *Healthcare Management Forum, 9*(2), 31-35.

Mackinnon, MP, Pitre, S. & Watling, J. (2007). Matching Methods with Policy Purpose: Two Case Examples of Public Engagement. *Canadian Policy Research Networks.* Retrieved from http://cprn.org/documents/47131_en.pdf

MacMillan, CM. (2010). Auditing citizen engagement in heritage planning: The views of citizens. *Canadian Public Administration, 53*(1), 87-106.

Martin, DK., Giacomini, M. & Singer, PA. (2002). Fairness, accountability for reasonableness, and the views of priority setting decision-makers. *Health Policy,* 61, 279-290.

Martin, GP. (2008). 'Ordinary people only': knowledge, representativeness, and the publics of public participation in healthcare. *Sociology of Health & Illness, 30*(1), 35-54.

Martin, PA. (1995). Recruitment of research subjects. *Applied Nursing Research, 8*(1), 50-54.

MassLBP. (2009). *Engaging With Impact: Targets and indicators for successful community engagement by Ontario's LHINs.* Retrieved from http://www.masslbp.com/journal_detail.php/engaging.html

Maxwell, J., Rossell, S. & Forest, PG. (2003). Giving citizens a voice in healthcare policy in Canada. *British Medical Journal, 326*(7397), 1031-1033.

Meetoo, D. (2013). The setting of healthcare priorities through public engagement. *British Journal of Nursing, 22*(7), 372-376.

Middendorf, G. & Busch, L. (1997). Inquiry for the public good: Democratic participation in agricultural research. *Agriculture and Human Values,* 14, 45-57.

Mitton, C., Smith, N., Peacock, S., Evoy, B. & Abelson, J. (2009). Public participation in health care priority setting: A scoping review. *Health Policy, 91,* 219-228.

Mitton, C., Smith, N., Peacock, S., Evoy, B. & Abelson, J. (2011). Integrating public input into healthcare priority-setting decisions. *Evidence & Policy, 7*(3), 327-343.

Min, SJ. (2007). Online vs. face-to-face deliberation: Effects on civic engagement. *Journal of Computer-Mediated Communication,* 12, 1369-1387.

Motsi, G. (2009). Evaluating citizen engagement in policy making. *Institute on Governance.* Retrieved from http://site.ebrary.com/lib/memorial/docDetail.action?docID=10309361

Nair, CS. & Adams, P. (2009). Survey platform: A factor influencing online survey delivery and response rate. *Quality in Higher Education, 15*(3), 291-296.

National Institute for Health and Care Excellence [NICE]. (2013). *Citizens Council.* Retrieved from http://www.nice.org.uk/aboutnice/howwework/citizenscouncil/citizens_council.jsp

Naylor, CD. (1999). Health care in Canada: Incrementalism under fiscal duress. *Health Affairs, 18*(3), 9-26.

New Brunswick Health Council. (2010). *Our Health. Our Perspective. Our Solutions: Results of our first engagement initiative with New Brunswick citizens*. Retrieved from http://www.nbhc.ca/sites/default/files/pdf/CEI_OHOPOS_EXSUMM_VF_EN.pdf

Nisbet, MC. (2009). Communicating climate change: Why frames matter for public engagement. *Environment, 51*(2), 13-23.

Norman, AT. & Russell, CA. (2006). The pass-along effect: Investigation word-of-mouth effects on online survey procedures. *Journal of Computer-Mediated Communication, 11*, 1085-1103.

Ontario Ministry of Health and Long-Term Care. (2008). *Citizen's Council.* Retrieved from http://www.health.gov.on.ca/en/public/programs/drugs/councils/about.aspx

Patton, MQ. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research, 34*(5), 1189-1208.

Petts, J. (2008). Public engagement to build trust: False hopes? *Journal of Risk Research, 11*(6), 821-835.

Philips, SD. & Orsini, M. (2002). *Mapping the links: Citizen involvement in policy processes.* Canadian Policy Research Networks. Retrieved from http://cprn.org/documents/ACFRJK8po.PDF

Pimbert, M. & Wakeford, T. (2001). Overview – deliberative democracy and citizen empowerment. *PLA Notes 40,* 23-28.

Plichta, SB. & Garzon, LS. (2009). Building blocks for using inferential statistics. *Statistics for Nursing and Allied Health.* Philadelphia, PA: Lipincott, Williams & Wilkins

Pollack, N. & Mackinnon, MP. (2012). Our health. Our perspectives. Our solutions: Establishing a common health vision. In Chafe, R., Levinson, W., Laupacis, A., Born, K. &

Lukensmeyer, C. (Eds.), *CIHR's Citizen Engagement in Health Casebook* (pp. 45-50). Ottawa: Canadian Institutes of Health Research.

Pong, RW., DesMeules, M., & Lagace, C. (2008). Rural-urban disparities in health: how does Canada fare and how does Canada compare with Australia? *Inaugural Rural & Remote Health Scientific Symposium*, 6-13.

