The value of frameworks as knowledge translation mechanisms to guide community participation practice in Ontario CHCs

Stephanie Rose Montesanti a, *, Julia Abelson b, c, John N. Lavis b, c, d, e, f, g, James R. Dunn h, i, j

a Department of Community Health Sciences, University of Calgary, Canada
b Centre for Health Economics and Policy Analysis, McMaster University, Canada
c Clinical Epidemiology and Biostatistics, McMaster University, Canada
d Program in Policy Decision-Making, McMaster University, Canada
e McMaster Health Forum, McMaster University, Canada
f Department of Political Science, McMaster University, Canada
g Department of Global Health and Population, Harvard School of Public Health, United States
h Department of Health, Aging and Society, McMaster University, Canada
i Centre for Research on Inner City Health in the Keenan Research Centre of the Li Ka Shing Knowledge Institute of St. Michael's Hospital, Canada
j McMaster Institute for Environment and Health, Canada

ABSTRACT

The community participation literature has produced numerous frameworks to guide practice and evaluation of community participation strategies in the health sector. These frameworks are useful starting points for differentiating the approaches for involving people in planning and decision-making for health services, but have been critiqued for being too generic and ignoring that community participation is highly contextual and situational. Health service organizations across Canada and internationally have begun to respond to this limitation by developing more context-specific community participation frameworks; however, such frameworks do not exist for Ontario Community Health Centres (CHCs)—local primary health care organizations with a mandate to engage marginalized groups in planning and decision-making for health services. We conducted a series of focus groups with staff members from four Ontario CHCs to: (1) examine the factors that would influence their use of a generic framework for community participation with marginalized populations; and (2) improve the “context-specificity” of this framework, to enhance its relevance to CHCs. Participants described the difficulty of organizing the contextual, multi-faceted and situational process of community participation that they experienced with marginalized populations into a single framework, which led them to question the value of using frameworks as a resource for guiding the design, implementation and evaluation of their community participation initiatives. Instead, participants revealed that tacit knowledge, in the form of professional and personal experience and local knowledge of a marginalized population, had a greater influence on guiding participation activities in Ontario CHCs. Our findings suggest that tacit knowledge is an essential feature of community participation practice and requires further exploration regarding its role in the community participation field.

© 2015 Elsevier Ltd. All rights reserved.

1. Background and rationale

Community Health Centres (CHCs) in Ontario are local primary health care organizations that provide programs and services to marginalized populations. For CHCs, community participation is argued to be at the very core of every program, service, or initiative. Moreover, CHCs are mandated to engage marginalized groups in planning and decision making for health services and programs. CHCs are also governed by community boards that include members of marginalized populations. Community boards provide a mechanism for CHCs to be responsive to the needs of diverse marginalized populations. Most CHCs, however, do not have a
framework in place to guide the design, implementation and evaluation of their community participation initiatives.

The literature on community participation in health service planning and decision-making includes numerous frameworks to guide practice and evaluation. These frameworks, derived from research evidence on community participation, are useful starting points for differentiating the approaches and extent of people’s involvement in planning for and decision-making about their health care. Two well-known frameworks frequently cited in the community participation literature include those of Sherry Arnstein (1969) and Susan Rifkin (1986). Despite being several decades old, Arnstein’s (1969) ladder of participation still draws considerable attention in the public participation literature. The ladder depicts citizen participation along a continuum. Each level represents a different degree of control that citizens should have in a planning or decision-making process, which influences the approach that is used. Essentially, the higher the rung on the “ladder,” the more that full citizen engagement (i.e., through citizen control) is achieved. Since Arnstein, there has been a shift towards understanding participation in terms of the empowerment of individuals and communities to make decisions about their own health. Rifkin’s typology of community participation has gained popularity in the health promotion and disease prevention fields. 

