



Data  
Discovery  
Better Health



# Community Engagement Pathways Initiative

Best Practices and Recommendations  
for Equity-Centered Engagement

January 2024



# Publication Information

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# Executive Summary

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The following report provides an overview of the current scope of engagement mechanisms with identified underserved populations under the Ministry of Health (MOH) and Ontario Health (OH). This report also provides recommendations for how to strengthen existing pathways and establish future pathways that are equity-centred. Establishing meaningful engagement pathways with underserved populations can improve health equity by allowing people experiencing inequities to influence health system priorities and decision-making.

To inform this work, a comprehensive scoping review of the existing literature on engagement with the public and underserved populations was undertaken, in addition to key informant interviews with stakeholder table representatives affiliated directly or indirectly with the MOH or OH (see note on page 6 on engagement with First Nations, Inuit, Métis and urban Indigenous [FNIMUI] partners). Seventeen studies were included and 27 interviews conducted; the results inform this report, which highlights key recommendations fundamental to successful and equitable engagement with underserved populations, some of which are already in place across certain stakeholder tables. The recommendations are grouped into system-level, process-level and community-specific categories and are summarized in the statements below:

### System-Level Recommendations:

- 1.1: Use specific and transparent language when defining underserved populations and health-related issues.
- 1.2: Prioritize inclusion of communities and intersecting identities that have been underrepresented in existing stakeholder tables.
- 1.3: Prioritize direct engagement through relationship-building with community agencies and individuals.
- 1.4: Emphasize engagement as a key deliverable for portfolios and projects in the MOH and modify processes that may create unintentional barriers to engagement.
- 1.5: Establish sustainable partnerships, resources and dedicated funding to support direct engagement with underserved populations.

### Process-Level Recommendations:

- 2.1: Co-design the purpose, goals and objectives of engagement with underserved populations and prioritize relationship-building from the beginning.
- 2.2: Co-design an engagement plan that includes a compensation approach with underserved populations.
- 2.3: Co-design a comprehensive recruitment plan with underserved populations that considers representation and intersections of identity and avoids tokenism.
- 2.4: Actively involve underserved populations to share or lead decision-making during engagement efforts.
- 2.5: Maintain open and transparent communication and ensure accountability to underserved populations once the engagement pathway is established.
- 2.6: Engage underserved populations in initiatives on decision-making around how their data is collected, interpreted and governed.

### Community-Specific Recommendations:

- 3.1: Consider the unique context of Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual (2SLGBTQIA+) communities.
- 3.2: Consider the unique context of Black communities.
- 3.3: Consider the unique context of Francophone communities.
- 3.4: Consider the unique context of migrant workers.
- 3.5: Consider the unique context of people living with HIV.
- 3.6: Consider the unique context of people living in poverty or unhoused people.
- 3.7: Consider the unique context of people who use drugs.
- 3.8: Consider the unique context of youth.

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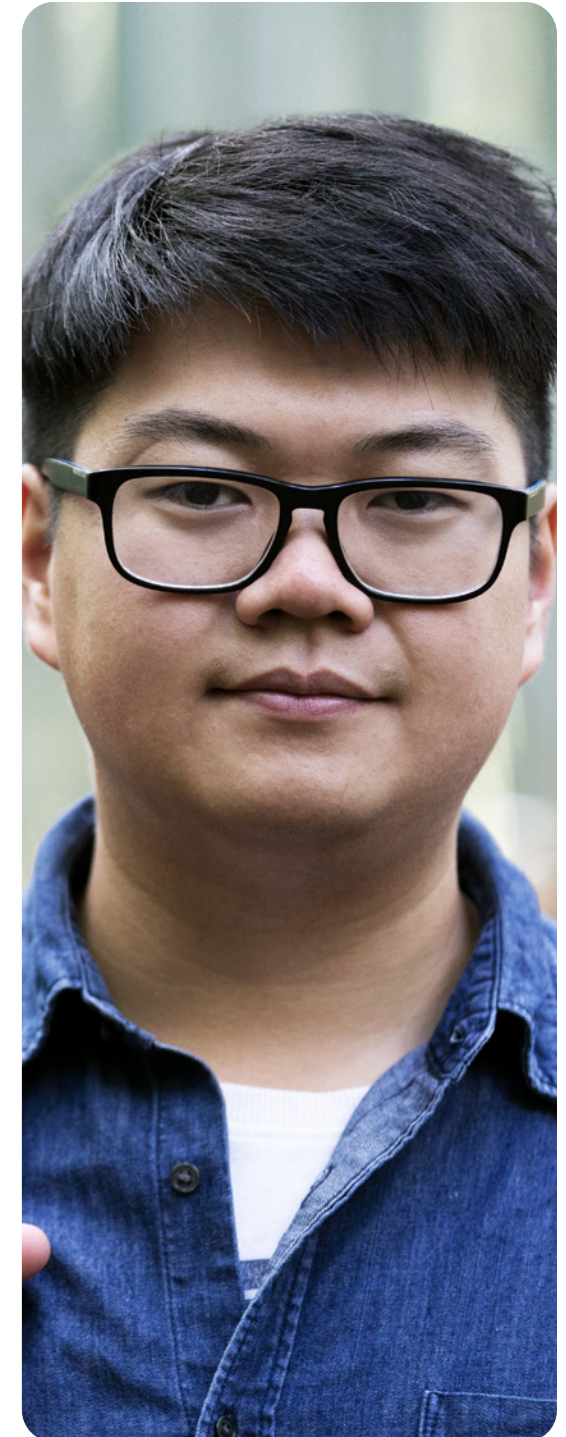
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This report represents a starting point for MOH and OH representatives and other governmental or non-governmental entities to consider when seeking to improve existing engagement pathways or establish new equity-centred pathways. Within this report, a Toolkit provides additional information on tables who were interviewed and tangible resources to guide engagement work. As with any approach to engaging those directly impacted by research or policy, there is no “one-size-fits-all” approach. Each community has unique needs that must be consulted before implementing an engagement strategy. Francophone communities in particular have unique legislative status under the French Language Services Act. In addition, individuals within communities are not all the same and can have multiple intersecting identities that influence their perceptions, experiences and the structural inequities they face. Tailored engagement approaches for intersections of identities across communities are necessary.

The recommendations in this report represent a starting point for engaging with underserved populations. Ultimately, communities themselves should inform the engagement approach and be provided opportunities to do so in their first language. We encourage readers to review the resources to support the implementation of these recommendations that are provided in the [Toolkit](#).

Note: We did not directly interview First Nations, Inuit, Métis and urban Indigenous (FNIMUI) partners through the Community Engagement Pathways Initiative for several reasons; one being that meaningful engagement with FNIMUI partners requires a dedicated approach that fully takes into account the impacts of colonization and historical trauma, and the importance of the dedicated resources, time and capacity-building needed for this work. There is an existing body of knowledge, detailed resources and extensive co-developed work in this area already that should be leveraged by those wanting to engage with FNIMUI partners. We also recognize the resource capacity burden that is placed on partners when conducting consultations for guidelines and reports, which was especially true at the time of this report development. Recommendations for FNIMUI engagement must be co-developed with communities and partners themselves, which we recognize is a limitation in the scope of this work. High-level approaches to engagement with FNIMUI partners and links to existing resources are included in this report. It is also important to note that pre-existing MOH or OH processes and protocols relating to equity, diversity, inclusion (EDI), anti-racism and Indigenous partner engagement must be considered and appropriately incorporated into government entity engagement with communities and partners.



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# Introduction

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**03**

First Nations, Inuit, Métis and  
Urban Indigenous Partners



# Introduction

**Meaningful and equity-centred engagement with underserved populations in policy and research recognizes that community members know best about what they need to be healthy and the solutions to address inequities.** Underserved populations often represent individuals with poorer health outcomes due to inequities they experience, including but not limited to: barriers to services, housing, or adequate income; experiences of racism; discrimination; experiences with colonization; rural location; or a combination of two or more of the above.<sup>1</sup> Historically, underserved populations have been excluded from health research and policy, stigmatized or harmed due to research and policy, and denied access and control of their data. Establishing engagement pathways with underserved populations means improving health equity by enabling people experiencing inequities to influence health system priorities and inform decisions.<sup>2</sup> In addition, meaningful engagement with underserved populations acknowledges the intersections of identities within communities which create complexities in achieving health equity for all. The intersections of race, sex, gender identity, sexual orientation, age, ability, socioeconomic status, culture, language, and other identities require thoughtful and meaningful reflection in policy and research, particularly to understand the impacts on existing structural inequities. The term “underserved populations” is used throughout this report and was chosen to represent the intersecting identities and communities that are inadequately served within our health care system, resulting in unmet health care needs and poor health outcomes.

The Health Equity Policy Unit (HEPU) within the Ontario Ministry of Health (MOH) sought to identify and proactively address equity gaps in the MOH’s existing engagement pathways with underserved populations to improve health equity and establish meaningful engagement with those populations. In addition, the HEPU wanted to understand the challenges and impacts resulting from the COVID-19 pandemic and how these may have impacted engagement pathways, as well as how the MOH should engage communities for collecting, using, governing and reporting on health equity data. To understand how to improve engagement between the MOH and underserved populations, the MOH collaborated with Ontario Health (OH) and ICES to conduct the Community Engagement Pathways Initiative. ICES undertook a two-tiered project with Amplify Engagement to understand the current scope of engagement mechanisms and provide recommendations for future engagement pathways. The project included: 1) a scoping review of best practices for engagement with underserved populations; and 2) key informant interviews with stakeholder table representatives who engage with communities. The scoping review and key informant interviews took place between February and March 2023.

\*For a comprehensive list of essential health equity terms created in consultation with practitioners, key informants, and a literature review, visit the National Collaborating Centre for Determinants of Health [Glossary webpage](#).<sup>3</sup>





01

## Objectives

- To determine what processes can be used to ensure continued, meaningful engagement to fill health equity gaps for underserved populations.
- To understand how underserved populations are currently engaged with the MOH and/or OH and what their level of engagement was during the COVID-19 pandemic.
- To understand what has been working well and what the challenges are for the current engagement mechanisms with underserved populations between the MOH and OH.
- To identify examples of community data advisory and governance structures and processes in which underserved populations govern their health data and/or related decision-making.

02

## Desired Outcomes for Government and Non-Government Entities

Through the implementation of this report's recommendations and [Toolkit](#) of supporting resources, the following outcomes can be supported by both government and non-government entities:

- Better Service Delivery: Improve engagement practices with communities, including through sociodemographic data collection and data governance.
- Alignment with Future Initiatives: Sustain engagement pathways to equip the Ministry to better support current and future initiatives, including the responsible governance of data collection.
- Alignment with Community Priorities: Enhance initiatives to align with the needs of underserved populations to ensure that future initiatives (e.g., sociodemographic data collection) do not perpetuate experiences of harm or stigmatization.



## 03

## First Nations, Inuit, Métis and Urban Indigenous Partners

We did not directly interview First Nations, Inuit, Métis and urban Indigenous (FNIMUI) partners through the Community Engagement Pathways Initiative for several reasons; one being that meaningful engagement with FNIMUI partners requires a dedicated approach that fully takes into account the impacts of colonization and historical trauma, and the importance of dedicated resources, time and capacity-building needed for this work. There is an existing body of knowledge, detailed resources and extensive co-developed work in this area already that should be leveraged by those wanting to engage with FNIMUI partners ([Appendix 1](#)). It is also important to note that pre-existing MOH or OH processes and protocols relating to equity, diversity, inclusion (EDI), anti-racism and Indigenous partner engagement must be considered and appropriately incorporated into government entity engagement with communities and partners. We also recognize the resource capacity burden that is placed on partners when conducting consultations for guidelines and reports, which was especially true at the time of this report development. Recommendations for FNIMUI engagement must be co-developed with communities and partners themselves, which we recognize is a limitation in the scope of this work. To address this limitation, we recommend the following high-level approaches to engagement:

- Prior to beginning any engagement, Indigenous Relationship and Cultural Awareness and Safety training should be completed. Online training is offered through [Ontario Health's Indigenous Relationship and Cultural Awareness courses](#) and [Indigenous Primary Health Care Council Indigenous Cultural Safety training](#).
- FNIMUI partners are distinct and represent diverse communities. It cannot be assumed that engagement for each partner will be the same. There are intersecting identities within each community that must be considered, in addition to the unique contexts of geographic location across Ontario and Canada.
- Prior to beginning any project with a focus on FNIMUI programs, services or partnerships, meaningful engagement should be prioritized and appropriately planned for. Early relationship-building should begin by identifying and connecting with partners to understand if and how they would like to be engaged. Whenever possible, FNIMUI communities should share or lead decision-making and all engagement should be reciprocal, with mutual benefit recognized for partners.
- Direct relationship-building is recommended to identify and connect with relevant partners in your region. It is important to note that those conducting engagement should be aware and appropriately follow the governance processes and structures for the partners they wish to engage. In Ontario, depending on the FNIMUI community, this could be facilitated through, but not limited to:
  - First Nations
  - Tribal Councils
  - Political Territorial Organizations (PTOs)
  - Indigenous Primary Care Organizations (IPCOs, including Aboriginal Health Access Centres [AHACs])
  - The Ontario Federation of Indigenous Friendship Centres (OFIFCs)
  - The Ontario Native Women's Association (ONWA)
  - The Métis Nation of Ontario (MNO)
  - Inuit service providers (e.g., Tungasuvvingat Inuit)

For more information and existing resources that can be referred to on FNIMUI engagement, see [Appendix 1](#).

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# Methodology

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with stakeholder table  
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# Methodology

The methodology for this report included: 1. An Engagement Best Practices Scoping Review and; 2. Key Informant Interviews with Stakeholder Table Representatives. The details of the methodology are described below.

## 01

### Engagement best practices scoping review

The objectives of the best practices scoping review were to understand the following:

1. The extent and type of evidence available about engaging with underserved populations by government and decision-makers.
2. The best practices for engaging underserved populations by government entities in Canada and Internationally.

*The following research question guided the scoping review: What are the best practices for government and decision-makers when engaging with underserved populations to establish meaningful partnerships?*

#### Methods

The Joanna Briggs Institute (JBI) scoping review methodology framework guided this scoping review.<sup>3</sup> It was adopted to review the literature on the engagement best practices for underserved populations in health policy and health system decision-making. The approach also included qualitative thematic analysis of descriptive themes found in the literature.

#### Sources

Two reference databases (PubMed and Google Scholar) were searched for literature published between 2018 and 2023 to identify peer-reviewed syntheses and primary research reports. Three grey literature sources were also searched (The Wellesley Institute,<sup>4</sup> McMaster Forum Evidence Products,<sup>5</sup> and the National Collaborating Centre for Methods and Tools<sup>6</sup>).

#### Search Terms and Search Strategy

The following assumptions were made to clarify the definitions of search terms further:

- “Priority groups,” “vulnerable groups” or “marginalized populations” are used as the overarching terms to include individuals that have poorer health outcomes due to inequities they experience, including barriers to services, housing or adequate income, experiences of racism or discrimination and experiences with colonization or rural location.<sup>1</sup>

- “Community engagement” refers to meaningful and active collaboration based on the five levels of engagement identified by the International Association of Public Participation Framework (IAP2).<sup>7</sup>
- Meaningful partnerships with government and decision-makers can include partnerships established for governance, priority-setting in research and health policy, integration in the research process, knowledge translation and mobilization and evaluation in health policy, health system decision-making and implementation.

A team of three reviewers implemented the final search strategy ([Appendix 2](#)) that commenced in February 2023. First, an initial search and screening of titles and abstracts were conducted simultaneously, and duplicates were removed. Those papers that were not related to the topic at hand were excluded, and only English-language articles were retained. Two reviewers conducted an abstract and full-text review with a third reviewer to resolve conflicts. Inclusion and exclusion criteria can also be found in [Appendix 2](#).

## Data entry and analysis

Three team members compiled the final full-text records from the database search and grey literature search into data extraction tables using Microsoft Excel. For the selected records, the following information was extracted: resource citation, type of resource, the author(s), country, the population of focus, the community that was engaged, type of engagement (research/clinical/government), focus (health care/policy), the goal of the engagement, decision-making scope of the population of focus, level of engagement based on the IAP2 framework,<sup>7</sup> engagement venue (virtual/ in person), engagement strategy or processes, key recommendations. When available, characteristics of the patient engagement frameworks, evaluation processes and findings, limitations and/or barriers to implementing a patient engagement framework or strategy and the impact of patient engagement on policy and decision-making were also included.

The articles were grouped by community to align with the description of key informant interviews. An informal thematic analysis was conducted to extract similar practices, barriers and facilitators to engagement across each population. Articles that described engagement approaches specific to a general audience were also included, as underserved populations may have been grouped as part of that classification.