Pope, ASA., Grams, GD., Whiteside, CBC. & Kazanjian, A. (1998). Retention of rural physicians: Tipping the decision-making scales. *Canadian Journal of Rural Medicine, 3*(4), 209-216.

Price, V. & Neijens, P. (1998). Deliberative Polls: Toward improved measures of "Informed" public opinion? *International Journal of Public Opinion Research, 10*(2), 145-176.

Puleston, J. (2011). Improving online surveys. *International Journal of Market Research, 53*(4), 557-560.

Punch, KF. (2003). Survey Research. London, England: SAGE Publications

QSR International. (2013). NVIVO 10. Retrieved from http://www.qsrinternational.com/products_nvivo.aspx

Ramos, MC. (1989). Some ethical implications of qualitative research. *Research in Nursing & Health*, 12, 57-63.

Rayner, S. (2003). Democracy in the age of assessment: Reflections on the roles of expertise and democracy in public-sector decision making. *Science and Public Policy, 30*(3), 163-170.

Redden, CJ. (1999). Rationing care in the community: Engaging citizens in health care decision making. *Journal of Health Politics, Policy and Law, 24*(6), 1363-1389.

Renn, O. (1992). Risk communication: Towards a rational discourse with the public. *Journal o[Hazardous Materials, 29*, 465-519.

Renn, O., Webler, T., Rakel, H., Dienel, P & Johnson, B. (1993). Public participation in decision making: A three-step procedure. *Policy Sciences, 26,* 189-214.

Romanow, R. (2002). *Building on Values: The Future of Health Care in Canada*. Retrieved from http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

Rowe, G. & Frewer, LJ. (2000). Public participation methods: A framework for evaluation. *Science, Technology & Human Values,* 25(1), 3-29.

Rowe, G. & Frewer, LJ. (2004). Evaluation of a deliberative conference. *Science, Technology & Human Values,* 29(1), 88-121.

Rowe, G. & Gammack, JG. (2004). Promise and perils of electronic public engagement. *Science and Public Policy,* 31(1), 39-54.

Rowe, G. & Frewer, LJ. (2005). A typology of public engagement mechanisms. *Science, Technology, & Human Values,* 30(2), 251-290.

Rowe, G., Horlick-Jones, T., Walls, J. & Pidgeon, N. (2005). Difficulties in evaluating public engagement initiatives: reflections on an evaluation of the UK GM Nation? Public debate about transgenic crops. *Public Understanding of Science, 14*(4), 331-352.

Rowe, G., Marsh, R. & Frewer, LJ. (2004). Evaluation of a deliberative conference. *Science, Technology and Human Values, 29*(88). doi: 10.1177/0162243903259194

Rowe, G., Poortinga, W. & Pidgeon, N. (2006). A comparison of responses to internet and postal surveys in a public engagement context. *Science Communication*, 27, 352-375.

Rowe, G., Horlick-Jones, T., Walls, J., Poortinga, W., & Pidgeon, NF. (2008). Analysis of a normative framework for evaluating public engagement initiatives: reliability, validity, and limitations. *Public Understanding of Science,* 17, 419-441.

Ryan, M., Scott, DA., Reeves, C., Bate, A.,Van Teijlingen, ER., Russell, EM., Napper, M. & Robb, CM. (2001). Eliciting public preferences for healthcare: a systematic review of techniques. *Health Technology Assessment, 5*(5).

Ryan-Nicholls, K. (2004). Health and sustainability of rural communities. *Rural and Remote Health, 4*(242). Retrieved from http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=242

Sale, JEM., Lohfeld, LH. & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed-methods research. *Quality & Quantity, 36,* 45-53.

Scott, I. & Mazhindu, D. (2005). *Statistics for health care professionals.* Thousand Oaks, CA: SAGE

Sheedy, A. (2008). Handbook on citizen consultation: Beyond consultation. *Canadian Policy Research Networks.* Retrieved from http://www.cprn.org/documents/49583_EN.pdf

Sher, G. (2008). Fostering public engagement. *Canadian Medical Association Journal, 179*(11), 1174-1175.

Shields, K, DuBois-Wing, G., & Westwood, E. (2010). Share your story, shape your care: engaging the diverse and disperse population of Northwestern Ontario in healthcare priority setting. *Healthcare Quarterly, 13*(3), 86-90.

Shields, K. (2012). Share your story, shape your care-Engaging northwestern Ontario. In Chafe, R., Levinson, W., Laupacis, A., Born, K. & Lukensmeyer, C. (Eds.), *CIHR's Citizen Engagement in Health Casebook* (pp. 21-27). Ottawa: Canadian Institutes of Health Research.

Singer, M. (1995). Community participation in healthcare decision making: is it feasible? *CMAJ, 153*, (4), 421-4.

Simmons, R., Birchall, J. & Prout, A. (2012). User involvement in public services: Choice about 'voice'. *Public Policy and Administration, 27*(1), 3-29.