Rifkin (1986) characterizes three approaches that health planners use to define community participation based on different assumptions about the effective ways that decision making can improve a population’s health and the role of individuals and communities in the decision-making process. Scholars have critiqued both frameworks for being generic and ignoring contextual and situational aspects of community participation (Abelson, 2001; Campbell and McLean, 2002; Cornwall, 2008; Draper et al., 2010; Kenny et al., 2013; Titter and McCallum, 2006). Furthermore, the application of these frameworks in different contexts and with different users has demonstrated that the search for a “gold standard” framework for community participation that can be replicated across different contexts is neither realistic nor appropriate (Draper et al., 2010; Titter and McCallum, 2006). The limitations in adapting these frameworks to different contexts and populations, pose challenges to practitioners in determining how their initiatives should be designed and the core features that make up a community participation process.

A plethora of community participation frameworks have been developed by health service organizations across Canada and internationally (e.g., regional health authorities and public health units across Canada, and Local Health Districts in Australia, among others) that contextualize community participation to their specific goals for engagement. However, it is unknown how a given community participation framework is adapted by a health service organization. In this study, we examine the prospects for CHCs to adapt a community participation framework to guide the design and implementation of community participation initiatives within their CHC. A draft generic community participation framework was shared with staff members in focus groups from four Ontario CHCs. Participants were asked to examine the elements of the draft framework for community participation with marginalized populations to understand the factors that would influence their attitudes towards adopting such a framework. The draft framework was informed by preliminary findings from a systematic review of the community participation literature with a focus on marginalized populations. The findings from this review provided key insights about the barriers to engaging marginalized populations, and how to design effective participation strategies to address these challenges (Montesanti, 2013, p. 23). Community participation with marginalized populations is described in the scholarly literature as involving a process that empowers marginalized people to take responsibility for diagnosing problems, identifying opportunities and strategies for change, by building on their knowledge and lived experiences (Rifkin, 2003).

2. The use of community participation frameworks within local health service organizations

Local health service organizations play important roles in delivering health services and programs to local populations, often with local citizens’ direct involvement in the planning and decision-making of their health care (Minkler, 1997; Wilson et al., 2010). Moreover, scholarly research has also been influenced by this political commitment towards greater community participation, with a substantial body of literature focused on the study of community development processes and community participation in health service planning (Minkler, 1997; O’Neill et al., 1997).

To guide health service organizations, health system managers, and community health planners in the design and implementation of their participation strategies, efforts have been made to conceptualize effective engagement based on evidence about participation practice through the development of frameworks of community participation (Arnstein, 1969; Charles and DeMaio, 1993; Rifkin, 1986, 2003; Thurston et al., 2005). There is significant variation across these frameworks; some are more starting points for health service organizations or practitioners (and include a set of basic definitions and principles of community participation, and different levels or types of participation), while others include extensive resources that involve contextual analyses (Abelson, 2001; Draper et al., 2010; Thurston et al., 2005; Levac, 2012).

Regional and local health service organizations across Canada and internationally have developed their own community participation frameworks that are appropriate to their local context, organizational goals and values towards participation, and the population(s) they serve. Some Canadian examples of community participation frameworks developed within the organizational structure of local health service organizations include: the Ontario Local Health Integration Network (LHIN) Community Engagement Frameworks (Ontario Ministry of Health and Long-term Care, 2011), the Vancouver Coastal Health Community Engagement Framework (Vancouver Coastal Health, 2009), and Waterloo Public Health iEngage initiative (Region of Waterloo Public Health, 2006). The absence of empirical evaluations of these frameworks, however, has been noted in the research literature (Collaborative Health Innovation Network, 2012).

Frameworks are one type of resource that can be useful for translating and sharing knowledge derived from research evidence about community participation processes among service providers and staff within and across health service organizations to inform their participation strategies. Knowledge translation (KT) is the term used in the health field to refer to an interactive process of knowledge exchange and application between health researchers and users of research evidence (Canadian Institutes of Health Research, 2010; Lavis et al., 2003). Within service organizations, research evidence is usually translated into the development of professional practice guidelines, toolkits, or evaluation frameworks, for service providers or health system managers (Kothari and Armstrong, 2011).