## 02

# Key informant interviews with stakeholder table representatives

**Amplify Engagement conducted a series of key informant interviews with various stakeholder tables and groups in Ontario to understand the current scope of engagement mechanisms and provide recommendations for future engagement pathways.** Leads, chairs, and/or representatives of 27 tables and groups were interviewed across 22 individual and group interviews. A full list of included tables and their geographic location can be found in [Toolkit Resource 2: Map and Overview of the Stakeholder Tables Interviewed for This Report](#). The rationale for MOH/OH's selection of the chosen tables was based on existing community relationships, deep understanding of health equity, connections to the MOH and OH, and the breadth of geographic reach each table exhibited. Interviews were approximately one hour long and held virtually in February and March 2023. Interviewees were asked about the communities they engage and support, their strengths and weaknesses and where there are gaps in representation and engagement (the interview guide for this work can be found in [Appendix 3](#)). Throughout this document, interviewees are referred to as stakeholder table representatives. It is important to note that the stakeholder table representatives had varying degrees of connection and proximity to the MOH and OH. Some groups were connected with only one government entity,

whereas others were connected to multiple entities. Some groups had little interaction with the MOH and/or OH, while others were directly staffed by these entities. Therefore, the responses represent insights from various perspectives directly and indirectly involved with the MOH or OH.

Communities that were included under the various stakeholder tables and groups, in no particular order, were: children and families, people living with HIV/AIDS, people living with hepatitis C, people experiencing houselessness or who are under-housed, people involved in the correctional system, street-involved youth, 2SLGBTQI+ communities, Francophone communities, sex workers, people who use drugs, Black communities, racialized communities, immigrants and newcomers, international agricultural workers, people living with disabilities, people living with mental illness, populations experiencing income disparity and communities that encompassed multiple populations and identities indicated above.

Existing stakeholder tables affiliated with the Ministry of Health but not included in this report can be found in [Toolkit Resource 3](#). More information on the review process for this report can be found in [Appendix 4](#).

We did not directly interview First Nations, Inuit, Métis and urban Indigenous (FNIMUI) partners through the Community Engagement Pathways Initiative for the reasons listed in the Introduction section. For existing resources to support engagement with FNIMUI partners, see [Appendix 1](#).

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**03**

Other topic areas affecting  
research and policy



# Findings

01

## Engagement best practices scoping review

### Summary of Included Records

The complete yield from the initial title and abstract screening was 104 records ([Appendix 5](#)). Details on each record are included in the data extraction table ([Appendix 6](#)). The final record yield for data extraction and inclusion was 17 (Table 1). Records focused on engagement in 12 different countries (Table 2).

**TABLE 1.** Total records included and the breakdown of study type in the scoping review.

RECORD YIELD = 17 RECORDS	
Synthesis Reviews <sup>8-12</sup>	6
Primary Research Reports <sup>1,13,22,23,14-21,24</sup>	10
Grey Literature Reports <sup>24</sup>	1

**TABLE 2.** Countries that were part of the included studies in the scoping review.

COUNTRIES INCLUDED = 12 ; GLOBAL = 1	
Canada <sup>8,14,16,17,20,23,24</sup>	7
The United Kingdom <sup>10,16,22</sup>	3
The United States <sup>1,15</sup>	2
Australia <sup>10,12,16</sup>	3
Uganda <sup>15</sup>	1
South Africa <sup>21</sup>	1
Thailand <sup>18</sup>	1
India <sup>16</sup>	1
Belgium <sup>11</sup>	1
New Zealand <sup>11</sup>	1
Scotland <sup>16</sup>	1
Sweden <sup>16</sup>	1
Global <sup>9</sup>	1



Engagement processes and the level of engagement achieved (based on the IAP2 Framework<sup>7</sup>) varied on whether the project focused on research or the health system priorities. Four records cited literature reviews, environmental scans and key informant interviews as key precursor activities to inform their subsequent engagement strategies.<sup>1,11,14,17</sup> Six records cited adapted deliberative strategies/processes, including forming advisory groups or steering committees, and hosting consultations, workshops, panels, Citizen’s labs and expert panels to determine public preferences in priority-setting and build consensus between citizens, experts and decision-makers in both research and health system priority-setting.<sup>8,9,11,18, 21,25</sup> Seven records cited collaborative engagement strategies that used a method of co-development and co-implementation of strategies<sup>9,10,16</sup> or participatory co-design<sup>11,13,14,21</sup> to build consensus between stakeholders experts and decision-makers. Two records used strategies aimed at longer-term collaboration with stakeholders,<sup>14,22</sup> and one used feedback loops that involved humble listening, community conversations and co-creative strategies to inform policy creation and implementation.<sup>13</sup>

Populations were grouped according to different criteria: the public, patients, caregivers, families, communities, urban communities, consumers and clients. The definitions for underserved populations varied considerably across each of the records. The findings across all 17 articles are described in three groups: 1) engagement approaches with a general public population; 2) engagement approaches with underserved populations (broadly defined); and 3) engagement approaches with specific subgroups under the underserved populations category.

The engagement processes and main findings for each group have been summarized and presented in the following text.





## Engagement Approaches with the General Public Population

### Engagement Process

Four records used engagement approaches with a broader public population rather than a specifically targeted community.<sup>8,9,11,18</sup> The classification of populations varied considerably: public, patient caregivers, clinicians;<sup>8,9</sup> general vulnerable population;<sup>10</sup> and caregivers of elders.<sup>18</sup> Regarding engagement approaches, all of the included records were undertaken by government/policy-makers<sup>8,9,11</sup> or researchers to improve services.<sup>18</sup> Three of the four records focused on large, national-level strategies<sup>9,11,18</sup> using collaborative approaches with key stakeholders. Decision-making was shared mainly throughout the process,<sup>9,11,18</sup> although the engagements were time-limited. One record described engagement in a complex series of efforts at a larger system and more local clinical levels.<sup>8</sup> The emphasis remained on collaboration, shared decision-making and using specific frameworks and models to guide the approaches.

### Findings

Preparedness before conducting deliberative policy-making engagements and a transparent, public consultation of options between decision-makers and public stakeholders was highlighted as a key theme of successful engagement efforts.<sup>11,18</sup> For policies of national interest, adequate time allocation and the direct involvement of senior members in the policy environment positively impacted the engagement process and outcomes.<sup>11</sup> Three additional studies also highlighted the importance of setting realistic timeframes to achieve meaningful engagement and build community trust.<sup>8,11,18</sup>

Many records addressed the importance of planning who would be engaged in the initiative and what structures allow for meaningful engagement. Two records stressed the importance of early consideration around the appropriate stakeholder for engagement roles, specifically considering how their strengths and responsibility in the community could align with the group.<sup>9,18</sup> One record described how deliberative groups like a citizen's jury could be an effective form of engagement on complex policy issues; however, attention to the group's makeup in terms of size, knowledge and representativeness is key to arriving at relevant decision-making.<sup>18</sup> Comprehensive communication, open, two-way

dialogue and mobilization strategies were also identified as key to improving the accessibility, accuracy, trust and consistency of information received by those engaged and improved transparency and relationships during the engagement process.<sup>8,9</sup> One study also highlighted that strategies focusing on the ethical obligation of engagement (e.g., ensuring individuals understood the process, what their involvement will look like, etc.) could avoid tokenism, address power dynamics, and improve community transparency and trust during the engagement.<sup>8</sup>

All four records<sup>8,9,11,18</sup> emphasized the challenges of linking the impact of the engagement planning processes to the quality of the partnership and the outputs with descriptive feedback alone. Descriptive feedback tended to be less structured and lacked information on adequately integrating public opinion with other forms of evidence. Ideally, descriptive feedback should not be used to establish causal linkages between program successes/operationalization and desired outcomes. Studies recommended the use of formal evaluation frameworks to measure the success of an engagement, in addition to descriptive feedback to reduce bias and address these challenges and gaps in the future.<sup>8,9,11,18</sup>

## Engagement Approaches with Broadly Defined Underserved Populations

### Engagement Process

Seven records identified engagements with broadly defined groups considered underserved, in which specific populations were not engaged separately but as part of a diverse cohort.<sup>1,10,12,13,16,17,24</sup>

It is important to note that studies which included engagement with underserved populations defined these groups in a variety of ways, with no one consistent definition or categorization. Communities engaged included:

- Black communities<sup>1,13,24</sup>
- Racialized communities<sup>1,10,24</sup>
- Immigrant communities<sup>1,10,12,13,24</sup>
- Youth and families<sup>10,16,17</sup>
- People living with mental health conditions<sup>16,24</sup>
- People experiencing poverty or living in under-resourced neighbourhoods<sup>1,10,16,24</sup>
- People living in rural areas<sup>1,10</sup>

A key prerequisite to engagement was a focus on relationship-building to forge and sustain relationships over time.<sup>10,12,13</sup> Tailoring engagement to the unique context of a particular community, including acknowledging specific historical harms, also contributed to building relationships.<sup>10,13</sup> Many engagements included co-designed processes<sup>1,10,12,13,16,17,24</sup> or shared decision-making,<sup>1,10,12,13,16,24</sup> and some relinquished final decision-making power to communities.<sup>10,17</sup>

### Findings

Although challenges with participant recruitment were described as a barrier in one case,<sup>16</sup> cases with the most effective recruitment used targeted mechanisms<sup>1,12,24</sup> that considered inclusion across different intersections of identity<sup>1,24</sup> or were based on previously established frameworks.<sup>12</sup> Even when participants share some facets of identity, communities are never a monolith: intersectionality should be considered during recruitment,<sup>12,17</sup> and divergence in opinion should be expected.<sup>1,10</sup>

A commonly identified barrier to engagement related to communication challenges,<sup>13,16</sup> but several facilitative elements were noted to mitigate these challenges:

- Interpreter services<sup>12</sup>
- Orientation and preparatory material for both participants and staff<sup>12</sup>
- Transparent expectations (sometimes outlined in formal agreements to hold organizations accountable)<sup>12,16</sup>

One author highlighted a communication wall between the staff facilitating engagements and the participants who were engaged when the demographics and lived experiences of staff were vastly different from participants.<sup>24</sup> Facilitative elements that mitigated this included:

- Community co-leadership<sup>12,16,17</sup>
- An anti-siloed (inter-organizational) approach<sup>24</sup>
- Trust built from pre-existing, sustained relationships<sup>1,12,16,24</sup>

Other identified barriers related to a lack of flexibility in organizational processes:

- Limited internal resources and time devoted to engagement<sup>1,10</sup>
- Status-quo decision-making (i.e., unequal power and/or tokenism)<sup>1,16,17</sup>

These barriers were minimized when organizational buy-in (including building accountability into strategic planning documents) led to dedicated financial resources for staff time and participant compensation and improved responsiveness to participant-identified concerns.<sup>12,16,17,24</sup>

## Engagement Approaches with Specific Subgroups of Underserved Populations

### People living with chronic health conditions

#### Engagement Process

Two unique studies (described in three articles) were found that engaged people living with specific chronic health conditions who also experienced structural marginalization and stigma. Both were Canadian examples: one pertained to local-level program delivery with people living with HIV,<sup>19,20</sup> and the other pertained to a national-level policy with people living with autism.<sup>14</sup> Both engagements included shared decision-making throughout the process among professionals, community organizations and people with lived experience. Engagement approaches incorporated opportunities for longer-term engagement (a Community-Based Participatory Research model<sup>19,20</sup> and a Community of Practice approach<sup>14</sup>).

#### Findings

Tailoring and adapting processes and tools to the unique needs of the participants was noted as a key

success factor.<sup>14,19,20</sup> Unique community needs may be best identified by a team of community members hired into “peer” staff roles.<sup>19,20</sup> This may include the co-development of a Terms of Reference document and capacity-building sessions responsive to identified needs.<sup>14</sup>

It is also critical to ensure people can participate on their terms, regardless of the engagement approach.<sup>19,20</sup> For example, by viewing nonparticipation through the lens of self-determination, the importance is made clear of creating fluid entry points for meaningful participation that accommodate people’s interests, desires and needs.<sup>19,20</sup> Accessibility must also be viewed through an intersectional lens: age, race, Indigeneity, gender identity, sexual orientation, class, drug use, citizenship, HIV status, language and disability uniquely intersect to contour people’s experiences.<sup>19,20</sup>

### People experiencing poverty

#### Engagement Process

Two records were identified that engaged people experiencing poverty: one in a rural jurisdiction in South Africa<sup>21</sup> and one in a large, urban community in Canada.<sup>23</sup> Both paired deliberation with shared decision-making and elicited feedback from participants. One relinquished decision-making power to the community by firmly committing to immediately implement the actions on which participants reached consensus.<sup>23</sup>

#### Findings

In both studies, participants were recruited purposively and face-to-face by service providers familiar with and trusted by the community.<sup>21,23</sup> One study also involved a co-planner with lived experience in recruitment.<sup>23</sup>

Both emphasized the importance of context-specific engagement processes geared to generate context-specific solutions.<sup>21,23</sup> One achieved this via co-designing all processes with participants,<sup>23</sup> while the other completed analysis of local policy, consulted with local professionals and translated all materials into the local language.<sup>21</sup>

Engagement approaches found to be helpful included issue briefs and orientation sessions before the engagement, the use of trained facilitators and iterative consensus-based decision-making.<sup>21,23</sup> Quick, actionable solutions that demonstrated change and improvement were also identified as necessary to maintain their community’s participation, support and trust (particularly in the context of pre-existing over-researched fatigue).<sup>23</sup>

## Women

### Engagement Process

Two records were identified that engaged women and both considered intersecting axes of oppression (such as ethnicity, sexuality, disability, age, migrant status, incarceration, education status, rurality, employment status and houselessness).<sup>15,22</sup> One record described engagement in government health system priority-setting, where facilitators elicited feedback from women (but did not include them in decision-making).<sup>15</sup> The other described engagement in clinical commissioning groups and included elements of shared decision-making.<sup>22</sup>

### Findings

Intersectional community representation was noted as a challenge, with the community workers who serve underserved populations often acting to represent community needs despite being a step removed from the source.<sup>22</sup> The authors emphasized that organizations should be sensitive to the 'informal impediments' that marginalized groups face, where certain modes of speech — particularly classed, gendered, and racialized — are ignored within the context of official public spheres.<sup>22</sup>

Several barriers to engagement were identified,<sup>15</sup> including:

- Financial (lack of compensation and reimbursement)
- Biomedical (illness, disability or experiencing menstruation)
- English language literacy
- Motivational (lack of information about opportunities to participate, lack of feedback or competing commitments)
- Sociocultural (deemphasized role of women in decision-making)
- Structural (poverty)

A concerted and strategic effort to proactively go to communities (rather than passively expecting people to come to organizations) may aid in recruitment of diverse voices.<sup>22</sup> However, some terms used during recruitment and planning, such as 'seldom heard' and 'hard-to-reach', may create unintentional barriers or be considered problematic by potential participants, as they imply that blame lies with individuals and communities rather than organizations and structures.<sup>22</sup>



## Key Informant Interviews with Stakeholder Table Representatives

### Summary of Equitable Engagement Feedback

Stakeholder table representatives shared their perspectives on various issues related to their work with underserved populations. Key discussion areas included the strengths and challenges of their current approach, recommendations for improvements when engaging communities and impacts of the COVID-19 pandemic. The findings from these discussions are summarized into the key themes of strengths, challenges and/or areas to improve, gaps in representation and other topic areas affecting research and policy.

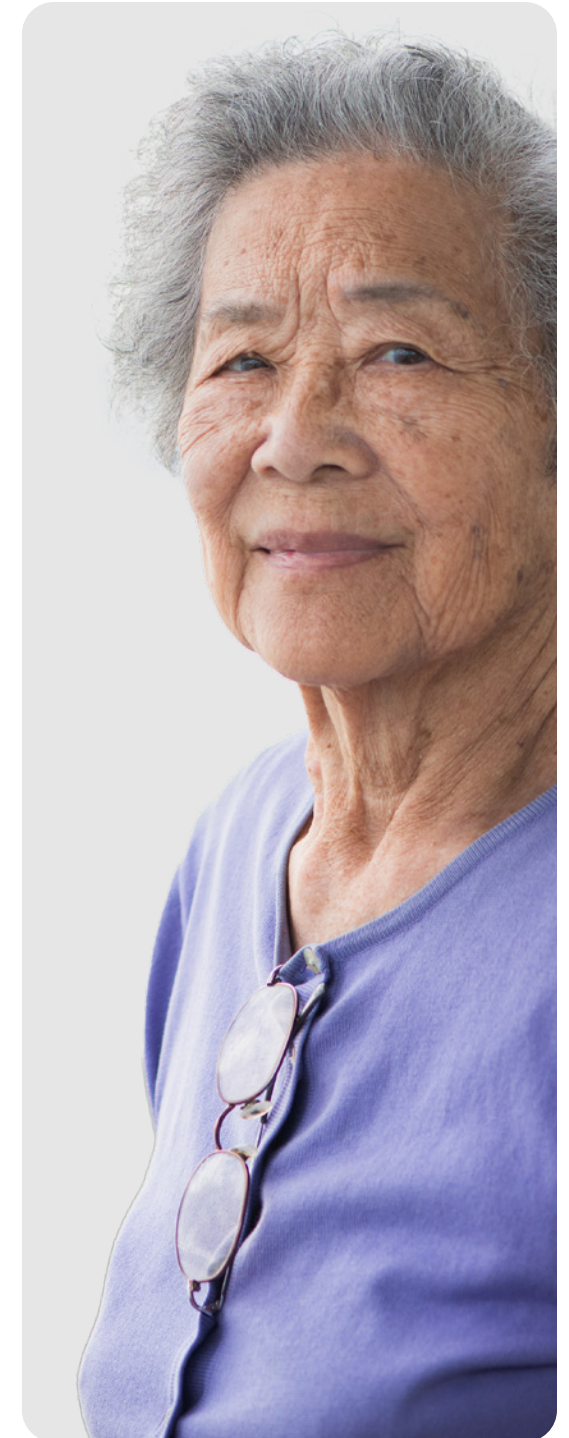
#### Strengths in current approaches

**Including and Empowering Communities to Lead at Decision Tables:** Stakeholder table representatives spoke about aspects of their work that have proven successful in their engagement efforts. One key approach often emphasized was when a table was led by or co-led with community organizations alongside government representatives. Many tables said they were successful because they included varied methods of participation (e.g., online, in-person, allowing folks to contribute in ways that work best for them), direct involvement with individuals with lived experience and community groups and included allied health professionals relevant to the work such as physicians, public health labs, health care workers and settlement organizations. Tables with community leaders had strong relationships and communication pathways, allowing for faster response and mobilization of programs/services and an understanding of existing limitations.