Simmons, WM. & Zoetewey, MW. (2012). Productive usability: Fostering civic engagement and creating more useful online spaces for public deliberation. *Technical Communication Quarterly, 21*(3), 251-276.

Smith, KB., Humphreys, JS. & Wilson, MGA. (2008). Addressing the health disadvantage of rural populations: How does epidemiological evidence inform rural health policies and research? *The Australian Journal of Rural Health,16*(2), 56-66.

Solecki, S., Cornelius, F., Draper, J. & Fisher, K. (2010). Integrating clicker technology at nursing conferences: An innovative approach to research data collection. *International Journal of Nursing Practice, 16*(3), 268-273.

Sun, M. (2010). Z-Score. In Salkind, NJ. (Eds.), *Encyclopedia of Research Design* (1668-1675). Thousand Oaks, CA: SAGE.

Statistics Canada. (2009). *Immigrants in Rural Canada: 2006.* Retrieved from http://www5.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=21-006-XWE2008002&lang=eng

Statistics Canada. (2011). *From urban areas to population centres.* Retrieved from http://www.statcan.gc.ca/subjects-sujets/standard-norme/sgc-cgt/notice-avis/sgc-cgt-06-eng.htm

Statistics Canada. (2012). *Table 105-0501 - Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2011 boundaries) and peer groups, occasional,* CANSIM (database).

Statistics Canada. (2013a). *2013 Health Profile*. Retrieved from http://www12.statcan.gc.ca/health-sante/82-

228/details/page.cfm?Lang=E&Tab=1&Geo1=HR&Code1=1012&Geo2=PR&Code2=10&Data=Rate&SearchText=Central%20Regional%20Integrated%20Health%20Authority&SearchType=Contains&SearchPR=01&B1=All&Custom=

Statistics Canada. (2013b). *Table 109-5325 - Estimates of population (2006 Census and administrative data), by age group and sex for July 1st, Canada, provinces, territories, health regions (2013 boundaries) and peer groups, annual (number),* CANSIM (database).

Statistics Canada. (2013c). *Employment income in 2005, by age group and educational attainment, Canada.* Retrieved from http://www.statcan.gc.ca/pub/89-503-x/2010001/article/11542/tbl/tbl011-eng.htm

Stewart, E. (2013). What is the point of citizen participation in health care? *Journal of Health Services Research & Policy, 18*(2), 124-126.

Stewart, DW., Shamdasani, PN. & Rook, DW. (2007). Focus groups theory and practice. Thousand Oaks, CA: SAGE Publishing.

Sullivan, LE. (2009). The SAGE Glossary of the Social and Behavioral Sciences. Thousand Oaks, CA: SAGE Publishing

Termeer, CJ. (2008). *Barriers for new modes of horizontal governance: A sensemaking perspective.* Paper presented at Twelfth Annual Conference of the international Research Society for Public Management, Brisbane, AU. Retrieved from http://www.irspm2008.bus.qut.edu.au/papers/documents/pdf/Termeer%20-%20Barriers%20for%20new%20modes%20of%20horizontal%20governance%20-%20IRSPM%20-%202008.pdf

The Organization for Economic Co-Operation and Development [OECD]. (2012). *Planning Guide for Public Engagement and Outreach in Nanotechnology.* Retrieved from http://www.oecd.org/sti/biotech/49961768.pdf [Retrieved June 15th, 2013]

Thurston, W., MacKean, G., Vollman, A., Casebeer, A., Weber, M., Maloff, B., & Bader, J. (2005). Public participation in regional health policy: A theoretical framework. *Health Policy, 73,* (3), 237-52.

Timotijevic, L. & Raats, MM. (2007). Evaluation of two methods of deliberative participation of older people in food-policy development. *Health Policy, 82*(3), 302-319.

Tomblin, SG. & Braun-Jackson, J. (2006). *Managing Change Through Regionalization: Lessons from Newfoundland and Labrador.* Harris Centre, Memorial University. Retrieved from http://www.mun.ca/harriscentre/reports/arf/2005/FinalReportTomblinRegionalization.pdf

Turning technologies. (n.d.). *TurningPoint.* Retrieved from http://www.turningtechnologies.com/polling-solutions/turningpoint

Traq, J. (2010). Z-Score. In Salkind, NJ. (Eds.), *Encyclopedia of Research Design* (1205-1207). Thousand Oaks, CA: SAGE.

Tritter, JQ. & McCallum, A. (2006). The snakes and ladders of user involvement: Moving beyond Arnstein. *Health Policy, 76*(2), 156-168.

Ugoni, A. & Walker, BF. (1995). The chi square test: An introduction. *Comsig Review, 4*(3), 61-64.

Van Selm, M. & Jankowski, NW. (2006). Conducting online surveys. *Quality & Quantity, 40,* 435-456. doi: 10.1007/s11135-005-8081-8

Warburton, D. (2008). Evaluation of Defra's public engagement process on climate change. *Shared Practice.* Retrieved from http://www.sharedpractice.org.uk/Downloads/Defra_CC_evaluation_report.pdf.