The limited support, to date, for community participation frameworks as a mechanism for translating and sharing knowledge about community participation practices within Ontario CHCs is of particular research interest in this study. An examination of the factors that influence CHCs’ use of community participation research to guide their participation initiatives can help to explain the likelihood of their adopting a community participation...
framework as a mechanism for translating and sharing knowledge about community participation practice. Evaluation studies of community participation strategies argue that the conceptual ambiguity of the concept of community participation, as well as lack of agreement on the core features for effective participation processes, pose challenges to using research evidence about community participation since there is no consensus on the knowledge that is generated from the research to be transferred (Cornwall, 2008; Draper et al., 2010). The challenges in defining community participation are contributed by differing ideological values and rationales for participation. For instance, some scholars view community participation as means or intervention to achieve a specific outcome; whereas other scholars view participation as an end through which people or individuals are empowered as they develop their skills, knowledge, and confidence to improve and gain control over the conditions that affect their lives (Rifkin, 2003).

The rationales for and pathways through which research evidence informs the professional practice of staff in health service organizations have been clearly articulated in the knowledge translation literature (Wilson et al., 2010). Organizational studies, in particular, highlight the role of an organization’s context in influencing the use or adoption of research evidence. Dobrow et al. (2006) argue, “to better understand how evidence-based decisions are, and should be made, further understanding of how context affects the introduction, interpretation and application of evidence is needed” (p. 215). Contextual factors that might influence the use or adoption of research evidence within an organization include organizational structures, organizational culture, preference for local and tacit knowledge over research evidence, and varying skills and expertise of staff and practitioners (Dobrow et al., 2004; Dobrow et al., 2006; Lavis et al., 2008; Kothari et al., 2012; Wilson et al., 2010). Within local or community-based health organizations, in particular, emphasis is placed on the value of community strengths and knowledge and the process of working in collaboration with stakeholders in order to achieve an outcome (Kothari and Armstrong, 2011; Wilson et al., 2010). This approach to working in collaboration has implications for traditional understandings of how knowledge translation is related to research dissemination (Kothari and Armstrong, 2011).

One specific type of knowledge – tacit knowledge – has been cited in the research literature as having an influence on the adoption of research by an organization. The term tacit knowledge has been used to describe knowledge that is acquired from practice and experience and has been used interchangeably with related concepts such as procedural knowledge, implicit knowledge, unarticulated knowledge, and practical or experiential knowledge (McAdam et al., 2007). Scholars have conceptualized tacit knowledge differently. According to Polanyi (1966), tacit knowledge is deeply related to skills and very difficult for the individual to articulate. Polanyi expressed this, as “we know more than we can tell.” In contrast, Nonaka (1994) suggests that a degree of tacit knowledge can be articulated and shared through interactive conversation and shared experience through the use of metaphors, analogies and stories. We draw on Nonaka’s concept of tacit knowledge given its dominance and applied focus in the management and organizational literature. Such knowledge gained through years of experience in a local context may be promoted in response to limited organizational or staff capacity to assess and apply research (Kothari et al., 2012). Moreover, the emphasis on tacit knowledge within local or community-based health organizations suggests the value of local knowledge.

Community-based organizations regularly engage in their own research—needs assessments, capacity/asset mapping, focus groups, and surveys—with target populations to capture this local knowledge (Kothari and Armstrong, 2011). Some CHCs have begun to conduct their own community-based research with the establishment of hired researcher positions within their centres. While “the information from local research efforts is highly valued for its contextual relevance, and is perhaps more likely to be put into action through health programs” (Kothari and Armstrong, 2011, p. 3), further investigation is still needed into the reasons why organizations prefer local knowledge over scholarly research or academic knowledge. We aim to fill this knowledge gap by gaining a better understanding of the use of frameworks as a mechanism for translating and sharing knowledge about community participation practice applied to marginalized populations to inform community participation initiatives within CHCs in Ontario.