**Compensation and Support for Community Expertise:** Tables that discussed their successful partnerships with communities also emphasized that they financially compensated their community representatives to remove barriers to participation. This was a key component of having individuals feel valued and empowered.

#### Further examples of how to support community leadership included:

- Hiring community ambassadors to build relationships and gain information on the local context
- Giving funding directly to Indigenous communities to deliver the programming
- Providing support to facilitate leadership (e.g., education, career planning, Equity, Diversity and Inclusion [EDI] training, management training)
- Hiring a planner or coordinator who is a community member
- Designating an internal government staff member to help support navigation and resourcing
- Requiring community representation to co-design programs and services that impact them
- Compensating community representatives fairly



## Challenges and Areas for Improvement

**Avoid Tokenism and Recruit Broadly:** Some stakeholder table representatives identified the ongoing need for more support to avoid tokenism on their tables. Stakeholder table representatives spoke about the importance of having the means to recruit multiple people with lived experience to avoid tokenism on a table and to avoid undue pressure on one individual to represent the values of a whole community. Tokenism can also be caused by only having one avenue of engagement for a community, for example, one Black health advisory group. These single pathways should not exempt efforts to have community voices across other equity-related engagement mechanisms.

**Exercise Reciprocity Not Extraction:** An identified area for improvement with MOH and OH engagement pathways was more demonstrated consideration of mutual benefit. When establishing engagement pathways, community members may only be told about the government project and not informed about what communities will get out of the process. Engagement can be extractive, where governments expect communities to come to them and help achieve their internal mandates. Communities are expected to share their stories to change the system, but institutions and governments are not expected to do the same. Government and non-government entities should be expected to make themselves vulnerable and analyze their flaws to establish meaningful engagement. There should also be a clear expectation to share the results of consultations with communities and any resulting plans to address the consultation feedback.

## Recognize Trauma and Emotional Burden:

An identified challenge of engaging with underserved populations was the emotional burden these efforts could place on individuals. Conversations may be triggering or traumatic when discussing inequity, discrimination and systemic oppression. Stakeholder table representatives recognized the importance of providing space for participants to engage in self-care, acknowledge trauma and manage triggers. People entering equity discussions are often in “fight” mode based on trauma experience and are actively dealing with issues that they are speaking about. Trauma-informed approaches and safe environments are necessary, as well as a specific focus on building trust to allow individuals to work through their trauma to participate effectively. Communities are also put in a position where they must continuously advocate, educate and request resources, which requires a significant amount of energy. Be mindful of the psychological and emotional toll of doing equity work and the burden on community members to push systemic change forward continuously.

## Provide Adequate Resources and Compensation:

Proper funding and resources (e.g., staff) were identified as critical areas of improvement for sustaining engagement pathways. Continuous funding and support are needed to advocate, maintain community relationships and support actionable change. Political climates can drastically impact funding streams, and considerations should be made to avoid funding fluctuation when government and leadership change. Compensation for community members

must also be provided to honour and respect the time and expertise of those involved. Stakeholder table representatives suggested different compensation methods, including hourly rates, gift cards and meals. Beyond direct compensation, barriers to participation should also be removed, e.g., providing or reimbursing childcare, transportation or language services.

## Maintain Open, Transparent Communication:

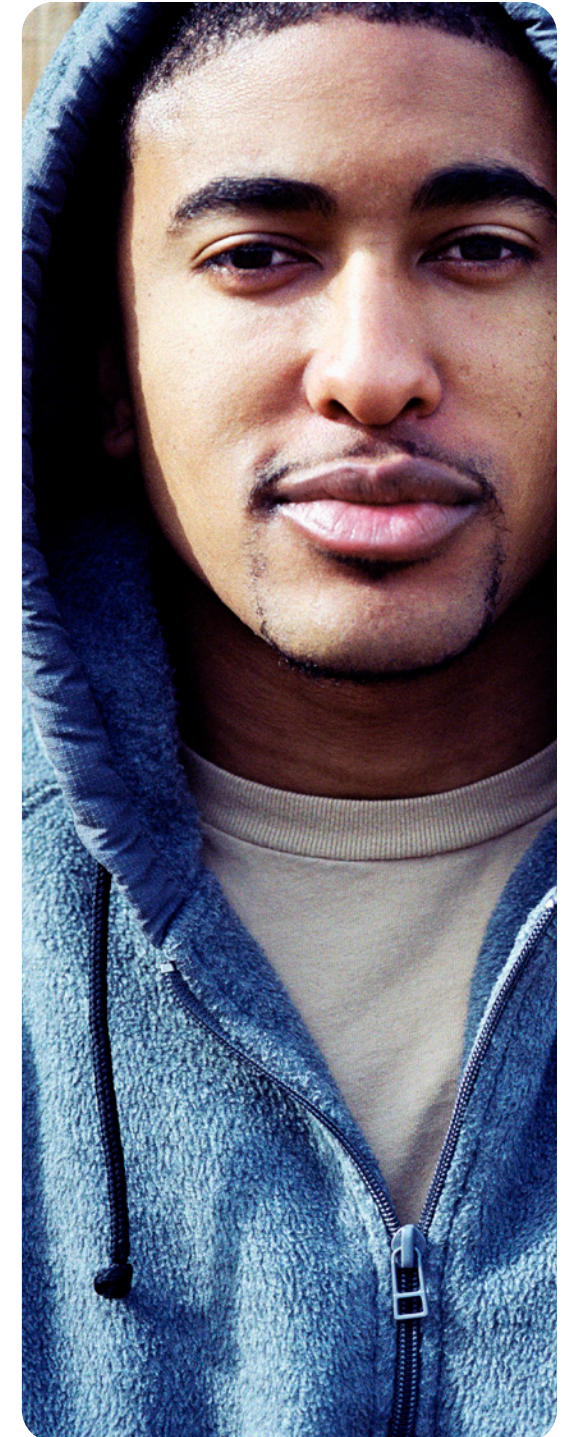
Transparency is essential to maintain trust with communities and was another identified area of improvement. Transparency includes sharing what was discussed and where that information was used. It also includes considering the community’s interests and keeping them informed as projects develop or changes are made. Transparency around terminology is also critical. When doing engagement, the word “community” is so often used in a way that does not specifically define any group. A definition of what “the community” means and who is represented should be provided whenever possible. Furthermore, “community leaders” are often self-selected by the community or have direct involvement through their employment, but there is not always agreement that they best represent the community’s voice.

## Gaps in representation

Several stakeholder table representatives expressed that underserved populations are not actively engaged or well-represented in governmental work. From their perspectives, there were several communities/individuals who were often missing in both their local efforts on their tables and from broader engagement initiatives they have witnessed. Stakeholder table representatives suggested that the MOH and OH should work towards further engagement with certain communities and organizations who may often be missing from tables by actively networking and lowering barriers to their involvement. The relevancy and needs of specific communities and organizations should be carefully and meaningfully considered on a case-by-case basis, as the table below (Table 3) only represents those that were mentioned during key informant interviews. The list below is in no particular order and is not exhaustive. It is meant to reflect groups that stakeholder table representatives have found missing from their tables (when/if relevant).

**TABLE 3.** Gaps in Representation Within Existing Tables

COMMUNITIES/INDIVIDUALS	
FNIMUI communities	People who do not have access to health care
Francophone communities	Two-Spirit individuals
People who speak English as a second language	Youth
Rural and remote communities	People who use drugs or are living with addiction and intersecting identities within this community (e.g., 2SLGBTQIA+ individuals)
New immigrants and newcomers	People living in poverty
People living with disabilities	People who are unhoused/have unstable housing
ORGANIZATIONS	
Settlement agencies	Food banks/community kitchens
Religious institutions	Grassroots activist organizations



03

## Other Topic Areas Affecting Research and Policy

**During key informant interviews with stakeholder table representatives, two additional topics were discussed with participants that have a larger impact on governmental work.** These areas were: the impact of COVID-19 on engagement efforts and community-led data governance. Although not directly related to engagement pathways with the MOH and OH, these discussion topics highlight the important nuances regarding issues affecting research and policy for underserved populations.

### Impact of COVID-19 on Engagement

Stakeholder table representatives discussed if and how the COVID-19 pandemic impacted their engagement with communities. Many tables expressed that the pandemic resulted in both negative and positive impacts on their approach and ability to engage their respective communities.

#### Positive Impacts:

- The COVID-19 pandemic showed a clear view of systemic and structural issues and demonstrated where inequity exists.
- Many stakeholder tables were created as a direct result of urgent COVID-19 priorities. This resulted in a strong equity and community-focused approach, accelerated the maturity of many tables and resulted in the representation of community partners directly at discussion tables.
- The pandemic also encouraged a transition to virtual meetings, collaborative approaches and increased access to data.

#### Negative Impacts:

- Stakeholder table representatives noted that the COVID-19 pandemic disproportionately affected underserved populations, and community outbreaks led to increased overt racist behaviour and acts of discrimination.
- The pandemic initially caused an overall decrease in engagement due to lockdowns, resulting in some areas losing momentum.
- Both communities and staff experienced significant burnout, and stakeholder tables found it more challenging to involve people with lived experience, particularly the elderly.

#### Sustainability Beyond the Pandemic:

- Stakeholder table representatives expressed hope that the lessons learned and novel approaches implemented continue beyond the pandemic.
- Some tables are considering their future roles and opportunities for continued engagement.
- Communities called for sustained dedication to equity, diversity and inclusion and a commitment to supporting the health of underserved populations.





## Community-Led Governance of Data

Stakeholder table representatives also discussed how the MOH should engage underserved populations in collecting, using, governing and reporting health equity data, specifically data on their communities. A number of themes emerged that the MOH should consider when collecting, using and reporting community data, including considering a community-led data governance approach in the future. The following section uses the word “data” in place of “health equity data” for simplicity. For more information on considerations for engaging with specific populations on collecting, using and reporting their data, see [Appendix 7](#).

### Data Collection and Trust:

- Communities are sensitive to being asked for and providing equity-based data due to many historical contexts of data being weaponized against them and causing harm.
- Community needs should be considered in what data is collected, why that data is collected and the associated risks. This is especially true for those who use the health system frequently and whose frequent data collection can have implications for future service delivery.

- During new data collection, it is important to train data abstractors on how to talk to people who are sensitive about giving equity information. Ideally, people from the community should be involved in data collection, and partnerships with community health centres that already have relationships with communities to collect the data should be leveraged to foster trust.
- The MOH should engage directly with communities to build and rebuild trust from the long ongoing history of data causing harm. The MOH should consider co-designing a plan to engage members with lived experience around the governance of data with communities.

### Education and Transparency:

- Before providing opportunities for engagement or co-design, the MOH should share information with community members on the benefits and risks of data collection and use.
- The MOH should engage people impacted by data use in an effort to explain the data, where it is going, what it can be used for and its implications.
- Case examples can help to provide concrete examples, and information-sharing and transparency of the process are important to build trust before starting any consultation.

### Data Access and Interpretation:

- Community access to their own data should be a key principle.
- Maintaining privacy is essential while releasing access and control to communities for governance.
- Creating clear standards and parameters for what data will be used when establishing any governance process will be necessary. Communities should also be able to provide input into interpreting their data and identifying issues and risks.

\* Although community-led data governance is mentioned here in the context of many underserved populations, there is extensive work in the area of Indigenous data sovereignty with FNMIUI. The First Nations principles of OCAP® (ownership, control, access, and possession) asserts that First Nations own their information and that they are stewards of their data. More information can be found on the [OCAP® website](#).<sup>29</sup>

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**03**

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# Recommendations

The following recommendations describe best practices for engaging with underserved populations and are an amalgamation of what was identified in the scoping review and by the key informant interviews. It is important to note that there is no “one-size-fits-all” approach to engagement pathways.

Each community has unique needs and must be consulted before implementing an engagement strategy. Communities should also be provided the opportunity to engage in their first language in order to remove unnecessary barriers to full participation. The recommendations below are a starting point for MOH and OH representatives and other governmental or non-governmental entities to consider when seeking to improve existing engagement pathways or establish equity-centred pathways. In addition, individuals within communities are not all the same and can have multiple intersections of identities that influence their perceptions, experiences and structural inequities. Tailored engagement approaches for intersections of identities across communities are necessary.

The recommendations are divided into: 1) those that are **system-level**, with a focus on governmental structural changes based on direct feedback and comments from key informant interviews; 2) those that are **process-level**, with a focus on engagement with any population; and 3) those that are **community-specific** to the unique needs of certain underserved populations. Recommendations are summarized below, followed by more detailed explanations of each:

## System-Level Recommendations

- [1.1: Use specific and transparent language](#) when defining underserved populations and health-related issues.
- [1.2: Prioritize inclusion of communities and intersecting identities](#) that have been underrepresented in existing tables.
- [1.3: Prioritize direct engagement](#) through relationship-building with community agencies and individuals.
- [1.4: Emphasize engagement as a key deliverable](#) for portfolios and projects in the Ministry and modify processes that may create unintentional barriers to engagement.
- [1.5: Establish sustainable partnerships,](#) resources and dedicated funding to support direct engagement with underserved populations.

## Process-Level Recommendations

- [2.1: Co-design the purpose, goals and objectives](#) of engagement with underserved populations and prioritize relationship-building from the beginning.
- [2.2: Co-design an engagement plan](#) that includes a compensation approach with underserved populations.
- [2.3: Co-design a comprehensive recruitment plan](#) with underserved populations that considers representation and intersections of identity and avoids tokenism.
- 2.4: Actively involve underserved populations [to share or lead decision-making](#) during engagement efforts.
- [2.5: Maintain open and transparent communication](#) and ensure accountability to underserved populations once the engagement pathway is established.
- 2.6: Engage underserved populations in initiatives on decision-making around [how their data is collected, interpreted and governed.](#)

## Community-Specific Recommendations

- 3.1: Consider the unique context of Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual ([2SLGBTQIA+](#)) [communities.](#)
- 3.2: Consider the unique context of [Black communities.](#)
- 3.3: Consider the unique context of [Francophone communities.](#)
- 3.4: Consider the unique context of [migrant workers.](#)
- 3.5: Consider the unique context of [people living with HIV.](#)
- 3.6: Consider the unique context of [people living in poverty or unhoused people.](#)
- 3.7: Consider the unique context of [people who use drugs.](#)
- 3.8: Consider the unique context of [youth.](#)

## System-Level Recommendations

Through the key informant interviews, recommendations emerged specifically for the government to consider from a broader system level. The stakeholder table representatives had varying degrees of connection and proximity to the MOH or OH. Some groups are connected with only one government entity, whereas others are connected to multiple entities. However, the feedback generally applies to both entities when developing processes for engaging with communities. Resources to help implement these recommendations can be found in [Toolkit Resource 1: A Guide to Supporting Equity-Centred Engagement \(A Modified Version of McMaster’s Step-by-Step Guide\)](#).

### **RECOMMENDATION 1.1: Use specific and transparent language when defining underserved populations and health-related issues.**

Stakeholder table representatives recommended that the Ministry should clearly define their terminology of “underserved populations” for both internal and external communication. Defining underserved populations should, in part, be tied to data where feasible to assess the impact of policies and engagement as a means of improving policies over time. Terms like underserved populations that convey inequitable systems and structures rather than placing blame on communities themselves are preferred as long as the intended communities are clearly defined. Clarity and transparency would also be beneficial for describing how and why these terms are chosen. It was also recommended to clarify the definition of health and health-related issues to engage communities not currently included because the services they provide are not seen as part of health care. An example expressed by stakeholder tables was food security, which is often seen as a social service issue. Therefore, groups like food banks and community kitchens are not engaged despite their profound impact on health.