Warburton, D., Wilson, R. & Rainbow, E. (2007). Making a Difference: A guide to evaluating public participation in central government. Retrieved from http://participationcompass.org/media/68-Making_a_Difference_.pdf

Wait, S. & Nolte, E. (2006). Public involvement policies in health: exploring their conceptual basis. *Health Economics, Policy and Law*, 1, 149-162.

Weber, LM., Loumakis, A. & Bergman, J. (2003). Who Participates and Why?: An Analysis of Citizens on the Internet and the Mass Public. *Social Science Computer Review 2003, 21*(1), 26-42.

Webler, T. (1995). "Right" Discourse in Citizen Participation: An Evaluative Yardstick. In O. Renn, T. Webler, & P. Wiedemann (Eds.), *Fairness and Competence in Citizen Participation* (pp. 35–86). Springer Netherlands. Retrieved from http://link.springer.com/chapter/10.1007/978-94-011-0131-8_3

Webler, T., Kastenholz, H. & Renn, O. (1994). Public participation in impact assessment: A social learning perspective. *Environmental Impact Assessment Review, 15*(5), 443-463.

Weiss, CH. (1998). *Evaluation, 2nd edition.* Upper Saddle River: Prentice Hall.

Whiting, LS. (2008). Semi-structured interviews: guidance for novice researchers. *Nursing Standard, 22*(23), 35-40.

Whitty, JA. (2013). An International Survey of the Public Engagement Practices of Health Technology Assessment Organizations. *Value in Health, 16*(1), 155-163.

Wondolleck, JM., Manring, NJ. & Crowfoot, JE. (1996). Teetering at the top of the ladder: The experience of citizen group participants in alternative dispute resolution processes. *Sociological Perspectives, 39*(2), 249-262.

Wright, K. B. (2005). Researching internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. *Journal of Computer-Mediated Communication, 10*(3), article 11.Retrieved from http://jcmc.indiana.edu/vol10/issue3/wright.html

Wright, C. & O' Rourke, B. (2012). Bringing evidence to healthcare decision making. *Healthcare Quarterly, 15*, 64, 65-104.

Yin, RK. (1999). Enhancing the quality of case studies in health services research. *HSR: Health Services Research, 34*(5), 1209-1224.

Appendix A: Interview guide for members of the Steering Committee

Pre- initiative interview

- What are your expectations of this initiative?
- How valuable do you feel the information collected from this project will be?
- Can you describe any previous involvement with public engagement initiatives?
- Did you receive any training in public engagement?
- How did you get involved in this process?

Post-initiative interview

- How successful do you think the entire engagement initiative was?
- Were your expectations of this process met?
- What were some strengths of this initiative?
- What were some limitations of this initiative?
- Which method posed more challenges? Was there a difference in cost?
- What method would you recommend to other organizers in a similar context?
- How do you think the information from this initiative is going to be used?
- How do you think we could improve the use of either method?
- How could we increase numbers? Representativeness?

Appendix B: Online questionnaire

1. What is your age?
   ___ 18-24 ___ 25-34 ___ 35-44 ___ 45-54 ___ 55-64 ___ 65-74 ___ 75+

2. What is your gender? Male ☐ Female ☐

3. What community do you reside in? _____

4. Would you rank your health status as:
   a. Poor, b. Fair, c. Good, d. Very Good, e. Excellent

5. What is your highest level of education achieved?
   a.University certificate, diploma or degree, b. College c. Apprenticeship/trades, d. High School certificate only, e. Without high school certificate

6. I feel that the nature and scope of this Online session has been well defined

1	2	3	4	5
Strongly Disagree				Strongly Agree

7. I feel that this Online citizen engagement session allowed me equal opportunity to provide input

1	2	3	4	5
Strongly Disagree				Strongly Agree

8. I feel that the sponsors of today's session provided me with enough time and information, to enable me to take part in the discussion

1	2	3	4	5
Strongly Disagree				Strongly Agree

9. I feel that today's session was run in an unbiased way

1	2	3	4	5
Strongly Disagree				Strongly Agree

10. I would participate in a similar initiative such as today's session again if the opportunity arises

1	2	3	4	5
Strongly Disagree				Strongly Agree

Appendix C: Focus group questionnaire

1. What is your age?
   ___ 18-24 ___ 25-34 ___ 35-44 ___ 45-54 ___ 55-64 ___ 65-74 ___ 75+

2. What is your gender? Male ☐ Female ☐

3. What community do you reside in? _____

4. Would you rank your health status as:
   a.Poor, b. Fair, c. Good, d. Very Good, e. Excellent

5. What is your highest level of education achieved?
   a.University certificate, diploma or degree, b. College c. Apprenticeship/trades, d. High School certificate only, e. Without high school certificate