3. Research objectives

The objective of this study was to examine the role of frameworks as one mechanism for translating and sharing knowledge about community participation practice with marginalized populations in CHCs. Specifically, the study sought: (1) to examine the factors that would influence the use of a generic framework for community participation with marginalized populations by CHCs; and (2) to improve the “context-specificity” of this framework, to enhance relevance to CHC staff involved in the planning and design of community participation initiatives.

4. Methods and data

4.1. Study design

Comparative case studies of four Ontario CHCs where carried out through focus groups with CHC staff (Montesanti, 2013, p. 120). Our research applied the principles of participatory research (Israel et al., 1998) in which co-learning, co-production and commitment are shared. The research goals and objectives for the larger case study were developed in collaboration with the Association of Ontario Health Centres (AOHC), the provincial organization representing community-governed primary health care organizations including CHCs.

Focus groups with CHC staff explored the adoption of a community participation framework to aid CHC staff in their implementation of participation initiatives with marginalized populations. The focus groups were convened between June and August 2012. Each group met once with each session lasting approximately 1.5 h. Focus groups varied in size from five to twelve participants, for a total of 28 participants across four sites. A generic framework including the proposed core elements of a generic community participation approach that can be applied to any marginalized population was developed from a preliminary synthesis of literature, and was presented to participants at each focus group session. The design of the focus group allowed participants to collaboratively discuss and share their views about, and suggest revisions to, the generic framework that was presented to them. Ethics approval of the study was obtained from the McMaster University Health Sciences Research Ethics Board (REB 10–639).

4.2. Focus group participant selection and recruitment

A maximum variation sampling strategy (Maxwell, 2005, p. 89) was used to guide the selection and recruitment of focus group participants, which was based on our interest in gaining diverse perspectives about and experiences with community participation with marginalized groups. A key contact person was identified at each CHC site to assist with participant selection and recruitment. Prospective participants were selected from a range of positions held within the CHC. Invitation letters and consent forms were sent
to prospective participants. The number of participants interviewed varied across the focus groups, relating to the number of staff at the CHC who were eligible to be included. The types of positions held by focus group participants at their CHC included:

i. Health promoters;
ii. Peer outreach workers;
iii. Health care providers (e.g., physicians and nurses);
v. Community health planners;
v. Executive directors of the CHC; and
vi. Members of community board of directors.

4.3. Focus group participant discussion guide

A common set of focus group questions was used to explore staff views about community participation frameworks and the likelihood of adopting such frameworks in the CHC context. The key contact person from each CHC site provided feedback on focus group questions. The following questions were included:

(1) Do you think this framework reflects the main components and key design features that are essential to involving marginalized communities?
(2) Could this framework be used to guide community participation initiatives within your CHC? What would be the barriers to adopting it? And what are the facilitators to assist with the use of the framework among CHC staff?
(3) What would you change in this framework? Do you think something is missing that explains the design or approach to participation with marginalized communities?
(4) What is the intention of your CHC to use this framework to guide future community participation strategies in local health services planning at your CHC?

4.4. Data collection and analysis

The focus groups were facilitated by the principal investigator (Montesanti). All focus groups were audio recorded and transcribed verbatim, and extensive notes were also taken to supplement the recorded material. Formatted transcripts were imported into the qualitative data analysis software program QSR NVivo (version 10) for analysis. The primary investigator (Montesanti) and one co-investigator (Abelson) read through a subset of the transcripts to generate a set of preliminary themes. We began with a constant comparative analysis that involved an iterative process of moving backwards and forwards between transcripts and memos, coding and analyzing passages (Charmaz, 2001; Strauss and Corbin, 1998).