**Implementation resources:** [Step 1. Prepare: Seek to deeply understand “equity” and related concepts.](#)

### **RECOMMENDATION 1.2: Prioritize inclusion of communities and intersecting identities that have been underrepresented in existing tables.**

Several stakeholder table representatives expressed that certain underserved populations are not actively engaged or well-represented in governmental work. From their perspectives, there were several communities/individuals who were often missing in both local efforts on their tables and from other engagement initiatives they have witnessed. Some tables also have broad communities of focus, making it challenging to focus on any one area and ensure multiple identities are included. Underserved communities often encompass many intersecting identities, and efforts for inclusion should consider not only the underserved population of interest but also the diversity across that community and how that may impact programs and services (e.g., considering diversity in gender, race, ability, language, geographic location, etc.). The following list is not meant to be exhaustive or represent every subgroup that should be included in every engagement effort. Rather, the MOH and OH should consider working with existing tables to

prioritize which voices are missing and applicable to their efforts and/or may require new tables to ensure their representation is not diluted or overlooked. The underrepresented communities identified include:

- FNIMUI communities
- Francophone communities
- People who speak English as a second language
- Rural and remote communities
- New immigrants and newcomers
- People living with disabilities
- People who do not have access to health care
- Two-Spirit individuals
- Youth
- People who use drugs or are living with addiction and intersecting identities within this community (e.g., 2SLGBTQIA+ individuals)
- People living in poverty
- People who are unhoused/have unstable housing

**Implementation resources:** [Step 2. Plan: Establish and understand who you want to engage and why.](#)

**RECOMMENDATION 1.3: Prioritize direct engagement through relationship-building with community agencies and individuals.**

The Ministry should consider having more direct representation and engagement with community members at their tables. Many stakeholder tables engage service providers, agencies and community organizations who share what they witness in the community, but ultimately, they are not the direct voice of the community and can only provide information that is one step removed from those they serve. There should also be evidence informing the rationale for choosing certain communities to be directly engaged with by the MOH or OH. This is to ensure the goal of engagement is tied to outcome data and health system improvement for the communities. Direct engagement by the MOH or OH should include a visible presence of a designated contact person at meetings and a willingness to be part of the engagement through multiple touch points, ongoing updates and transparency in work. The MOH and OH can directly engage with community members by actively building relationships with those with lived experience or organizational representatives that work with these populations that may or may not be system-level providers (e.g., a peer support worker). The presence of the MOH or OH as an equal player at the table (e.g., having a point person from the MOH or OH be available to connect with) was recommended to help facilitate connections, visible commitment to changing the health system, advocacy with other ministries, and senior-level discussions to move actions forward. Having the MOH or OH actively partnering through face-to-face engagement (e.g., “live” engagement,

whether virtually or in-person) was also recommended to establish stronger relationships with communities and was preferred over one-way email communication or indirect communication on a periodic basis. When designing best practices for engaging communities in their project plans, the Ministry should intentionally consult with communities on their needs, preferences and concerns. In cases where there may not be an opportunity to engage community members directly, the MOH should consider listening in on other engagement sessions or recordings to hear community input firsthand.

**Implementation resources:** [Step 3. Connect: Establish trust and build meaningful relationships.](#)

**RECOMMENDATION 1.4: Emphasize engagement as a key deliverable for portfolios and projects in the Ministry and modify processes that may create unintentional barriers to engagement.**

Engagement should be a key deliverable when Ministry portfolios develop programs or projects. Program teams should naturally consider how engagement fits into their project plan and add it as a milestone to consult with relevant underserved populations. Engagement should also be considered at the onset of program or project development to ensure that an existing table is identified that represents the underserved population of interest appropriately or that a new table is created. Planning for engagement at the onset for a program or project development is critical to ensure community feedback can be adequately considered and meaningfully incorporated in all aspects of the initiative. Community feedback must be gathered early while programs, policies and services are still

being developed and can be influenced. However, MOH or OH processes can unintentionally impact and slow the ability to recruit, conduct engagements and implement solutions early in the initiative. For example, recruitment to fill diversity gaps relies on the collection of demographic data to ensure there is representation across communities and identities. However, some tables have encountered barriers to achieving representativeness due to privacy policies that limit the ability to collect demographic information during recruitment. Other process barriers can include a lack of compensation or resourcing for those who are engaged, which can create unintentional barriers to consistent participation from community members or organizations. Barriers may look different for each community, and the MOH or OH should have channels (e.g., though periodic update meetings or email check-ins) to gather open feedback from stakeholder tables and/or engaged community members on potential barriers that result from existing Ministry processes. Feedback should be gathered (either formally or informally) with the intention to consider flexibility and modifications to limiting processes encountered when planning for engagement to ultimately improve a table’s ability to push for and impact change.

**Implementation resources:** [Step 3. Identify and eliminate barriers to engagement.](#)

**RECOMMENDATION 1.5: Establish sustainable partnerships, resources and dedicated funding to support direct engagement with underserved populations.**

Many stakeholder tables had limited connectivity with the MOH or OH and were recommending

more formal partnerships with sustainable support. This mirrored what tables with strong engagement and connectivity were emphasizing, which is that they had adequate resourcing, support and compensation for their programs and services. Many stakeholder tables emphasized that the MOH or OH should consider fostering relationships with underserved populations beyond the lifecycle of one project or initiative. For example, after engaging with a community on a specific project, the MOH or OH could establish ongoing opportunities for feedback or continued engagement with stakeholder tables and community members (e.g., town halls, periodic updates or follow-up on progress, annual meetings, etc.). It was also recommended that the Ministry provide more resources and dedicated funding for community partners, staff and time to support building and maintaining engagement. The sustainability of programs for underserved populations depends on resources and funding, and service delivery organizations and self-run tables do not have the capacity, funding or extra staff to continue the work and put programs into action. Self-run tables, those that are not funded, facilitated or compensated directly by government or non-government entities, often rely on partners and agencies to advance action items or overstretch their staff beyond their existing work. Inconsistent funding also results in hired community staff running these engagements leaving their roles due to financial uncertainty, and often the valuable relationships with communities are lost.

**Implementation resources:** [Step 5. Sustain: Maintain relationships and continue to build trust.](#)

02

## Process-Level Recommendations

The following recommendations were developed based on findings from the key informant interviews on general best practices for engaging with underserved populations and evidence synthesized from the scoping review. For a detailed list of all best practices in the engagement process identified by the stakeholder table representatives, see [Toolkit Resource 4: Engagement Process Questions and Best Practices](#). Resources to help implement these recommendations can be found in [Toolkit Resource 1: A Guide to Supporting Equity-Centered Engagement](#) (A Modified Version of McMaster’s Step-by-Step Guide).

**RECOMMENDATION 2.1: Co-design the purpose, goals and objectives of engagement with underserved populations and prioritize relationship-building from the beginning.**

Before formally beginning any engagement, a detailed plan should be created to guide the purpose, goals and objectives of engagement for the MOH or OH, and how the MOH or OH will establish meaningful relationships with communities that maintain accountability for the goals and objectives of the work. The purpose, goals and objectives should be written with the needs of the community in mind and an understanding of how the initiative can create mutual benefits. Ideally, the government or non-government entity undertaking the engagement should write this plan and collaborate with stakeholder tables and community members for feedback (e.g., co-design) as part of relationship-building and commitment to accountability. Part of this review process can also help to identify if there are already existing community-led engagements being undertaken (e.g., a consultation process, focus groups, ongoing advisory council, etc.) that already addresses the MOH or OH purpose or goals. If so, rather

than duplicating efforts, the MOH or OH should consider collaboration and providing resource/funding support for the existing community-led engagement to support reciprocal efforts. Stakeholder table representatives emphasized the importance of establishing meaningful relationships before beginning a formal engagement and acknowledging the emotional burden that engagement can sometimes place on communities. Relationships take time, but trust can be demonstrated to a community through an ongoing commitment to sustainable partnerships, continued funding and resources and establishing a safe space for discussing difficult topics and providing feedback. A safe space will look different depending on each community and the MOH, OH or any non-government entity leading the engagement must take the time to understand specific nuances from communities themselves. Initial considerations are included in the community-specific recommendations (3.1–3.8).

**Implementation resources:** [Step 2. Plan: Proactively and collaboratively set goals.](#)

**RECOMMENDATION 2.2: Co-design an engagement plan that includes a compensation approach with underserved populations.**

Similar to the creation of the engagement purpose and goals, a detailed engagement plan should be drafted by the MOH or OH (or non-government entity) and reviewed with community members (i.e., co-designed) to ensure alignment and mutual benefit. An engagement plan outlines all the steps of the engagement, including who will be engaged and how. Several studies noted the importance of planning and outlining an engagement plan well before beginning recruitment, especially in collaboration with underserved populations. Important areas to address in the engagement plan, particularly if assembling or working with a new stakeholder table, include things like how long the group will be assembled, whether membership will be open or closed after recruitment, how many members there will be, and how an equitable lens will be used throughout the work (e.g., planning for multiple modes of engagement that can allow for contribution both inside and outside a meeting space can help meet people where they are at). There are no right or wrong approaches in size, preexisting knowledge or membership structure, but the context of the engagement and community interests should inform these decisions. Another key area of the engagement plan emphasized by the literature and key informant interviews was a compensation approach for those included in the stakeholder table and/or engagement. Those being engaged should be compensated by the government or non-government agency leading this work. Compensation was identified as important to

support equitable participation by all individuals included in the engagement (e.g., covering not only time in meetings but structural barriers like childcare, language interpretation services, transportation, etc.). Compensation forms (e.g., gift card, cash, direct deposit, etc.) should be discussed with community members, as there are implications for taxes and other sensitivities with paying via direct deposit or cheque (e.g., individual may not have a fixed address, bank account, etc.). Additionally, budgeting for dedicated staff or co-leadership with community members to facilitate ongoing engagement was considered crucial to engagement sustainability.

**Implementation resources:** [Step 1. Prepare: Recognize the importance of equity-centred approaches.](#)

**RECOMMENDATION 2.3: Co-design a comprehensive recruitment plan with underserved populations that considers representation and intersections of identity and avoids tokenism.**

A recruitment plan written by the MOH, OH or non-government entity planning for a new engagement requires careful consideration to ensure it will adequately reach an underserved population, as well as the intersections of identity within that population. As with the previously described process-level recommendations, it is important to seek community input and feedback on the recruitment plan. A co-designed recruitment plan can help to ensure that recruitment calls are tailored for communities themselves (e.g., clear language and messaging) and also that they are distributed through channels that can

potentially identify other intersecting identities (for example, shared through a community recommended Facebook page for Queer and Trans Youth). Recruitment should carefully consider who is needed at the table and why to ensure that the plan will yield a representative range of voices. Ways to achieve representation in recruitment may look different depending on the community that is the focus of engagement, hence the importance of co-design to understand who is often missing from these discussions. Stakeholder table representatives emphasized the importance of considering and listing the qualities needed in the engagement roles for the recruitment, especially considering what community strengths and specific skill sets might be mutually beneficial for the community and the organizer. However, government and non-government entities should ensure that their recruitment plan avoids tokenizing individuals or communities in an attempt to fill a 'checkbox' on their table. If planning a new engagement, the MOH or OH should recruit individuals with a range of experiences and identities and not limit an entire community's representation to one person or table. Recommendations for avoiding tokenism include not relying on the same individuals consistently for every engagement effort and considering forming more than one table to speak on behalf of an entire community with many intersecting identities. Avoiding tokenism may look different depending on the community being engaged, and further information is provided in the community-specific recommendations ([3.1-3.8](#)).

**Implementation resources:** [Step 3. Connect: Recruit diverse voices while avoiding tokenism.](#)

**RECOMMENDATION 2.4: Actively involve underserved populations to share or lead decision-making during engagement efforts.**

The literature on engagement with the public and underserved populations emphasized “working with” communities rather than “doing for” and many had a focus on sharing decision-making, co-designing processes with or relinquishing decision-making entirely to those individuals. When incorporating engagement as part of an MOH, OH or non-government entity project or program planning, this process could look different depending on the needs and capacity of stakeholder tables and/or communities who are being engaged (e.g., some groups may want to be actively involved in both co-designing and co-producing outcomes, whereas other groups may want to decide together but not be responsible for actioning the decisions). For example, shared decision-making may look like the government or non-government entity designing different concepts and asking for community feedback on the desired result, whereas a community leading decision-making may be conducting their own consultations to bring forward their own solutions. The key to actioning this recommendation is asking underserved populations who are being engaged how they envision decision-making. It is important to emphasize that there is no “one-size-fits-all” approach to engagement, and the needs and wishes of the communities themselves should be used by government or non-government entities

to tailor and guide the approach depending on community capacity and where they would like to have more influence. Similarly, stakeholder table representatives also identified the importance of government or non-government entities demonstrating small wins and progress towards shared goals through ongoing updates to those being engaged.

**Implementation resources:** [Step 4. Engage: Respect and value the community and their needs.](#) [Step 4. Engage: Address power imbalance and empower community to lead.](#)

**RECOMMENDATION 2.5: Maintain open and transparent communication and ensure accountability to underserved populations once the engagement pathway is established.**

The literature identified communication, transparency and accountability as important elements to engagement success. Good communication on behalf of the government or non-government entity leading the engagement meant being clear on expectations for the stakeholder table or engaged community, including how the engagement will benefit their communities, and creating channels that allow for open communication between all members. These communication channels can include an orientation meeting with preparatory materials before the first engagement, avoiding jargon or terms that may be less familiar to the community and using interpretation and translation services

as needed for each meeting. The importance of these elements was echoed in the key informant interviews, with an additional emphasis on accountability and removing language barriers. Stakeholder table representatives highlighted the importance of the MOH or OH being transparent about what the group can influence, reporting back clear outcomes on how their feedback was used and consistent follow-through on all committed actions to maintain trust. Evaluating communication and accountability was also highlighted in the key informant interviews as an important step, although acknowledging that evaluating partnerships effectively can be challenging. Evaluation can be facilitated by government or non-government entities by either using consistent post-meeting evaluations distributed to all members or ongoing informal opportunities for feedback depending on the preferences of the community. Post-meeting evaluations are often more formal written surveys on community members’ understanding of the meeting and ways to improve communication, whereas ongoing opportunities for feedback may be informal discussions or open invitations to contact those leading the engagement with thoughts or ways to improve.

**Implementation resources:** [Step 4. Engage: Communicate openly;](#) [Step 5. Sustain: Act on community input; follow up;](#) [Step 5. Sustain: Evaluate for ongoing learning and improvement.](#)



**RECOMMENDATION 2.6: Engage underserved populations in initiatives on decision-making around how their data is collected, interpreted and governed.**

Meaningful engagement with underserved populations is important not only in understanding the needs of communities in the establishment of programs and services, but also in building trust around data. Building trust is a cornerstone of the appropriate collection and use of data, and transparency at all stages was identified through discussions during the key informant interviews. A number of themes emerged that the MOH or OH should consider when collecting, using and reporting community data, including considering a community-led data governance approach in the future. It was emphasized that there are sensitivities to data being collected from certain communities and community needs should be considered for what data is collected and why. During new data collection, it is important for

the government or non-government entity using the data to train data abstractors on how to talk to underserved populations who are sensitive about giving equity information. Part of these discussions about giving information should include information on the benefits and risks of data collection and use and an explanation of the data, where it is going, what it will be used for and its implications. Case studies or examples of past work can help to provide concrete examples during these discussions and help to provide transparency of the process to help build trust. Ideally, people from the community should be involved in data collection, and partnerships between the MOH or OH and community health centres that already have relationships with communities should be established to collect the data and foster trust. In terms of existing data use for research or policy, the MOH or OH should engage directly with communities to build and rebuild trust from the long ongoing history of data causing harm. Community-led data governance

(i.e., decision-making led by communities on the use and reporting of their data) was identified as an example of a trust-building approach, but one that would need to be co-designed with the communities themselves and more carefully considered to ensure a sustainable process with clear standards. The MOH or OH should consider co-designing a plan to engage members with lived experience around the governance of data with communities. Creating clear standards and parameters for a governance process will be necessary and communities should also be able to provide input into interpreting their data (e.g., providing context to the findings before broader release) and identifying issues and risks.

**Implementation resources:** For considerations on engaging with specific populations on collecting, using and reporting data that the stakeholder table representatives identified, see [Appendix 7](#).

## Community-Specific Recommendations

**Stakeholder table representatives provided recommendations specific to engaging with some of the communities they serve. The communities described below are not exhaustive, and only encompass a small subset of underserved populations that were specifically highlighted during the key informant interviews.** Community-specific recommendations are provided below and organized by community groups to clarify the unique approaches. Supporting evidence from the research is also included where applicable. It is important to note that although the recommendations below are specific to certain communities, individuals within those communities differ. Individuals can have multiple intersections of identities that influence their perspectives and experiences. For example, an individual may identify as Black and Francophone while being a member of the 2SLGBTQIA+ community. Therefore, tailored engagement, including removing language barriers, may be necessary even within communities and may require a blend of considerations from more than one recommendation below.

**Implementation resources:** Helpful implementation resources for all the recommendations below can be found in [Step 1. Prepare: Reflect on your role and position.](#)

### **RECOMMENDATION 3.1: Consider the unique context of Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual (2SLGBTQIA+) communities.**

The primary feedback from tables representing 2SLGBTQIA+ communities was that these groups should not be lumped together but instead given separate engagement pathways. Each community has complex issues and histories that must be recognized and considered. For example, it is crucial to recognize the unique experience of colonialism among Two-Spirit Indigenous individuals, and intersex, trans and gender-diverse individuals can have significantly different experiences around gender. Engagement was most successful when institutions took the time to build relationships with leaders in spaces where they had already gathered and built trust to repair fraught histories. Regardless of group, having trusted community partners lead engagement and act as central communicators proved to be an effective method to engage these communities. Engagement environments need to be built to ensure community members feel safe and can

express themselves as preferred: for example, allowing anonymous participation or providing an option where identifying one's gender/sexuality is not required. The Equality Network for Lesbian, Gay, Bisexual, and Transgender rights in Scotland has also created a [general guide to engaging LGBTQ communities](#). The Equality Network's Guide highlights a few key takeaways for effective engagement, including:

- Initiate trust-building exercises with the local community first, to quell assumptions that engagement is just a 'box-ticking' exercise.
- Work in partnership with other local public bodies to ensure wide participation.
- Manage the expectations of participants.
- Ensure a diversity of views is captured.
- Enable participants to challenge and criticize.