6. I feel that the nature and scope of this Focus Group session has been well defined

1	2	3	4	5
Strongly Disagree				Strongly Agree

7. I feel that this citizen engagement session allowed me equal opportunity to provide input

1	2	3	4	5
Strongly Disagree				Strongly Agree

8. I feel that the sponsors of today's session provided me with enough time and information, to enable me to take part in the discussion

1	2	3	4	5
Strongly Disagree				Strongly Agree

9. I feel that today's session was run in an unbiased way

1	2	3	4	5
Strongly Disagree				Strongly Agree

10. I would participate in a similar initiative such as today's session again if the opportunity arises

1	2	3	4	5
Strongly Disagree				Strongly Agree

Appendix D: Z-score results

Demographic criterion		Z-score focus group	Z-score online
Age category	15-24	1.44308	-1.6172
	25-34	-1.39166	1.543431
	35-44	0.154508	1.853856
	45-54	-1.79755	1.602077
	55-64	3.368221	1.086411
	65-74	3.076654	-1.71346
	75 +	-2.06745	-1.42762
Health Status	Poor	-1.67711	-0.99162
	Fair	-0.07191	0.630537
	Good	1.414563	-0.04352
	Very good	-1.5452	-0.98289
	Excellent	0.580496	1.459984
Education	University	14.0771	14.92126
	College	2.122116	-0.52533
	Apprenticeship	-1.3731	-1.65051
	High School	-2.24553	-2.30838
	Without High School	-6.49495	-3.69821
Gender	Male	-4.26885	-2.59311
	Female	2.632426	2.593115

Appendix E: Conversation guide provided to engagement participants

Conversation Guide

Central NL Citizen Engagement

2013

About citizen engagement

Steering Committee

Debbie Armstrong	Central West Regional Council
Dave Regular	Gander New-Wes-Valley Regional Council
Linda Brett	Rural Secretariat
Tanya Noble	Rural Secretariat
Paul Chafe	College of the North Atlantic—Grand Falls-Windsor Campus
Doreen Neville	Memorial University of Newfoundland
Heather Brown	Central Health
Rosemarie Goodyear	Central Health
Doug Prince	Central Health
Kim Cheeks	Central Health

Engagement session

Participants are asked to:

- Review the conversation guide
- Speak up during the engagement session and contribute your ideas
- Think about and suggest values that are important to you
- Listen carefully and respectfully to others
- Work together as a group
- Have fun

Using the information

Your input will provide information for analysis and discussion by decision makers and will lay the groundwork for planning and improving future engagement opportunities.

Please use this conversation guide to write down your thoughts and ideas. Thank you for taking the time to participate in today's engagement session.

Message from the Steering Committee

The Central NL Citizen Engagement Project is a collaborative effort between the Gander-New-Wes-Valley and Grand Falls-Windsor – Baie Verte-Harbour Breton Regional Councils of the Rural Secretariat, College of the North Atlantic, Memorial University – Faculty of Medicine, and Central Health . The purpose of this project is to learn how to better engage and involve you as a citizen of the region in providing input that will influence decision making regarding matters that affect you.

The population of Central Newfoundland is changing. As demographics change, services need to also change in order to best suit everyone's needs. However, these changes can be very complicated and affect many people. Even though change may be beneficial overall, it may also cause some concerns. As a result, no single person or group can solve these problems on their own – many groups must come together and share their thoughts and ideas to ensure all information is considered when decisions are being made.

When making decisions about services, realistic expectations must be considered along side identified needs. Decision makers face the challenge of making the most of existing resources when availability of workers and funds may be limited. To make decisions about complex issues that will have long-term benefits, decision makers need feedback from community stakeholders including residents, community groups and local governing bodies.

Through this Citizen Engagement initiative the partners would like to enhance open dialogue about community growth and sustainability by engaging rural citizens in discussions related to service delivery in their part of the central region. The Citizen Engagement partners are ready to hear from citizens and explore how you would like to be engaged or involved in influencing decisions regarding matters that affect you. These engagements will focus on determining what citizens value with respect to service delivery and the impact on the region's sustainability. The information collected from citizens who participate in this engagement opportunity will be used for planning future citizen engagement opportunities with a goal to improve future engagements.

Goals

Goal 1: To enhance understanding of what citizens value.

What a person values tells a lot about who they are. Individuals give consideration to their values when discussing and making decisions that affect service delivery now and in the future. Health and education are very important to the long term development and sustainability of our communities because they have the ability to help keep people healthy. However, before these issues can be fully considered, decision makers need and want to understand what citizens of the communities' value.

Goal 2: To discuss with citizens how values influence decision making with respect to service delivery.