During initial research team discussions about the transcript data, we identified an emerging theme across each of the focus groups that challenged our original research objective (to examine the prospects for CHCs to adopt a generic community participation framework derived from evidence about participation practice applied to marginalized populations). Instead, we found that CHC staff members did not strongly support the use of a framework as a resource to guide their community participation initiatives with marginalized populations. This unexpected theme was investigated more fully using a qualitative descriptive analytical approach, which is dynamic and reflective. Sullivan-Boyai et al. (2005) explain that the goal of qualitative description is “not thick description (ethnography), theory development (grounded theory) or interpretative meaning of an experience (phenomenology) but a rich description of the experience depicted in easily understood language” (p. 128). The researcher works hard to stay close to the “surface of the data and events” (Sandelowski, 2000, p. 336), where the experience is described from the viewpoint of the participants (Sullivan-Boyai et al., 2005, p. 128). The findings from the focus groups were shared with key contact individuals from each CHC site.

5. Findings

Our findings are organized around five themes that explain the prospects for CHCs to adopt a community participation framework to guide their efforts to engage marginalized populations, which include: (1) the contextual nature of engaging marginalized populations which involves a flexible and iterative process of participation; (2) the preference among CHC staff for drawing on their personal and professional experience and knowledge, to guide community participation initiatives with different marginalized populations; (3) the role of the community development approach in facilitating engagement with marginalized populations within CHCs; (4) the limitations of generic community participation frameworks for engaging marginalized populations; and (5) the value of using frameworks within CHCs despite their opposition towards generic community participation frameworks. These five themes help to explain the emerging theme regarding the limited support of frameworks as a type of resource to guide CHCs with their community participation initiatives.

5.1. “It all depends”: context and community participation with marginalized populations

When focus group participants were asked to review the generic community participation framework, they disagreed with the portrayal of community participation as a linear process with discrete phases that showed a progression from planning to implementation. Instead, they described the community participation process as context-specific and “depend[ing] on the population engaged and the issue at hand” (Participant, CHC 1). They portrayed community participation initiatives as requiring a flexible process to allow planners or facilitators to “jump in at any point […] enter from different areas at different times, and go back to an earlier phase when an unexpected change happens […]” (Participant, CHC 3). When asked about the phases of a community participation process, which include planning, implementation and assessment of outcomes, participants viewed these as “inter-twined…[and] requires [staff] to go back to the planning stage after implementing an initiative [to] make changes and reconsider how to engage the population” (Participant, CHC 4).

Focus group participants identified barriers that would change the course of a community participation initiative which relate to the social and cultural characteristics of marginalized populations, or events within the political environment that influence the funding of CHC programs or health interventions. One participant explained that it is the responsibility of CHC staff who facilitate community participation initiatives to become aware of the social and cultural characteristics of the population that is engaged:

You have to be really conscious about how the community is structured, how the community functions, how the community evolves over time […] before you can actually approach the community. (Participant, CHC 4)

Participants, therefore, argued that initiating engagement strategies without the knowledge of a population’s characteristics could impede its success.

Participants further portrayed community participation with marginalized populations as a complex process involving multiple
components and steps. They reflected on the difficulty of organizing the contextual, multi-faceted and situational process of community participation that they experienced with marginalized populations into a single framework, which led them to question the value of using frameworks as a resource for CHC staff and providers. One participant used the analogy of a broccoli or cauliflower to express the multi-faceted process of community participation with this type of population:

Think about how broccoli and cauliflower are structured. You can see one whole object, but it’s got distinct parts […] So like a broccoli or cauliflower, […] engaging a community involves intricate pieces that define community engagement. (Participant, CHC 1)

The intricate components that reflect the elements of community participation processes that seek to involve marginalized populations demonstrate the difficulties of illustrating this engagement process in a framework.