However, as mentioned, each initiative should ideally consider the unique needs and considerations for the groups they want to engage.

### **RECOMMENDATION 3.2: Consider the unique context of Black communities.**

Black community stakeholder table representatives advised that it is crucial to use a target population approach where engagements specify their focus on Black health or Black populations. Grouping the Black community under catch-all terms like equity-deserving can dilute individual characteristics, intersectionality, experiences and histories. Additionally, tokenism can result by only having one avenue of engagement for the Black community, for example, one Black health advisory group. There is intersectionality and diversity in the Black experience, and it is critical to engage the different segments of the community rather than trying to use a blanket approach. [A comprehensive resource on engagement practice and policy approaches for addressing anti-Blackness](#) was created in collaboration with students and scholars and demonstrates the importance of addressing the unique experiences of Black communities. In one of the case studies included in this report, storytelling was highlighted as a means of engagement with

Black communities for community development and urban planning. There is value in engagement through storytelling (e.g., informal engagement that allows for the exchange of stories with residents) in place of traditional, formal engagement that happens during a planned meeting, which may inadvertently prioritize individuals who possess systemic power and knowledge of technical terminology. Stories can be an effective way to counter this power imbalance and connect with those who may not access pathways for more formal recruitment efforts.

In addition, meaningful engagement regarding the collection, use and governance of data on Black communities is critical. Appropriate and community-led governance of data on Black, African, and Caribbean communities requires unique strategy and consideration outlined in The Black Health Equity Working Group’s [Engagement, Governance, Access, and Protection \(EGAP\) framework](#). The EGAP Framework describes the governance needed for collecting, managing, analyzing, and using data from Black communities and should be used as a starting point to guide appropriate data use.

**RECOMMENDATION 3.3: Consider the unique context of Francophone communities.**

The primary feedback from Francophone stakeholder table representatives was that French language services and Francophones should not be amalgamated with other groups deserving of equity, diversity and inclusion frameworks, but should be treated as a standalone population. Francophone communities expressed that although there are examples of organizations and tables created for and by Francophones, the Francophone community largely remains an underserved population regarding access to culturally and linguistically appropriate and safe care. Living in a minority setting leads to being underserved in the current health care system and there remains to be an insufficiency, or at times nonexistence, of French language services in the health, mental health and long-term care sector. There also remains a lack of continuum of care in parts of the province for French language services.

French is an official language of Canada and Ontario, and is protected by law in by the [French Language Services Act \(FLSA\)](#) and

its regulations; therefore, grouping Francophones with equity-deserving groups does not account for their unique legislative status. Instead, government entities should make French Language Services a standard offering and consider how to provide equitable services while considering the intersections of identity and diversity of individuals within these communities. Language and minority status are social determinants of health for linguistic minorities in Canada and any engagement and corresponding materials should be translated into French at minimum. The Ministry of Health and Ministry of Long-Term Care currently engage Francophone communities through two existing channels which could be used as a starting point to understand best practices for engagement with Francophone communities:

1. the Minister of Health’s and Minister of Long-Term Care’s French Language Health Services Advisory Council ([FLHSAC](#)), and
2. the French Language Health Planning Entities (Entités).

*French Language Health Services Advisory Council (FLHSAC)*

FLHSAC members reflect the diversity of the Francophone community and provide perspective from different health-related sectors. The FLHSAC’s primary responsibility is to offer guidance on health and service delivery concerns to improve health outcomes for Francophones and addressing the health service delivery needs of French-speaking communities.

*French Language Health Planning Entities (Entités)*

The MOH, in consultation with OH, selects the French Language Health Planning Entités who are mandated to advise OH on engaging French-speaking communities, identifying health needs and health service providers capacity for the provision of French language health services as well as strategies to improve access, planning and integration of French language health services.

The MOH collaborates actively with OH’s French Language Services Managers and Leads to ensure a constant flow of information on the health needs of Francophone communities and engages the Entities in collaboration with OH. The Entities have established strong relationships with Francophone communities in their respective regions and work collaboratively with OH to identify needs and gaps in services.

*Additional Resources*

[HC Link](#) has a helpful resource on meaningful engagement with Francophone communities by Anglophone groups. [McMaster’s Rapid-Improvement Support and Exchange \(RISE\)](#) portal also provides several resources to support engagement of Francophone communities. As an additional resource for those employed at the Ontario Public Service, the Ministry of Francophone Affairs’ Communications in French Directive is available on the internal intranet. For those who are outside of the MOH, you can connect with a Ministry of Francophone Affairs representative to obtain a copy. To identify a Ministry of Francophone Affairs representative, please see: [Organization details | INFO-GO](#).

**RECOMMENDATION 3.4: Consider the unique context of migrant workers.**

Organizations that work with and provide services to migrant workers have a comprehensive understanding of this population and often a deeper sense of how many individuals are living and working in their region (as a result of local data collection efforts). Therefore, broader engagement is needed not only with migrant workers in Ontario, farmers who employ them and regions that provide services for them, but also local and grassroots organizations working specifically with migrant workers. Direct engagement with migrant workers should be done after farm hours or on Sundays, and transportation should be provided. Special accommodations are needed to bridge language and cultural barriers, as many migrant workers have limited English proficiency. Practitioners and facilitators should come from similar cultures and speak additional languages

(e.g., Spanish, Thai, Vietnamese) to build trust. For example, [We Speak](#), works through [Access Alliance Language Services](#) to support the removal of language barriers across all sectors. You don’t need to be a medical professional, and anyone wishing to register for their own services in their sector can do so across the province. The service helps to access scheduled or on-demand interpretation services in-person or by phone and video. Although the resource is mentioned here, it is not exclusive to migrant workers, can may be beneficial for newcomers, asylum seekers, francophone communities, international students, etc.

Another consideration is the lack of data on migrant workers in Ontario: organizations do not know how many migrant workers there are, where they are coming from, their skill level or where they are working. This data should be collected provincially or by service providers and made transparent to inform engagement, services and funding. However, as noted during the key informant interviews, migrant workers may be concerned about doing anything that could lead to losing their jobs or creating friction with their employer, whether real or perceived, when it comes to data collection. The MOH or OH should consider engaging migrant workers in how these questions are asked and how they want to identify themselves during a data collection initiative. In addition, [a case study focusing on empowerment of newcomers in Peel region](#) provides key considerations on engagement using a shared decision-making model for grantmaking. Although the case study is not specific to migrant workers, it may be a helpful primer to engaging with newcomer communities more broadly.

**RECOMMENDATION 3.5: Consider the unique context of people living with HIV.**

The HIV community and sector uphold expectations for engagement, including how to engage, developing team roles and adequate compensation. There are specific [resources from the Canadian HIV Trials Network](#) that outline these expectations for engaging people living with HIV in research, many of which also apply for policy-making or government entities. For example, the Canadian HIV Trials Network notes that “community” is often equated with people living with HIV; however, there are other groups who may also identify as community members and should be considered in an engagement. These groups may include, but are not limited to:

- People living with HIV
- Those from HIV/AIDS service organizations and community-based organizations
- Staff at community health centres and public health agencies/departments
- Caregivers, chosen/biological family, friends

To ensure a greater breadth of input, intersections of identity must also be considered. Broad outreach to different individuals, groups and agencies, and considering the social determinants of health are important when considering engaging with people living with HIV. [Target HIV](#) also has a variety of trainings, webinars and resources on community engagement with people living with HIV. These include considerations for community advisory boards and peer engagement. Peers in HIV care are specially-trained individuals who provide people living with HIV with information, support and assistance in navigating services.

HIV peers are often living with HIV, but not always. Peers can help to create a safe space for engagement and avoid tokenism in research and policy development

**RECOMMENDATION 3.6: Consider the unique context of people living in poverty or unhoused people.**

People who are living in poverty or are unhoused often live in traumatic circumstances where staying alive and avoiding death are everyday realities. There is also significant heterogeneity in this population, with a wide range of needs. Be mindful that many individuals experience prejudice and discrimination, specifically when interacting with health care settings. Key informant interviews emphasized the importance of adapting methods to circumstances for people living in poverty (e.g., online meetings may not work for those without a mobile device or computer) and ensuring that individuals are involved in a decision-making capacity that meets them where they are at. The Tamarack Institute has collected [best practices and case examples](#) for engaging people with lived experiences of poverty, including a guide for including people in poverty reduction strategies. The guide outlines 10 steps to consider for engaging those with lived experience, one of which emphasizes the importance of trust and follow-through especially in poverty reduction. For example, it was noted in the guide that at times, recommendations made by people with lived/living experience often do not make it to policy, and this lack of follow-through can hinder the development of trust with those leading the engagement. It was recommended that if communities are to be engaged, both those with lived experience and the government or

non-government entity leading the engagement should reflect and clearly communicate on the extent to which they are comfortable, willing, ready and able to take recommendations forward, for example by leveraging resources and networks, or by advocating for policy and systems change.

**RECOMMENDATION 3.7: Consider the unique context of people who use drugs.**

Through the key informant interviews, it was recommended that people who use drugs need to be directly engaged, as some stakeholder tables only engage service providers or support workers, rather than community members themselves. When engaging with people who use drugs, it is also critical to consider the context of criminalization. Drug use in Ontario is criminalized, and as a result, anonymity within the context of data collection and engagement may be important to foster trust. Criminalization of people who use drugs may also impact the trust of those leading engagement. The Canadian Association of People Who Use Drugs and the Canadian Drug Policy Coalition have created [best practices](#) for engaging people who use drugs. The best practices, although specific to harm reduction work, have implications for research and policy engagement. An important recommendation within the guide is to consider the very real experiences of trauma among people who use drugs. Governmental or non-governmental entities should consider making deliberate efforts to provide genuine emotional and psychological supports for those who may be reflecting on their past experiences during an engagement. These supports may come from coworkers (e.g., team debriefing), or from access to confidential outside counseling or therapy.

Flexibility is also important to this work, allowing for periodic leaves from the engagement for mental or physical health.

When engaging people who use drugs, it is also important to consider the range in circumstances, identities and experiences from an equity lens. For example, people who use drugs by other methods beyond injection (e.g., inhalation, orally, intranasally) must also be engaged. Carefully reviewing what groups should be engaged by considering social determinants of health and community risk, and who is often underrepresented in services/ support is important. Determining answers to these questions should be done in consultation with organizations, service providers and community members.

**RECOMMENDATION 3.8: Consider the unique context of youth.**

Key informant interviews also highlighted the importance of considering youth engagement in any community, when appropriate. Reaching youth is often a challenge, but can be achieved through different methods by determining where the youth of interest for the engagement socialize, work and play.

The diversity in youth must be considered as well as which voices may be missing from a stakeholder table or engagement approach. For example, not all young people are in school and recruitment efforts through that route alone, especially for youth who use drugs, may not be effective. The Young Canadians Roundtable on Health outlined [principles and actions](#) for inclusive and accessible engagement. These principles outline ways to ensure youth engagement is not tokenistic, by:

- Considering creating leadership roles for youth that are embedded into the organizational work (or engagement process).
- Focusing on issues that are important to youth.
- Co-evaluating what works and doesn't work.

An example of a larger scale engagement is [FRAYME](#), created to ensure that young people in Canada benefit from the latest youth mental health resources and knowledge in substance use. It is also a good example of how an organization can engage with vulnerable youth and create effective integrated systems of care.



# Limitations

**This scoping review of best practices was a targeted search containing grey literature and peer-reviewed publications.** Although we thoroughly searched grey literature and published sources, papers may have been unintentionally missed, especially those published in French or before 2018. Our search was also focused on engagement best practices with a health and social service focus, and engagement practices in other disciplines may have been excluded during the selection process. Additionally, the included papers encompass approaches used in different settings and contexts, often describing a singular engagement effort at one point in time and, therefore, may not be generalizable to a specific jurisdiction.

It is important to note that all representatives included in the key informant interviews were based in Ontario with an Ontario-specific context and focus. The representatives had varying degrees of connection and proximity to the MOH or OH. Some groups had little interaction with the MOH and/or OH, while others were directly staffed by these entities, which could have unintentionally

introduced bias into certain responses. Therefore, the system-level recommendations may not be generalizable to other Canadian jurisdictions. Additionally, because key informant interviews were conducted only with stakeholder table leads, community members from underserved populations were not directly interviewed and may have alternative views about the effectiveness of existing engagement mechanisms to the stakeholder table representatives.

Although inclusive to many communities and intersections of identities, the partner tables did not include representatives from First Nations, Inuit, Métis and urban Indigenous (FNIMUI) partners, which as previously described, was outside the scope of this report and represents a limitation to the recommendations. We also acknowledge that many racialized communities have important equity considerations not highlighted in this report. Despite our best efforts to be as inclusive as possible in our scoping review and key informant interviews, some groups have been missed. We acknowledge that future

iterations of this work should attempt to capture groups not highlighted here. Key informant interviews were also conducted in English only. Although there was an option for Francophone respondents to answer in French, we recognize this as a missed opportunity to tailor the interview and interview material to the needs of each participant. The omission of exclusively French-speaking focus groups and interviews may have missed key perspectives from other individuals in Francophone communities and unintentionally excluded important considerations on meaningful engagement with Francophones. Future initiatives should consider language barriers to participation, especially for Francophones and other communities (e.g., immigrants, refugees, etc.) and how these barriers can be reduced through dedicated translation and interpretation services. Finally, the potential for recall bias does exist. However, most key informants were asked to speak more broadly about their experiences rather than recalling one specific event, which may provide some protection against bias.

# Toolkit

**This Toolkit contains resources to assist with establishing new engagement pathways or refining existing pathways for governmental and non-governmental entities.**

The Toolkit includes the following:

## **RESOURCE 1: A Guide to Supporting Equity-Centred Engagement**

This guide was modified from one developed at [McMaster University](#)<sup>26</sup> and informed by a framework from [Ontario Health](#).<sup>27</sup> The McMaster University tool was selected as a starting point due to its rigorous and collaborative development process, and the modifications reflect the specific recommendations for the MOH from key informant interviews. The supporting resources included are not exhaustive but, rather, are intended as a starting point.

## **RESOURCE 2: Map and Overview of the Stakeholder Tables Interviewed for this Report**

This resource includes a visual representation of where the stakeholder tables interviewed for this report reside across the province and a description of the communities they serve.

## **RESOURCE 3: Additional Stakeholder Tables Affiliated with the Ministry of Health Not Included in This Report**

This table includes additional stakeholder tables identified by teams across the MOH but who were **NOT** included in this report. This list, although not exhaustive, can be used as a starting point to identify communities of interest to engage on initiatives for the MOH or OH.

## **RESOURCE 4: Engagement Process Questions and Best Practices**

This resource organizes common engagement process questions, the best practice 'answers' and links to the corresponding step in Toolkit Resource 1: Guide to Supporting Equity-Centred Engagement to supporting resources on how to undertake these best practices. Although not unique to all underserved populations, these best practices provide a starting point for engagement considerations.



**RESOURCE 1: A Guide to Supporting Equity-Centred Engagement (A Modified Version of McMaster’s Step-by-Step Guide<sup>26</sup>)**

This tool was modified from the [McMaster University step-by-step guide<sup>26</sup>](#) (licensed under a Creative Commons Attribution-Non Commercial-No Derivatives 4.0 International License) and informed by a framework from [Ontario Health<sup>27</sup>](#). This tool was selected as a starting point due to its rigorous and collaborative development process, and the modifications reflect the specific recommendations informed by the key informant interviews and supporting literature. There is no “one-size-fits-all” approach to equitable engagement, however the resources included, although not exhaustive, are intended as a starting point based in evidence and best practice.