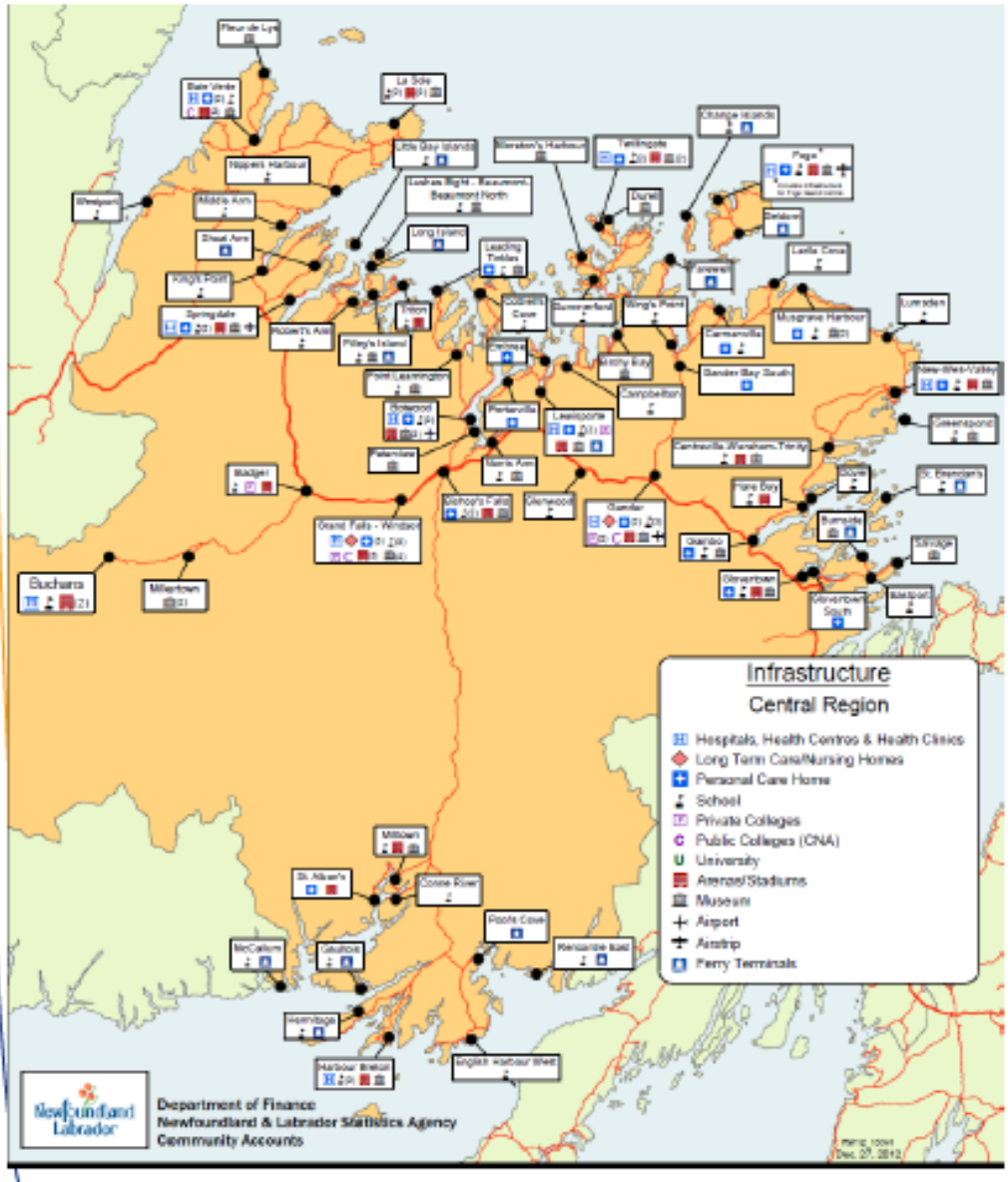
The challenges that decision makers face often need creative initiatives, utilizing community partnerships, to develop sustainable solutions. Resources are decreasing, the age of our population is increasing, labour market trends are changing and the demand for more complicated services is increasing. More and more, decision makers are required to set priorities while trying to address the greatest needs within a community. Needs are identified through feedback from various concerned groups in the community. It is helpful for decision makers to know how citizens values influence what services when they advocate for in their community.

Goal 3: To enhance communication between the citizens of the region and decision makers.

Developing and enhancing open communication leads to building trust between citizens of the region and decision makers. Engaging in discussions related to the delivery of services allows for the exploration of values that citizens' believe are important and define the community in which they live. It provides a means for shared understanding of the challenges that decision makers face; helps build community capacity and positively impacts the regional sustainability of service delivery.

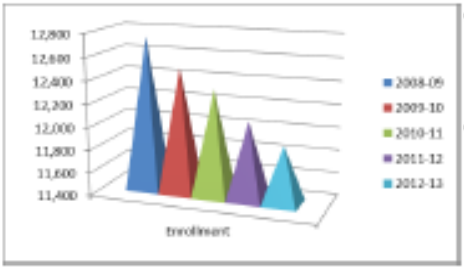
Regional infrastructure map

This map outlines various services offered in communities within the region.