5.2. The role of experiential knowledge

When focus group participants were asked whether they would use a community participation framework to guide their community participation initiatives, they indicated their preference for drawing on past experience (whether professional or personal), knowledgeable staff members, and interactions with members of relevant populations rather than rely solely on frameworks to guide their work. Participants reflected that knowing how to facilitate and manage community participation initiatives is best learned through experience with testing different methods or approaches that were learned from existing research evidence about community participation practice or personal experience with engaging marginalized populations to see what works best. One participant in the same focus group elaborated on their use of experiential knowledge in the following way:

…I think we’re probably drawing on a whole host of our own education, community-based research skills, and our lived experience. So if we were to sit down and address some issue, like the contamination of ground water, I don’t know if we’d actually as our first step say let’s find a framework. (Participant, CHC 1)

Focus group members all considered their CHC staff that work directly on the ground with marginalized populations as experienced community participation practitioners who have been working in their community for a long time. The heavy reliance placed on specific members of the organization for this expertise was also emphasized:

If I think about our CHC we have more than two decades of organizational history and wisdom in community engagement […] When I think about how we have approached engagement […], we draw on the experience of our staff, collectively and individually, who are facilitating community engagement. (Participant, CHC 1)

Given the complexity of community participation, participants explained that their expertise in designing community participation processes for marginalization populations was developed over time in an experiential and contextual manner. Participants described experiential knowledge as knowledge gained by several years of working closely with engaging a specific population in planning and decision making for their health care. The length of time that CHC staff spent engaging with a marginalized population was described as an important feature of community participation practice with marginalized populations. This also shaped the degree to which they felt it was necessary to rely on resources such as a community participation framework to guide their community participation practice. One participant explains:

We really have built that trust […] so for instance, with our prenatal nutrition clinic, it’s taken many years to develop participation methods to get their input on the planning of the clinic. […] But now, after running the clinic for more than 15 years, the women are much more comfortable with giving input […] so it’s really knowing the history of different groups and what they want. (Participant, CHC 1)

Another participant articulated the importance of relying on the experiential knowledge of both self and others:

I think if you’ve been doing it for 20 plus years you’re more likely to have looked at a number of frameworks and the evidence […] but I also might be thinking, who can I talk to that can help me? What have we done in the past? (Participant, CHC 2)

As this reflection suggests, for many CHCs, the decision to use any type of resource, such as frameworks, toolkits, or guidebooks, is influenced by how much experiential knowledge they have from working with the population. Therefore, a strong preference was articulated among CHC staff and providers to rely on past experience, knowledgeable staff members, and in-depth knowledge of the community to inform community participation activities, as compared to a focus only on relevant research evidence that is embedded within a framework.

5.3. The community development approach to participation

The likelihood of a CHC using a community participation framework also appeared to relate the organization’s particular approach to participation. Participants emphasized the role of the community development approach in facilitating engagement with marginalized populations. One principle of the community development approach that was emphasized is the principle of ownership and decision making power of marginalized populations in health service planning and decision making. Based on this principle, the CHC’s role in a community participation initiative is to facilitate and support the involvement of marginalized populations, rather than dictate how marginalized populations can participate. Essentially, this requires “celebrating the sort of capacities of the community, and looking at assets and strengths” (Participant, CHC 3).

For a community initiative to be successful over the long term, participants indicated that the issue(s) to be addressed must be identified by the community as a priority that compels action. Supporting a marginalized population’s ownership for their health care is about “getting information from them on how they interpret their health problems, as opposed to CHCs providing information and identifying the problems for them to share their views on” (Participant, CHC 3). Furthermore, participants viewed marginalized populations as the drivers of community participation, “deciding how they want to be engaged …” (Participant, CHC 3) and working collaboratively with CHCs to design and implement community participation initiatives. This focus on the marginalized population driving their own participation might reflect the reluctance of CHCs to rely on frameworks or other resources to
assist them in guiding community participation initiatives.