<b>1. PREPARE</b>	<p><b>SEEK TO DEEPLY UNDERSTAND “EQUITY” AND RELATED CONCEPTS</b></p> <p>Supporting resources for Recommendation 1.1</p> <ul style="list-style-type: none"> <li>• <a href="#">Glossary of essential health equity terms</a>: web glossary</li> <li>• <a href="#">The urgency of intersectionality</a>: video</li> <li>• <a href="#">Key principles and terms for communication</a>: nuanced principles for phrasing</li> </ul>	<p><b>RECOGNIZE THE IMPORTANCE OF EQUITY-CENTRED APPROACHES</b></p> <p>Supporting resources for Recommendation 2.2</p> <ul style="list-style-type: none"> <li>• <a href="#">Community knowledge for equity in healthcare</a>: recommendations for diverse partnerships</li> <li>• <a href="#">Community engagement for health equity</a>: best practices</li> </ul>	<p><b>REFLECT ON YOUR ROLE AND POSITION</b></p> <p>Supporting resources for Recommendations 3.1-3.8</p> <ul style="list-style-type: none"> <li>• <a href="#">Privilege and critical allyship</a>: video explaining how <a href="#">intersectional</a> social structures produce unearned advantage</li> <li>• <a href="#">Racism and health equity</a>: introduction to white supremacy, structural racism and anti-racist action</li> </ul>
<b>2. PLAN</b>	<p><b>ESTABLISH AND UNDERSTAND WHO YOU WANT TO ENGAGE AND WHY</b></p> <p>Supporting resources for Recommendation 1.2</p> <ul style="list-style-type: none"> <li>• <a href="#">Community engagement framework: an asset-based approach</a>: prompts consideration of context to move towards building sustainable relationships</li> </ul>	<p><b>DETERMINE RESOURCES AND COMPENSATION NEEDED</b></p> <p>Supporting resources for Recommendation 2.2</p> <ul style="list-style-type: none"> <li>• <a href="#">Budgeting for public engagement</a>: budget items for this <a href="#">template</a></li> </ul>	<p><b>PROACTIVELY AND COLLABORATIVELY SET GOALS</b></p> <p>Supporting resources for Recommendation 2.1</p> <ul style="list-style-type: none"> <li>• <a href="#">Co-designing engagement to promote health equity</a>: key points for co-designed processes and goals</li> </ul>
<b>3. CONNECT</b>	<p><b>ESTABLISH TRUST AND BUILD MEANINGFUL RELATIONSHIPS</b></p> <p>Supporting resources for Recommendation 1.3</p> <ul style="list-style-type: none"> <li>• <a href="#">Balancing power dynamics</a>: checklist of “do’s &amp; don’ts” for relationship-building</li> </ul>	<p><b>RECRUIT DIVERSE VOICES WHILE AVOIDING TOKENISM</b></p> <p>Supporting resources for Recommendation 2.3</p> <ul style="list-style-type: none"> <li>• <a href="#">Tokenism: seeing it, fixing it</a>: examples of tokenism and suggestions to address them</li> </ul>	<p><b>IDENTIFY AND ELIMINATE BARRIERS TO ENGAGEMENT</b></p> <p>Supporting resources for Recommendation 1.4</p> <ul style="list-style-type: none"> <li>• <a href="#">Recruiting for diversity</a>: advice to reduce barriers to diverse recruitment</li> </ul>
<b>4. ENGAGE</b>	<p><b>COMMUNICATE OPENLY</b></p> <p>Supporting resources for Recommendation 2.5</p> <ul style="list-style-type: none"> <li>• <a href="#">A manifesto for ethical research in the downtown Eastside</a>: community expectations for communication</li> </ul>	<p><b>RESPECT AND VALUE THE COMMUNITY AND THEIR NEEDS</b></p> <p>Supporting resources for Recommendation 2.4</p> <ul style="list-style-type: none"> <li>• <a href="#">Flipping orthodoxies to design inclusive meetings</a>: challenges status-quo practices and assumptions</li> </ul>	<p><b>ADDRESS POWER IMBALANCES AND EMPOWER COMMUNITY TO LEAD</b></p> <p>Supporting resources for Recommendation 2.4</p> <ul style="list-style-type: none"> <li>• <a href="#">Co-creation for power-sharing</a>: tool for planning where power can be shared with community</li> </ul>
<b>5. SUSTAIN</b>	<p><b>ACT ON COMMUNITY INPUT; FOLLOW UP</b></p> <p>Supporting resources for Recommendation 2.5</p> <ul style="list-style-type: none"> <li>• <a href="#">A manifesto for ethical research in the downtown Eastside</a>: community expectations for reciprocity</li> </ul>	<p><b>MAINTAIN RELATIONSHIPS AND CONTINUE TO BUILD TRUST</b></p> <p>Supporting resources for Recommendation 1.5</p> <ul style="list-style-type: none"> <li>• <a href="#">Community engagement for health equity</a>: best practices for building authentic relationships</li> </ul>	<p><b>EVALUATE FOR ONGOING LEARNING AND IMPROVEMENT</b></p> <p>Supporting resources for Recommendation 2.5</p> <ul style="list-style-type: none"> <li>• <a href="#">Engagement indicators for health system improvement</a>: refer to Figure 2 for indicators to measure engagement</li> </ul>

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## RESOURCE 2: Map and Overview of the Stakeholder Tables Interviewed for this Report

This map provides a visual for geographic representation of stakeholder tables interviewed for this report across the province. The chosen stakeholder tables were selected based on existing community relationships, deep understanding of health equity, connections to the Ministry of Health and Ontario Health, and the breadth of geographic reach each table exhibited. The numbers in each of the pins on the map indicate the number of tables represented (whether provincial, regional or local) across the province.



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TABLE NAME	GEOGRAPHIC REPRESENTATION	COMMUNITY OF FOCUS	OTHER COMMUNITY CHARACTERISTICS
<a href="#">Minister's Patient and Family Advisory Council</a>	Provincial representation	None	Broadly defined and diverse, including: <ul style="list-style-type: none"> <li>• African, Caribbean and Black communities</li> <li>• Indigenous communities</li> <li>• South Asian communities</li> <li>• 2SLGBTQIA+ community</li> <li>• Refugees</li> <li>• Rural and remote communities</li> <li>• People living with disabilities</li> </ul>
<a href="#">Ontario Advisory Committee on HIV/AIDS</a>	Provincial representation	People living with HIV	Communities with higher HIV prevalence, including: <ul style="list-style-type: none"> <li>• African, Caribbean and Black communities</li> <li>• Indigenous communities</li> <li>• Gay, bisexual, Trans men and other men having sex with men</li> <li>• People who use drugs</li> </ul>
<a href="#">Ontario HIV Epidemiology and Surveillance Initiative &amp; Ontario HIV Treatment Network</a> Epi Unit Champions Committee	Provincial representation	People living with HIV	Communities with higher HIV prevalence, including: <ul style="list-style-type: none"> <li>• African, Caribbean and Black communities</li> <li>• Indigenous communities</li> <li>• Gay, bisexual, Trans men and other men having sex with men</li> <li>• Women and Trans women facing systemic risk</li> <li>• People who use drugs</li> </ul>
<a href="#">Hepatitis C Elimination Roadmap Advisory Committee</a>	Provincial representation	People impacted by hepatitis C (HCV)	Communities with higher HCV prevalence, including: <ul style="list-style-type: none"> <li>• Indigenous communities</li> <li>• Newcomers from countries where HCV is common</li> <li>• Gay, bisexual, Trans men and other men having sex with men</li> <li>• Baby boomers (people born between 1945–1975)</li> <li>• Pregnant people and youth</li> <li>• People who use drugs</li> <li>• People who have experienced or</li> </ul>
<a href="#">MPOX Community Mobilization Table</a>	Provincial representation	Gay, bisexual, Trans men and other men having sex with men	<ul style="list-style-type: none"> <li>• Organizations that serve gay men</li> <li>• Community-based HIV/AIDS organizations</li> <li>• Sexual health organizations</li> </ul>

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TABLE NAME	GEOGRAPHIC REPRESENTATION	COMMUNITY OF FOCUS	OTHER COMMUNITY CHARACTERISTICS
Harm Reduction Advisory Committee	<b>Provincial representation</b>	People who use drugs (past or current)	Communities with greatest risk to drug use harms, including: <ul style="list-style-type: none"> <li>• African, Caribbean and Black communities</li> <li>• Indigenous communities</li> <li>• Gay, bisexual, Trans men and other men having sex with men</li> <li>• Unhoused people</li> <li>• Harm reduction street-based outreach teams</li> </ul>
<a href="#">COMOH Substance Prevention Working Group</a>	<b>Provincial representation</b>	People who use drugs (past or current)	Professionals working with: <ul style="list-style-type: none"> <li>• Indigenous communities and urban populations</li> <li>• Youth and school-aged students</li> <li>• People who identify as low income</li> <li>• Unhoused people</li> <li>• People living with disability</li> </ul>
<a href="#">High Priority Communities Strategy</a> Strategic Planning Table	<b>Provincial representation</b>	None	Agencies that engage communities include: <ul style="list-style-type: none"> <li>• Black and racialized communities</li> <li>• Low income</li> <li>• Indigenous communities</li> </ul>
Black Health Plan Working Group	<b>Provincial representation</b>	African, Caribbean and Black people	
<a href="#">Northern Ontario Pride Network</a>	<b>Northeast &amp; Northwest Regions</b> (broadly)	2SLGBTQIA+ community	Intersectional identities, including: <ul style="list-style-type: none"> <li>• African, Caribbean and Black communities and youth</li> <li>• Indigenous communities and youth</li> <li>• Francophone communities</li> </ul>
Central Region <a href="#">High Priority Communities Strategy</a> Table	<b>Central Region</b> (broadly)	None	Broadly defined and diverse, including: <ul style="list-style-type: none"> <li>• Community organizations serving people who identify as racialized, low-income, unhoused and/or international students</li> <li>• Regional Public Health Units</li> <li>• Food banks</li> <li>• Faith-based organizations</li> </ul>
Black Health Advisory Table (Central)	<b>Central Region</b> (broadly)	African, Caribbean, and Black people	<ul style="list-style-type: none"> <li>• Leadership from Black-led organizations</li> </ul>

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TABLE NAME	GEOGRAPHIC REPRESENTATION	COMMUNITY OF FOCUS	OTHER COMMUNITY CHARACTERISTICS
Central Region Patient and Family Advisory Table	<b>Central Region</b> (broadly)	None	Broadly defined and diverse, including: <ul style="list-style-type: none"> <li>• Indigenous communities</li> <li>• African, Caribbean and Black communities</li> <li>• Asian communities</li> <li>• Francophone communities and newcomers</li> <li>• People living with disabilities</li> <li>• Rural and remote communities</li> </ul>
Food Security Working Group (OH Central)	<b>Central &amp; Toronto Regions</b> (broadly)	Organizations that serve low-income and food-insecure populations	Communities with higher food insecurity prevalence, including: <ul style="list-style-type: none"> <li>• Organizations that serve racialized groups (including newcomers, refugees and new immigrants)</li> </ul>
Toronto Region Ontario Health Team Collaborative Table	<b>Toronto Region</b> (broadly)	None	Leadership and health care providers serving newcomers, unhoused people, refugees, Black and racialized populations
Health Equity and Accessibility Table, West Region	<b>West Region</b> (broadly)	None	Leadership and health care providers from OH teams
<a href="#">French Language Health Services Community of Practice, Entité 2</a>	<b>West Region</b> (broadly)	Francophone community	
<a href="#">Community of Practice for Bilingual Professionals, Entité 1</a>	<b>West Region</b> (broadly)	Francophone community	
<a href="#">Manitoulin Drug Strategy</a>	<b>Manitoulin</b> (Northeast Region)	Organizations that serve people who use drugs	
<a href="#">Timmins and Area Drug Strategy</a>	<b>Timmins</b> (Northeast Region)	Organizations that serve people who use drugs	
<a href="#">Community Drug Strategy of Greater Sudbury</a>	<b>Sudbury</b> (Northeast Region)	Organizations that serve people who use drugs	

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TABLE NAME	GEOGRAPHIC REPRESENTATION	COMMUNITY OF FOCUS	OTHER COMMUNITY CHARACTERISTICS
<a href="#">Poverty and Housing Advocacy Coalition</a>	<b>Sudbury</b> (Northeast Region)	People living in extreme poverty	People experiencing related life circumstances, including: <ul style="list-style-type: none"> <li>• Unhoused people</li> <li>• Sex workers</li> <li>• Individuals with lived experience of violence, drug use and/or trauma</li> </ul>
<a href="#">Champlain Regional Planning Table for Trans Health Services</a>	<b>Champlain</b> (East Region)	Transgender, gender-diverse and intersex people	
<a href="#">Workplace Wellness for Agricultural Workers</a>	<b>Essex County</b> (West Region)	Newcomer and immigrant services	International migrant worker services International student services
<a href="#">Niagara Migrant Workers Interest Group</a>	<b>Niagara</b> (West Region)	Migrant workers	Migrant workers' community services and agencies
<a href="#">French Mental Health and Addictions System Network Table</a>	<b>London</b> (West Region)	Mental Health and Addictions  Francophone communities	
<a href="#">Entité 1</a>	<b>Windsor</b> (West Region)	Francophone community	

Note that this is not intended to be an exhaustive list of all existing tables across the province, but rather reflects those that were directly interviewed for this project.

### RESOURCE 3: Additional Partner Tables Affiliated with the Ministry of Health **Not Included in This Report**

The following table includes additional partner tables identified by teams across the MOH but who were NOT included in this report. This list, although not exhaustive, can be used as a starting point to identify communities of interest to engage on initiatives for the MOH or OH.

*Note: OH and the Ontario Health Regions also support a number of dedicated engagement venues with Indigenous partners that have not been captured below.*

TABLE NAME	GEOGRAPHIC REPRESENTATION	COMMUNITY OF FOCUS	OTHER COMMUNITY CHARACTERISTICS
Mental Health and Addictions Systems Coordinator Network	<b>Provincial</b>	First Nations, Métis and urban Indigenous	Includes representatives from: <ul style="list-style-type: none"> <li>• Indigenous Primary Health Care Council</li> <li>• Independent First Nations</li> <li>• Association of Iroquois and Allied Indians</li> <li>• Nishnawbe Aski Nation</li> <li>• Grand Council Treaty #3</li> <li>• Six Nations of the Grand River</li> <li>• Anishnabek Nation</li> <li>• Métis Nation of Ontario</li> <li>• Ontario Federation of Indigenous Friendship Centres</li> <li>• Ontario Native Women's Association</li> </ul>
Urban Indigenous Health Table	<b>Regional</b>	Urban Indigenous	Includes representatives from: <ul style="list-style-type: none"> <li>• Métis Nation of Ontario</li> <li>• Ontario Federation of Indigenous Friendship Centres</li> <li>• Ontario Native Women's Association</li> </ul>
Indigenous Primary Health Care Engagement Table	<b>Provincial</b>	First Nations, Inuit, Métis and urban Indigenous	Includes representatives from: <ul style="list-style-type: none"> <li>• Indigenous Primary Health Care Organizations and other Indigenous organizations (which provide the perspective of on and off-reserve, rural, urban and isolated areas across the province)</li> </ul>
Association of Iroquois and Allied Indians (AI) Bilateral Table on Health	<b>Across Ontario</b>	First Nations	
Nishnawbe Aski Nation (NAN) Tripartite First Nations Health Transformation Table	<b>Northern Ontario</b>	First Nations	

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TABLE NAME	GEOGRAPHIC REPRESENTATION	COMMUNITY OF FOCUS	OTHER COMMUNITY CHARACTERISTICS
Grand Council Treaty (GCT#3) Tripartite First Nations Health Transformation Table	<b>Northwest Ontario</b>	First Nations	
Anishnabek Nation-Union of Ontario Indians (AN-UOI) Tripartite First Nations Health Transformation Table	<b>Across Ontario</b>	First Nations	
Six Nations of the Grand River (Six Nations) Tripartite First Nations Health Transformation Table	<b>Ohsweken/Brantford</b>	First Nations	
<a href="#">Minister's French Language Health Services Advisory Council</a>	<b>Provincial</b>	Provide advice to the Minister of Health and Minister of Long-Term Care about health and service delivery issues related to francophone communities	
<a href="#">Entité 1</a>	<b>Erie St. Clair, Southwest</b>	Francophone communities and French language health services	French language health planning entity
<a href="#">Entité 2</a>	<b>Waterloo Wellington, Hamilton Niagara, Haldimand Brant</b>	Francophone communities and French language health services	French language health planning entity Also coordinates a <a href="#">French language health services Community of Practice</a>
<a href="#">Entité 3</a>	<b>Central West, Mississauga Halton, Toronto Central</b>	Francophone communities and French language health services	French language health planning entity
<a href="#">Entité 4</a>	<b>Central, Central East, North Simcoe Muskoka</b>	Francophone communities and French language health services	French language health planning entity
<a href="#">Réseau des services de santé en français de l'Est de l'Ontario</a>	<b>Southeast, Champlain</b>	Francophone communities and French language health services	French language health planning entity (5)
<a href="#">Réseau du mieux-être francophone du Nord de l'Ontario</a>	<b>Northeast, Northwest</b>	Francophone communities and French language health services	French language health planning entity (6)



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TABLE NAME	GEOGRAPHIC REPRESENTATION	COMMUNITY OF FOCUS	OTHER COMMUNITY CHARACTERISTICS
<a href="#">Association des conseils scolaires des écoles publiques de l'Ontario (ACEPO)</a>	<b>Provincial</b>	Children and families	
<a href="#">Association franco-ontarienne des conseils scolaires catholiques (AFOCSC)</a>	<b>Provincial</b>	Children and families	
<a href="#">Assemblée de la francophonie de l'Ontario (AFO)</a>	<b>Provincial</b>	Organization and the political voice of Francophonie in Ontario	
<a href="#">Fédération des aînés et retraités francophones de l'Ontario – FARFO</a>	<b>Provincial</b>	Francophone retirees and seniors	
<a href="#">Action positive (VIH/Sida)</a>	<b>Provincial</b>	Francophones living with HIV/AIDS	
<a href="#">Réseau de soutien à l'immigration francophone (RIF) de l'Est/Conseil Économique &amp; Social d'Ottawa Carleton</a>	<b>Eastern Ontario</b>	French-speaking immigrant populations	
<a href="#">Réseau de soutien à l'immigration francophone (RIF) du Centre-Sud-Ouest de l'Ontario</a>	<b>Central Southwestern Ontario</b>	French-speaking immigrant populations	
<a href="#">Réseau de soutien à l'immigration francophone du Nord de l'Ontario</a>	<b>Northern Ontario</b>	French-speaking immigrant populations	
<a href="#">FrancoQueer</a>	<b>Provincial</b>	2SLGBTQI+ francophone communities	
<a href="#">Fédération de la jeunesse franco ontarienne (FESFO)</a>	<b>Provincial</b>	Francophone Youth	

#### RESOURCE 4: Engagement Process Questions and Best Practices

During the key informant interviews, stakeholder table representatives provided many additional or more detailed best practices beyond what is described in the recommendations. Stakeholder table representatives shared these best practices based on what worked well while engaging and meeting the specific needs of their communities or as suggested approaches to improve engagement mechanisms on a more granular level. This table organizes these details into common engagement questions, best practice ‘answers’ and links to the corresponding step in [Toolkit Resource 1: Guide to Supporting Equity-Centred Engagement](#) to supporting resources on how to undertake these best practices. These best practices are specific to conducting engagement, and work under the assumption that preparation and planning have already been conducted.