Regional quick facts

- In 2006, 18.5 per cent of the population in Central Newfoundland and Labrador (NL) was 65 years and over compared to 14.8 per cent in NL. The population of NL is aging faster than is the case for any other province in Canada.
- The median age in Central NL was 44 in 2006. The 2006 median age in NL was 42.
- College of North Atlantic has three campuses in Central NL hosting a total of 37 services and programs. Full-time credit program enrollment is approximately 500 students per semester at the GFW Campus; 125 for the Baie Verte Campus and 250 for Gander which is a 1.3 per cent increase in enrollment since 2008.
- Central NL has five private Training Institutions; Central Training Institute, Corona College, Dietrac Technical Institute, Gander Flight Training Center, and Keyin College.



- Student enrolment for Nova Central School District (NCSD), grades K to 12, is approximately 11,900 for 2012-2013 school year.
- Out of the 942 NCSD students eligible to graduate in June 2012, 94.4per cent graduated, which was the highest graduation rate for all of the school districts in the province. Of that 94.4 per cent, 24.5 per cent graduated with honours, 43.4 per cent graduated with an academic diploma, and 32.1 per cent graduated with a general diploma.
- In June 2012, 68 per cent of NCSD graduates graduated with an honours/academic diploma compared to 53 per cent in 2009, and eighteen out of thirty-seven schools with students writing public exams posted a 100 per cent graduation rate.
- In 2009-2010, 50.8 per cent of population in the Central NL, age 12+, stated that they were physically inactive. The provincial rate was 52.8 per cent.
- The rate of smoking (current daily smokers) among those 12 years of age and older in Central NL in 2009-2010 was 20.1 per cent. The provincial rate was 18.6 per cent. (76.7 per cent of those 12 years of age and older in Central NL reported they did not smoke. The provincial rate was 76.7 per cent)
- The percentage of people who were overweight or obese (adult body mass index 25 or greater) among those 18 years of age and older in Central NL in 2009-2010 was 69.9 per cent .The provincial rate was 64.7 per cent. Obesity has been linked with many chronic diseases, including hypertension, type 2 diabetes, cardiovascular disease, osteoarthritis and certain types of cancer.

DID YOU KNOW? Three students from College of the North Atlantic's GFW Campus came out on top of the tenth annual Business Case Competition. The team of three will travel to the Middle East in February 2013 to compete against teams from colleges and universities in Qatar.

- In 2006, the number of individuals, between the ages of 18 and 64, who have not completed at least high school in the Central Region was 33.6% compared to 25. 1 per cent of people in the entire province.

- In 2006, the percentage of migrants (5 years and over) within a five year period was 12.4 per cent for the Central Region compared to 14% for the entire province.

Sustainability

Our social, cultural and environmental values are what define us as a people. These factors must be considered when discussing, and making decisions that affect services in the region.

Most people will live where they can work and earn a living, making the creation of new jobs very important. However, when jobs are created, other public services and social support services are needed for the people who work. For example, it is nice to have a high paying job but workers might also need access to daycare, health care and other services for themselves and their families.

Services are important to long term development, or "sustainability" of a region, because they benefit not only the present population but also have the ability to help keep people living happily and healthily where they reside. People who live in rural areas are often concerned about the sustainability of their communities and region, as the changing demographics has resulted in out migration of families and individuals. Changes in services that support individuals are often perceived to impact the sustainability of the community. It is essential to provide the most appropriate, safe and quality services to support citizens in the community while also making the best use of available resources.

Organizational values

Organizations that provide services are governed by values such as the ones listed below:

Collaboration—All stakeholders work together as a team and partner with other providers and organizations to best meet the holistic needs of clients.

Accountability—All stakeholders are responsible to give their absolute best effort to achieve the best service delivery within available resources.

Excellence—Each stakeholder contributes to quality improvement and a culture of safety through development of their knowledge, skills and the use of best practices.

Respect—Each stakeholder is committed to fostering an environment that supports respect, dignity and diversity and encourages honest, effective communication.

Responsible stewardship—Each stakeholder commits to ensure that the right services are provided to the right people in the right place within fiscal allocations.

Applying values to real life

Here are some common values that citizens could use to determine what is of the greatest importance to them when looking at decisions related to any service including the situations described in the next section.

Closeness to Family

In the current economic climate, family often includes friends and neighbours rather than just blood relations. Being close to these supports adds a depth of quality to one's life with regard to support and social interaction. When accessing services closeness to family may be of great value to some people.

Quality

The quality of a service can be determined by examining it in the following ways:

- Effective—based on evidence; results in improvement; based on actual need
- Efficient—avoids waste and makes best use of resources
- Client centered—takes opinions of users into account
- Safe—safe guards against harm to users of the service

When making decisions about services, quality may be of great value to some citizens.

Accessibility

Citizens often consider accessibility when making decisions. Valuing accessibility means putting importance on how timely services are, where they are located and how easy or difficult it is to get the service when you feel it is needed.

Accountability

Valuing accountability is having an expectation that providers will give their best effort to achieve the successful delivery of services based on the assessed needs of the community. It involves clear, open communication between all and a commitment to ensure that the needs of the community are met while maintaining service quality and level of delivery.

8

Applying values to real life

Let's look at the following situations and see how values can be used to make challenging decisions:

Situation 1: Sharron, 79 years old, has experienced a decline in her physical abilities to perform tasks associated with daily living. Her care team, through completion of the provincial home care assessment, has determined that her needs require long-term care. This means that she no longer has the ability to live on her own or at home with the amount of home supports available to her through the Home Care program. At present, she is on an acute care unit in the local hospital in her home-town. Her care requirements can best be met in a long term care home, however the closest available bed and facility is about 2 hours away. The hospital bed she is in is needed for other patients to permit surgery and admission from Emergency. Sharron and her family have been approached regarding temporary transfer to the bed in the facility two hours away until a long term care bed in her home town becomes available. Sharon and her family do not want her to be moved farther away.

Situation 2: At a small, local school, enrolment numbers are dropping. Many parents want to send their children to a larger school in a different town because the larger school offers a fuller curriculum and after-school programming. Other parents are advocating for an upgrade to the small local school and enhancement of the distance learning technology. If moved to the larger school, there would be a minor upgrade required to accommodate the new students and an increase in annual bussing costs. Costs associated with the upgrade to the smaller school, though more, are a one time capital expense.

Questions to ponder:

Imagine you are given the task of deciding if Sharron should move or determining which option was more beneficial to the students.

What would your decision be?

What values did you use to help you come to this decision?

Were there any values that were more important than others in making this decision?

Moving forward

As you can see, sometimes we cannot act on all of our values. Sometimes we have to decide which values are the most important and make our decision based upon those. Sometimes different values might be more important in different situations. In the examples given earlier try thinking about how other values might come into play.

There are many, many different values. So many that we could not possibly list them all. We listed just a few as examples. We want to hear which values you would find most important in making decisions for your local area. There are probably many that we have not mentioned.

We have listed some values that people often use in determining what is important to them. What values are not captured on this list that influence you when you make decisions ?

_____
_____
_____
_____
_____
_____
_____

What three values are most important to you when making decisions as to what services should be available in your local area and why?

1. _____
_____
_____

2._____
_____
_____
_____

3._____
_____
_____
_____

Moving forward

Values are important in creating the basis for a decision making model that allows for different perspectives and concerns to be heard and considered.

What perspectives or concerns do you think should be considered when making decisions?

Acknowledgements

Indicator sources:

1. Compiled by the Community Accounts Unit based on information provided from Statistics Canada
2. Nova Central School District
3. http://www.cna.nl.ca
4. Central Health
5. Government of Canada – List of Designated Educational Institutions – CanLearn.ca
6. Corona College—http://www.coronacollege.com

Appendix F: Ethical approval

Ethics Office
Suite 200, Eastern Trust
Building 95 Bonaventure
Avenue
St. John's, NL
AlB 2X5

January 23, 2013

Mr. Peter Wilton
7 Yellowknife Street
St. John's, NL

Dear Mr.Wilton:

RE: The effectiveness of In-Person and On-Line Public Engagement Methods in Central Newfoundland

This will acknowledge receipt of your correspondence.

This correspondence has been reviewed by the Chair under the direction of the Board. *Full board approval* of this research study is granted for one year effective January 10, 2013. This is to confirm that the Health Research Ethics Board reviewed and approved or acknowledged the following documents (as indicated):

- Revised consent form, dated December 18, 2012
- Questionnaire for on-line survey and focus group participants
- Interview script for interviews with steering committee members

MARK THE DATE

This approval will lapse on January 9, 2014. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the HREB office prior to the renewal date. *The information provided in this form must be current to the time of submission and submitted to HREB not less than 30 nor more than 45 days of the anniversary of your approval date.*

The Ethics Renewal form can be downloaded from the HREB website http://www.hrea.ca.

The Health Research Ethics Board advises THAT IF YOU DO NOT return the completed Ethics Renewal form prior to date of renewal:

- *Your ethics approval will lapse*
- *You will be required to stop research activity immediately*
- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

Lapse in ethics approval may result in interruption or termination of funding

It is your responsibility to seek the necessary approval from the Regional Health Authority or other organization as appropriate.

Modifications of the protocol/consent are not permitted without prior approval from the Health Research Ethics Board. Implementing changes in the protocol/consent without HREB approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HREB website) and submitted to the HREB for review.

This research ethics board (the HREB) has reviewed and approved the research protocol and documentation as noted above for the study which is to be conducted by you as the qualified investigator named above at the specified site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Health Research Ethics Board currently operates according to *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; ICH Guidance £6: Good Clinical Practice* and applicable laws and regulations. The membership of this research ethics board is constituted in compliance with the membership requirements for research ethics boards as defined by *Health Canada Food and Drug Regulations Division 5; Part* C.

Notwithstanding the approval of the HREB, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,

Dr. Fern Brunger
Chair, Non-Clinical Trials
Health Research Ethics Board