QUESTION	BEST PRACTICES	CORRESPONDING STEP IN THE <i>GUIDE TO SUPPORTING EQUITY-CENTRED ENGAGEMENT</i>
How do I start to build meaningful relationships with communities?	<ul style="list-style-type: none"> <li>• Building relationships with communities is important before starting any engagement.</li> <li>• Trust must be earned through a visible commitment to work that is sustained, adequately funded and resourced, and equitable methods in all aspects of engagement from the MOH or OH.</li> <li>• Relationship-building involves following through on commitments to build long-standing relationships beyond an initial engagement, as applicable.</li> <li>• Connect with organizations in the communities of interest and work with community leaders to establish an understanding of community needs and values.</li> <li>• To avoid duplicating engagement initiatives and demonstrate a desire to fulfill shared goals, consider collaborating with community members who are already doing engagement independently that is aligned with your goals/project/program.</li> </ul>	<p><b>3. Connect:</b></p> <ul style="list-style-type: none"> <li>• Establish trust and build meaningful relationships</li> </ul>
How do I ensure I am being inclusive when seeking community members to engage with?	<ul style="list-style-type: none"> <li>• Lower barriers to applying to an engagement effort (e.g., complicated or long forms may automatically exclude those with a lower level of education, and online-only forms may exclude those without a computer or mobile device).</li> <li>• Create values-based recruitment questions to uncover hidden biases (e.g., questions that get to the heart of an individual’s values, such as “what are the most important issues facing your community?”).</li> <li>• Actively connect with communities and community networks to get the right people involved.</li> <li>• Look beyond leadership positions to frontline workers or peer support workers.</li> <li>• Recruit for specific skill sets that are needed (e.g., group work, communication, reflective practice, sharing space).</li> <li>• Recruit multiple community members with lived experience in the area of interest to avoid tokenism and to avoid undue pressure on one individual to represent the values of a whole community.</li> <li>• Consider how recruitment practices perpetuate colonialism and how those recruited have privilege, access and specific knowledge levels.</li> </ul>	<p><b>3. Connect:</b></p> <ul style="list-style-type: none"> <li>• Recruit diverse voices while avoiding tokenism</li> <li>• Identify and eliminate barriers to engagement</li> </ul>

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QUESTION	BEST PRACTICES	CORRESPONDING STEP IN THE <i>GUIDE TO SUPPORTING EQUITY-CENTRED ENGAGEMENT</i>
How do I engage with underserved populations in ways that use an equity lens?	<ul style="list-style-type: none"> <li>• Co-design with communities terms of reference with a shared mandate, realistic goals and prioritized activities based on available resources.</li> <li>• Offer multiple modes of engagement as there are different comfort and accessibility levels with virtual, hybrid and in-person formats.</li> <li>• Engage people in an interactive process (e.g., a consensus-building exercise to determine a solution) rather than through passive feedback (e.g., providing thoughts via email).</li> <li>• Acquire resources and funding to support proper participation.</li> <li>• Be realistic about what you're asking from participants, as participation is often voluntary, and they have other life priorities (e.g., working, caring and families).</li> <li>• Provide orientation and mentorship when onboarding new members.</li> <li>• Avoid jargon and ensure the language used at the meeting is accessible (e.g., provide access to language translation and interpretation).</li> <li>• Host evening meetings that avoid working hours to make sessions accessible to more members.</li> <li>• Provide transportation options to engagement sessions.</li> <li>• Coach members on working towards solutions instead of focusing on blame and negativity.</li> <li>• Share decision-making with community members or, if desired by the community, have them lead decision-making.</li> <li>• Demonstrate small wins and progress to maintain energy and enthusiasm.</li> <li>• Include culturally appropriate food and activities to create a comfortable space.</li> </ul>	<p><b>4. Engage</b></p> <ul style="list-style-type: none"> <li>• Communicate openly</li> <li>• Respect and value the community and their needs</li> <li>• Address power imbalances and empower community to lead</li> </ul>
How do I sustain relationships and remain accountable to the communities I am engaging with?	<ul style="list-style-type: none"> <li>• Be honest about what the group can influence and work within those parameters.</li> <li>• Set realistic expectations around timelines for seeing change as system change takes a long time.</li> <li>• Follow through on commitments.</li> <li>• Provide frequent updates and report back on the outcomes by demonstrating how the feedback was used and how it led to action.</li> <li>• Keep lines of communication and information open.</li> <li>• Engage people from the beginning of development rather than bringing a completed policy or program to them.</li> </ul>	<p><b>5. Sustain</b></p> <ul style="list-style-type: none"> <li>• Act on community input; follow up</li> <li>• Maintain relationships and continue to build trust</li> </ul>
How do I know if my engagement was mutually beneficial?	<ul style="list-style-type: none"> <li>• Document and evaluate engagement approaches for shared learning.</li> <li>• Conduct post-meeting evaluations or provide opportunities for ongoing informal feedback (e.g., sharing what worked well or what didn't work well at the end of each meeting).</li> </ul>	<p><b>5. Sustain</b></p> <ul style="list-style-type: none"> <li>• Evaluate for ongoing learning and improvement</li> </ul>

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## APPENDIX 1: Existing Resources on Engagement with First Nations, Inuit, Métis and Urban Indigenous (FNIMUI) Partners

The following table includes existing resources that can be used as a starting point when planning for engagement with FNIMUI partners. Please note this list is not exhaustive or in any particular order.

RESOURCE NAME	DESCRIPTION	LINK
<b>Ontario Health's Indigenous Relationship and Cultural Awareness courses</b>	These 13 Indigenous Relationship and Cultural Awareness courses are designed to empower those working with First Nations, Inuit and Métis people with the knowledge needed to provide culturally appropriate, person-centred care. The courses promote greater awareness of First Nation, Inuit and Métis history, culture and the health landscape.	<a href="#">Ontario Health E-Learning: Indigenous Relationship and Cultural Awareness Courses</a>
<b>Indigenous Primary Health Care Council Indigenous Cultural Safety training</b>	Anti-Indigenous racism has profound negative impacts on the health and wellness of Indigenous communities in Ontario and across Canada. To support equitable care for First Nations, Inuit and Métis people, the IPHCC aims to educate the broader health care system through transformative, decolonizing, Indigenous-informed coordinated approaches and strategies	<a href="#">Cultural Safety Training - Indigenous Primary Health Care Council (iphcc.ca)</a>
<b>Relationship with Indigenous Communities Guidelines</b>	This guideline was co-developed with Indigenous communities in 2018 with the Ministry of Health. It describes fundamental practices to begin forming meaningful relationships with Indigenous communities that come from a place of trust, mutual respect, understanding, and reciprocity.	<a href="#">Relationship with Indigenous Communities Guideline, 2018 (gov.on.ca)</a>
<b>Culturally Safe Engagement: What Matters to Indigenous (First Nations, Métis and Inuit) Patient Partners? Companion Guide</b>	The Patient Voices Network of BC Patient Safety & Quality Council and several BC Indigenous partners have co-created key principles and related actions for engaging Indigenous people and communities.	<a href="#">Culturally-Safe-Engagement-Companion-Guide_Final.pdf (bcpsqc.ca)</a>

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## APPENDIX 2: Scoping Review Search Terms

The search strategy used for each database for the scoping review was comprised of the following search terms: “public engagement” OR “health policy,” “participatory policymaking” AND “health,” “engagement” AND “policy” AND (“diverse” OR “inclusive” OR “underrepresented” OR “marginalized”), “engagement” OR “community engagement” AND “priority populations” OR “vulnerable populations” OR “vulnerable communities” in “health policy” OR “health care decision-making” OR “priority-setting,” “Implementation” AND “engagement strategies” AND “healthcare” AND “decision-making.” The search terms were adapted as needed to meet the requirements of each database best. Additional filters (e.g., year of publication, language) were applied to refine further that the search and yield were appropriate to the inclusion and exclusion criteria described. With searching the Wellesley Institute and McMaster forum for grey literature reports, the entire repository was screened due to the lack of a “search term” filter in the library.

Records were included based on the following inclusion criteria: 1) identified underserved populations, 2) focused on health care and social services policy and decision-making, 3) partially or fully described the utilization of a predefined conceptual engagement theory, theory, framework, or engagement strategy 4) partially or fully described the utilization of engagement practices and tools, and 5) partially or fully described the utilization of any evaluation methods or tools. Records were excluded based on the following criteria: 1) theoretical reflection only (no engagement was done, no information on strategy or process), 2) academia-focused only (engagement occurred in a research context with no relevance/connection to decision-making in health policy/programs/services), 3) focused on describing clinical strategies and outcomes and not engagement strategies and outcomes, 4) engagement was only at the “inform” level (absence of two-way communication) 5), reports that were still in draft, 6) editorial and opinion pieces, and 7) unpublished protocols with no information on implementation or evaluation.

### Summary of the Search Strategy

TOTAL NUMBER OF RECORDS FOUND	INITIAL SCREEN OF ABSTRACTS	ABSTRACTS INCLUDED	ABSTRACTS SELECTED FOR FULL TEXT REVIEW	FULL-TEXT RECORDS DATA EXTRACTED
2522	2522	104	74	17

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## Community Engagement Pathways Initiative

Purpose: Identify current engagement pathways with underserved populations via stakeholder tables, inform recommendations to improve engagement practices, inform future engagement activities for policy and programming by MOH and OH.

### Current stakeholder engagement pathways

1. Which communities does your stakeholder table engage with?
2. In what ways do you interact with the MOH or OH?
3. What do you feel your role or influence is on their work?

### Strengths and challenges to engagement

4. What are the strengths of your table's engagement approach with underserved populations?
5. What are the challenges of your table's engagement approach? Do you have any recommendations for how to overcome these challenges?
6. What supports do underserved populations need to engage in these pathways?
7. How did the COVID-19 pandemic impact the way your table approached engagement?

### Representation in engagement

8. What underserved populations should the MOH or OH (via stakeholder tables) engage with that they are currently not engaging with? What are some areas of focus that should be considered in these engagements?
9. Do you have recommendations and best practices on how MOH or OH (via stakeholder tables) can engage with these populations?

### Future engagement activities by MOH or OH

10. What would ideal/successful engagement between MOH or OH and underserved populations look like?
11. What approaches (e.g., best practices) have you observed for engaging underserved populations that you think the MOH or OH should adopt to move closer to this ideal?

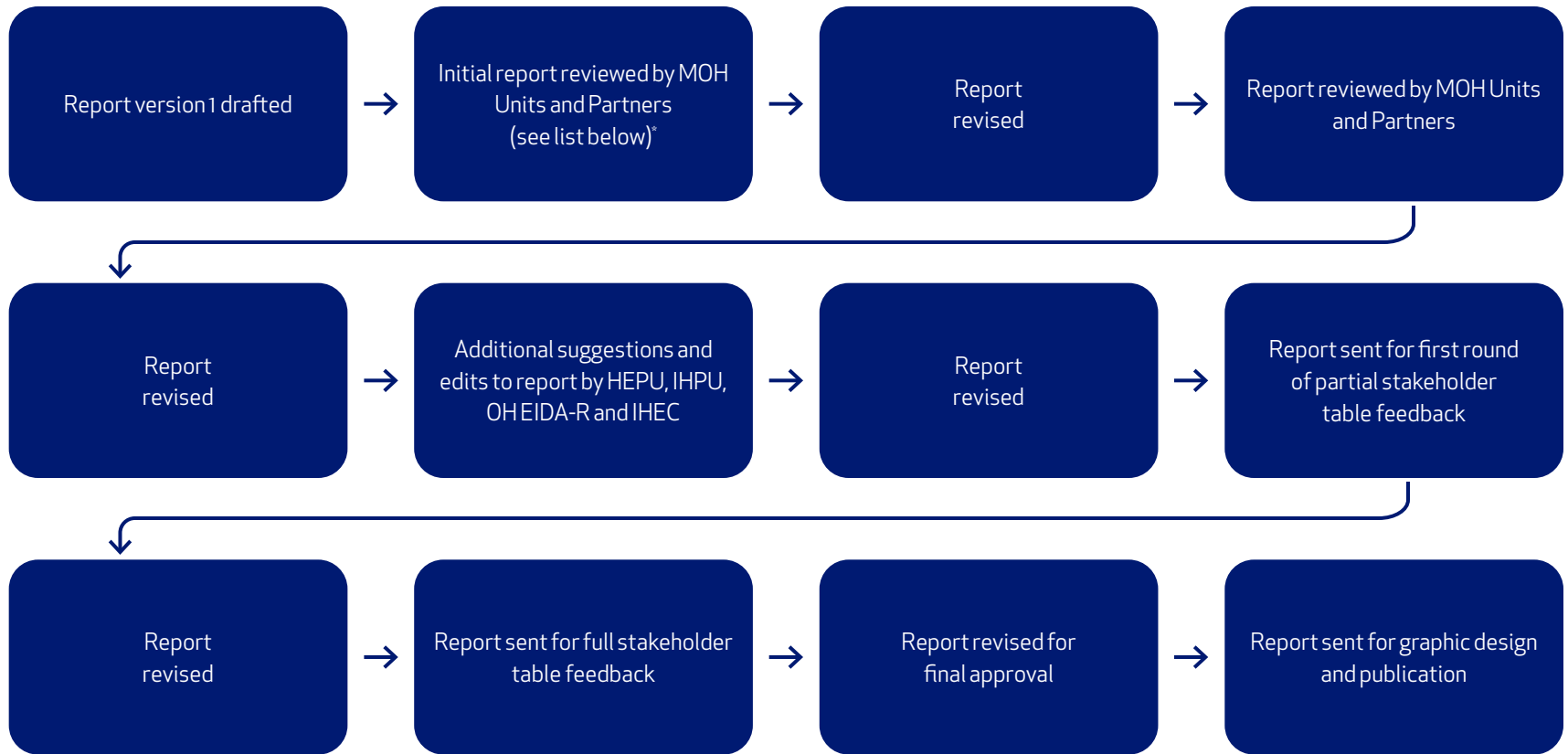
### Community-led governance

12. Community-led governance of sociodemographic data allows communities to oversee health equity data (e.g., race, gender, and income data). They provide oversight on how these data are collected, used, and shared to ensure data use aligns with community values. MOH is exploring how communities should be engaged in data governance. From your perspective how should MOH engage communities on how their health data should be best collected, used and reported?



**APPENDIX 4: Report Review Process**

This report underwent several rounds of review and revision prior to publication. The following diagram portrays the review process that was conducted between May and October 2023.



**Reviewers of the Draft Report\*:**

**Ministry of Health (MOH)**

- Health Equity Policy Unit (HEPU)
- Indigenous Health Policy Unit (IHPU)
- French Language Services Office (FLSO)

**Ministry of Citizenship and Multiculturalism (MCM)**

- Anti-Racism Directorate (ARD)

**Canadian Institute for Health Information (CIHI)**

- Population and Indigenous Health, Patient Engagement, and Equity, Diversity, and Inclusion teams

**Ontario Health**

- Equity, Inclusion, Diversity and Anti-Racism (EIDA-R)
- Indigenous Health Equity and Coordination Unit (IHEC)

**Stakeholder tables as identified in [Resource 2](#)**

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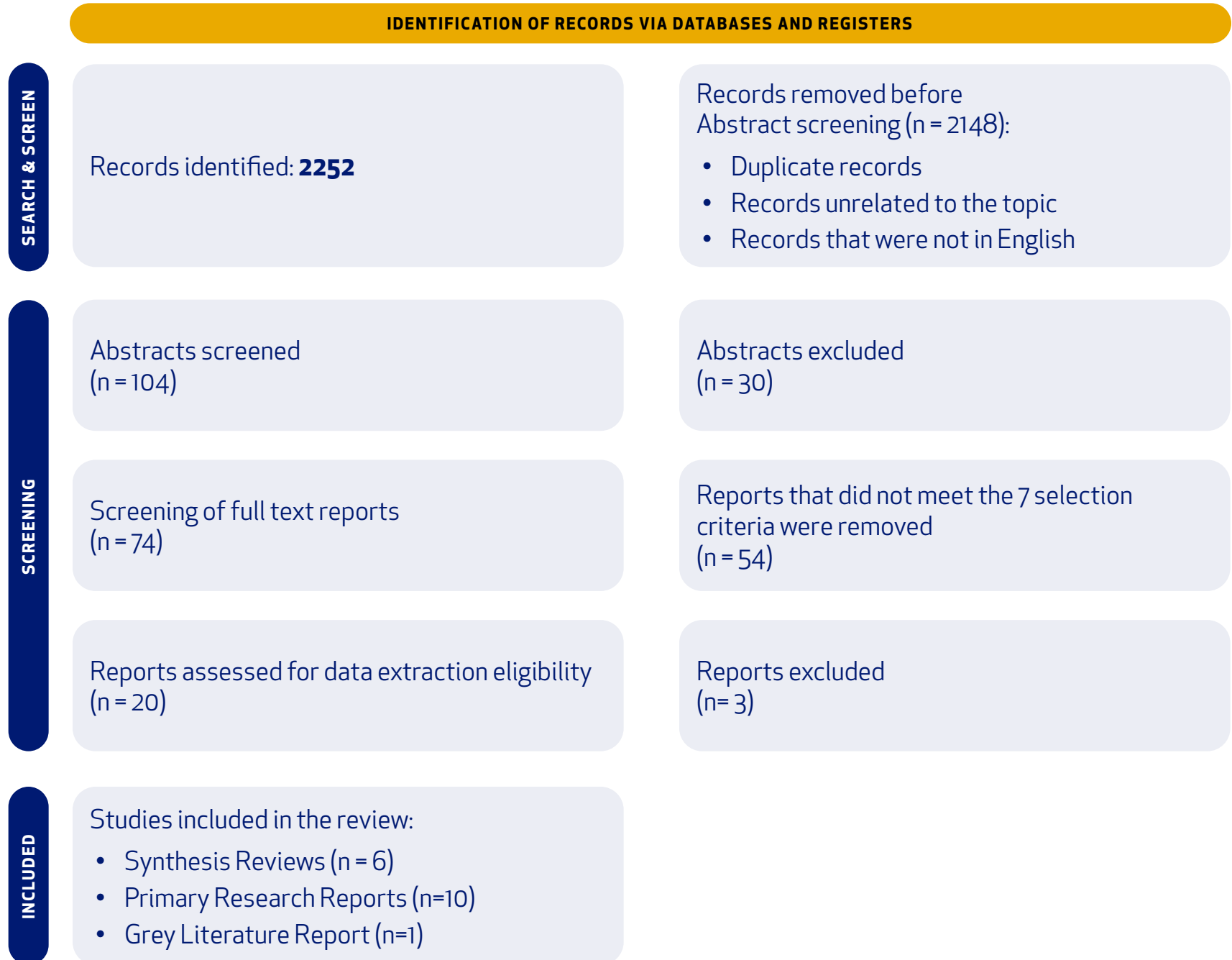
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## APPENDIX 6: Data Extraction Table (Scoping Review)

### Primary articles

ARTICLE	POPULATION	SECTOR	DESCRIPTION	EVALUATION	KEY FINDINGS AND RECOMMENDATIONS
<b>Jackson et al., 2018<sup>3</sup></b>	Underserved population (broadly defined)	Government	Describes a municipal pilot project that used a feedback-loop approach to community engagement.	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Participant observation</li> </ul>	<p>Establishing trust and being wary of “language privilege” is critical to developing reciprocal, mutually beneficial relationships.</p> <p>Relationship-building can be realized through co-creation. Assumptions of understanding across diverse cultures lead to miscommunication, ineffective engagement, and discord.</p>
<b>Walker et al., 2022<sup>1</sup></b>	Underserved population (broadly defined)	Government	Describes 15 community listening sessions across a diverse county with minoritized groups to demonstrate how codesign can increase public input in decision-making.	<ul style="list-style-type: none"> <li>• Informal (author reflection)</li> </ul>	By leveraging existing processes and relationships, the public health department could rapidly mobilize community groups to contribute to policy priority setting through listening sessions and participatory ranking sessions.
<b>Tomas et al., 2022<sup>4</sup></b>	Patients with specific conditions	Government	Describes a virtual, inclusive community of practice convened in developing policy recommendations for a Canadian National Autism Strategy.	<ul style="list-style-type: none"> <li>• Informal (author reflection)</li> </ul>	Key factors to success were named as communication and mobilization channels/ networks, capacity-building, tailoring and adaptation, and formalized terms of reference.
<b>Razavi, 2019<sup>5</sup></b>	Women	Government	Describes targeted consultations with intersectionally marginalized women about their experiences in health-system priority setting, including identifying and addressing barriers to participation.	<ul style="list-style-type: none"> <li>• Key informant interviews</li> </ul>	Transparency and accountability are necessary to maintain community interest in the participatory process. Remaining receptive to feedback about programming is essential to maintaining a trusting relationship with communities.
<b>Mulvale et al., 2019<sup>6</sup></b>	Underserved population (broadly defined)	Research	Describes a symposium with practitioners, academics, and service users that explored citizen involvement in codesigning services for vulnerable groups, including identifying challenges and suggesting improvements.	<ul style="list-style-type: none"> <li>• Thematic analysis of group discussions</li> </ul>	<p>Trust, flexibility, and responsiveness were recommended to address challenges with recruitment and continued engagement.</p> <p>Empowerment of service users and power-sharing across perspectives was noted as essential to address power differentials. Formal agreements are often advisable, and leadership must be shared.</p>

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ARTICLE	POPULATION	SECTOR	DESCRIPTION	EVALUATION	KEY FINDINGS AND RECOMMENDATIONS
<b>Yogalingam, 2021<sup>17</sup></b>	Underserved population (broadly defined)	Health/social care, services, and/or programs	Describes a Canadian, youth-led roundtable with a national advisory of youth leaders to participate in child and youth health decision-making.	<ul style="list-style-type: none"> <li>• Key informant interviews</li> </ul>	<p>Walk the talk: Ensure youth engagement is not tokenistic. Demonstrate value placed on youth input and unique experiences.</p> <p>Provide support and maintain flexibility to enable engagement from all participants. Work with youth to create the opportunities, spaces, and processes that would enable optimal engagement and ensure you have representative membership at the table.</p>
<b>Chuengsatiansup et al., 2019<sup>18</sup></b>	General public	Research	Examines a participatory policy process using a citizens' jury to promote public engagement in eldercare policy in Thailand.	<ul style="list-style-type: none"> <li>• Informal (author reflection)</li> </ul>	<p>The group deliberation process and result strongly suggest that jurors can understand complex policy issues and reach reasonable recommendations.</p> <p>Preparation of the following is crucial: (1) the question itself, (2) recruitment: size and representativeness, (3) the presentation of expert witnesses, (4) facilitation, and (5) enough time to know each other, to break the ice, to discuss, and to agree and disagree.</p>
<b>Switzer et al., 2019, 2021<sup>19,20</sup></b>	Patients with specific conditions	Health/social care, services, and/or programs	Explores stakeholder engagement at three HIV community-based organizations that provide programming and service delivery.	<ul style="list-style-type: none"> <li>• Photovoice: photo-elicited focus groups and interviews</li> </ul>	<p>View accessibility through an intersectional lens: age, race, Indigeneity, gender identity, sexual orientation, class, drug use, citizenship, HIV status, language, and disability uniquely intersect to contour people's experiences.</p> <p>Reframe the way you look at nonparticipation. Create more fluid entry points for meaningful participation that accommodate people's interests, desires, and needs.</p>
<b>Tugendhaft et al., 2021<sup>21</sup></b>	People experiencing poverty	Government	Describes a context-specific public deliberation tool applied in a rural community in South Africa to determine priorities (budget planning) for health services.	<ul style="list-style-type: none"> <li>• Informal (author reflection)</li> </ul>	<p>Sticker allocation helped visualize costs, but it ignored effectiveness and prevalence information. It was difficult to reconcile differences (divergent opinions) within the groups.</p>

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ARTICLE	POPULATION	SECTOR	DESCRIPTION	EVALUATION	KEY FINDINGS AND RECOMMENDATIONS
<b>Craddock, 2022<sup>22</sup></b>	Women	Health/social care, services, and/or programs	Describes how a network of public, statutory, voluntary, and community services bridged the gap between ‘seldom-heard’ women and health care providers in the UK, including identifying what had worked well for WHN and areas for improvement.	<ul style="list-style-type: none"> <li>• Key informant interviews</li> </ul>	<p>Problematizes the terms ‘seldom heard’ and ‘professionals’ for assuming homogeneity and masking diversity; needs to recognize diversity within ‘seldom heard’ rather than viewing the group as homogenous. Terminology needs to be context-specific and sensitive.</p> <p>Organizations should be sensitive to the ‘informal impediments’ that marginalized groups face, where certain modes of speech – particularly classed, gendered, and racialized – are ignored within the context of official public spheres. Models of community engagement that go to communities are more successful in engaging marginalized groups and improving health outcomes.</p>
<b>Scurr et al., 2022<sup>23</sup></b>	People experiencing poverty	Health/social care, services, and/or programs	Describes a co-designed deliberative dialogue among tenants of rent-geared-to-income housing complexes and health/social service providers.	<ul style="list-style-type: none"> <li>• Participant observation</li> <li>• Participant surveys</li> <li>• Focus groups</li> </ul>	<p>Involving members of the public in deliberative dialogues brings new perspectives to policy discussions and is highly valued by all stakeholder groups. Including those affected by the issue increased community trust in the initiatives undertaken in their name.</p> <p>Five main lessons and recommendations emerged: recognize diverse types of knowledge sharing, use facilitation to maintain balanced discussions, manage action-oriented outcomes, ensure transparency, and allow flexibility in the planning process.</p>

## Reviews

ARTICLE	POPULATION	DESCRIPTION	OUTCOME REPORTING	KEY FINDINGS AND RECOMMENDATIONS
<b>Manafò et al., 2018<sup>8</sup></b>	General public	A systematic review of 70 cases of public engagement in priority-setting for health care and research	<b>Descriptive reporting</b> on the role and level of public engagement and decision-making (deliberative vs consultative)	<p>One size does not fit all: all methods and strategies should be translated and adapted to suit the context.</p> <p>Make any public contribution visible and the process transparent about how the public has been involved.</p> <p>Maintain adequate data monitoring, collection, and evaluation to support continued interest and buy-in from the public, researchers, and decision-makers.</p>
<b>Gilmore et al., 2020<sup>9</sup></b>	General public	Rapid review of 37 cases of community engagement used for infectious disease prevention and control during epidemics	<p><b>Descriptive reporting</b> on the who, what, and how of community engagement</p> <p><b>Evaluative reporting</b> on barriers, facilitators, and best practices</p>	<p>Start community engagement early as an ongoing, collaborative process with members who influence the community. A regular feedback mechanism is needed to monitor and course-correct the process.</p> <p>Establish a two-way dialogue with communities through multiple channels. Communities should be involved in issue identification and codesign of interventions.</p> <p>Conduct context-specific engagements considering local realities, cultures, traditions and customs, social norms, and collective beliefs.</p>
<b>Haldane et al., 2019<sup>10</sup></b>	Underserved population (broadly defined)	A systematic review of 49 cases of participative health service development	<b>Evaluative reporting</b> on process outcomes (participation structures), community outcomes (attitudes/beliefs), health outcomes (impact), stakeholder perspectives (satisfaction), and extent of community empowerment	<p>Community engagement must be viewed as a “process” rather than an isolated initiative. Empowerment requires sustained engagement.</p> <p>There is no “one size fits all” approach to community participation. Failing to account for contextual learning can result in failure to work together to achieve goals, and this is especially important in vulnerable populations and communities with a history of colonization and forced assimilation.</p> <p>Changes to health status and health outcomes usually require long-term monitoring and may not be measurable over a single program cycle. While descriptive reports provide insight into program successes and operationalization, there is a need for more robust program evaluations and studies that measure and report long-term outcomes.</p>

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ARTICLE	POPULATION	DESCRIPTION	OUTCOME REPORTING	KEY FINDINGS AND RECOMMENDATIONS
<b>Leopold et al., 2020<sup>11</sup></b>	General public	Comparative review of 2 deliberative processes used to engage the public in national reimbursement decisions	<b>Descriptive reporting</b> on the content of the decisions made (minimal reporting on the engagement processes)	<p>Asking citizens for their opinions as an individual puts solidarity under pressure. It is recommended to provide time and opportunity for group discussions instead.</p> <p>Public consultations increase transparency on existing processes and prospective changes. Involving stakeholders from the beginning of the change process can give everyone a sense of change ownership.</p> <p>Involving senior-level management in community outreach increases public access to engagement by providing a human face to the decision-making process, which invites opportunities for questions and feedback.</p>
<b>Chauhan et al., 2021<sup>2</sup></b>	Underserved population (broadly defined)	A narrative review of 11 engagement frameworks used in Australia at federal and state level health departments to assess their utility in supporting culturally and linguistically diverse engagement	<p><b>Descriptive reporting</b> on the presence of framework elements: engagement definition, process and extent (tokenistic vs meaningful), activities, special consideration for culturally/linguistically diverse populations</p> <p>Limited <b>evaluative reporting</b>: participant feedback surveys</p>	<p>Being purposeful was commonly recommended, described as co-defining a clear expectation/understanding of tasks, activities, and outcomes. Partnered facilitators and the community should share process ownership and accountability.</p> <p>Strategic plans that recognize the needs of culturally/linguistically diverse populations, committees representing these populations, and adequate resources/time were identified as key mediums. Specifically, identifying local communities was considered essential for advisory committees and governance activities – these communities shouldn’t be grouped into one broad category (called “priority groups” or similar).</p> <p>There is a need for increased provision of accredited interpretation services, including the policy that mandates this. All staff and providers should be trained in cultural responsiveness to create a culturally safe environment that addresses language barriers. This can be achieved through tailored training programs developed in partnership with local communities.</p>
<b>Mamatis et al., 2019<sup>24</sup></b>	Underserved population (broadly defined)	A scoping review of 18 interventions to support civic engagement and social participation.	<p><b>Descriptive reporting</b> on the presence of attributes: community-led, arts-based, built-environment-based, technology-based</p> <p><b>Descriptive reporting</b> on which communities were engaged and on whether they were passive program recipients vs involved volunteers</p> <p><b>Evaluative reporting</b> on health outcomes (impact)</p>	<p>Inclusion should prioritize the most marginalized, as conceptualized across different intersecting identities (e.g., gender identity, race, age, class, and ability). However, traditional engagement strategies (e.g., open calls for input) tend to fail to engage these communities, instead acting to perpetuate exclusion systemically.</p> <p>Barriers to engagement include lack of compensation for participation, fragmented engagement processes that do not promote sustained involvement, and sociocultural differences between people facilitating engagement and groups being engaged.</p> <p>There is also a need for better processes to evaluate and measure success.</p>

## APPENDIX 7: Considerations for Engaging with Specific Populations on the Collection, Use and Reporting of Their Data (Key Informant Interviews)

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- **Migrant workers** may be concerned about losing their jobs or creating friction with their employer, whether real or perceived, when it comes to data collection. Consider engaging migrant workers in how these questions are asked and how they want to identify themselves during a data collection initiative.
- Collecting personal data on **people who use drugs** is a barrier in itself due to the criminalization of drug use. It would be important for data collection to be anonymous and voluntary for this population. Harm reduction programs, for example, lower the barrier to access and don't require information such as name or health card number; instead, they use individual codes.
- **Black, African, and Caribbean** populations' community governance is hugely important and requires unique strategy and considerations into data collection, use, and reporting. The Black Health Equity Working Group released the Engagement, Governance, Access, and Protection (EGAP) framework, describing the governance needed for collecting, managing, analyzing, and using data from Black communities and should be used as a starting point to guide appropriate data use.
- Although community-led data governance is mentioned here in the context of many underserved populations, there is extensive work in the area of Indigenous data sovereignty with **First Nations, Inuit, Métis and urban Indigenous** (FNIMUI) partners. Historically, FNIMUI partners have not been consulted on data collected about them and how it has been used, which has resulted in harm and misuse of data. The First Nations principles of OCAP® (ownership, control, access, and possession) asserts that First Nations own their information and that they are stewards of their data.<sup>29</sup> The right of First Nations communities to own, control, access, and possess information about their peoples is fundamentally tied to self-determination and to the preservation and development of their culture. OCAP® enables a community to make decisions regarding why, how and by whom information is collected, used or shared and should be the basis of any data use.<sup>30</sup>

### Suggested Examples and Guidance Documents on Community Data Governance:

- The Engagement, Governance, Access and Protection Framework ([EGAP framework](#))
- [Toronto Region Confronting Anti-Black Racism](#)
- "Ability to Caucus" is a committee of community members who can veto or have the final say on topics that are relevant to them. For example, if research is proposed about the Black community, the Black community members of the committee get to have the final say on whether to collect.
- The First Nations Principles of [OCAP® website](#)



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