5.4. Critiques of generic community participation frameworks

Participants felt that the framework they were asked to review was too generic and ignored the highly contextual nature of community participation. Participants explained that if they were to use a framework it would have to be adapted to the local context of CHCs, which was described to be a difficult task given the complexity and multifaceted nature of community participation with marginalized populations. Generic frameworks were described as “one dimensional, suggesting that somebody [referring to practitioners] needs to assess and also identify the problem” (Participant, CHC 4). Participants across focus groups shared similar concerns about generic frameworks, and they talked about how methods of participation vary by marginalized populations (in order to relate to differences in their social and cultural characteristics). Many focus group members noted that the diversity of marginalized populations poses a challenge to using one generic community participation framework for all CHCs in the province. As one participant expressed:

...trying to get diverse groups and even individuals from the same group to work together is difficult, even though they all have the same problem, for instance they’re all trauma survivors, living in dire poverty, marginalized, etc. [...] (Participant, CHC 3)

Some participants went on to describe the limitations of generic frameworks for not specifying the tools for enabling the participation of diverse marginalized populations. For one CHC, participants in the focus group talked about the training of CHC staff and providers on the principles of anti-racism and anti-oppression as a core component in their community participation process, which would need to be included in a framework for their CHC. One participant addressed the limitations of the generic framework, arguing:

The steps here don’t include that there has to be some awareness and education on behalf of those who want to engage marginalized populations. So where’s the preparation around the providers or the organization?...so for us commitment to anti-racism and anti-discrimination principles would figure into the framework. (Participant, CHC 4)

In contrast to using a generic framework to guide their community participation activities, there was a general view shared across the focus groups regarding the value of a framework tailored to their specific CHC context as opposed to a single framework that can be applied to all CHCs.

5.5. Finding the value in community participation frameworks

Despite their general opposition to generic community participation frameworks, focus group participants considered how such a generic framework could be of use within their organization. A suggestion raised in all four focus groups included the use of frameworks to orient new staff or providers to the principles of community participation:

...if we were a new CHC, or if a staff member retired and we bring on a brand new health promoter who doesn’t have that lived experience [in engagement] and familiarity of the research, then I can certainly see it being helpful as a starting point for discussion. (Participant, CHC 1)

Another participant described how a framework could be used to inform new staff and volunteers about a typical community participation process:

...and I think that is a real asset to have something that you can distribute and show and kind of walk through these are the various steps, these are things that need to be thought through, that’s really helpful. Because some people are very naïve about how much goes into planning community engagement. (Participant, CHC 1)

Focus group participants also thought frameworks could be useful for CHCs and their partner organizations when establishing a common understanding of community participation principles and developing a process for engaging marginalized populations. One participant stated that “for partners who may not have been involved in community participation before, being able to have something that lays out the components” (Participant, CHC 2). In particular, a common language among CHCs and their partners is “useful for creating a culture of inclusivity and a culture of understanding that it’s essential to practice community participation in this way” (Participant, CHC 1).

Another suggested use of a framework is to demonstrate to funders and local decision-makers that CHCs are being transparent about their community participation process, and “how much effort, resources, time and careful planning is required to achieve meaningful outcomes from community participation” (Participant, CHC 1).

6. Discussion

Numerous community participation frameworks have been developed to guide practice of community participation strategies in the health sector. These frameworks have been critiqued, however, for failing to acknowledge that participation is heavily contextualized and situational (Abelson, 2001; Draper et al., 2010; Tritter and McCallum, 2006). Moreover, numerous studies have demonstrated the particular complexities and multifaceted nature of engaging diverse and marginalized populations (Campbell and McLean, 2002; Kenny et al., 2013; Maalim, 2006).

Our findings support these critiques but also reveal a clearly stated preference among CHC staff for relying on experiential knowledge of community participation with marginalized populations. Participants described the limitations of community participation frameworks derived from research evidence about community participation practice for not specifying how to enable the participation of marginalized populations. Instead, experiential knowledge was felt to play an equal if not more important role in making sense of, and implementing, research evidence about community participation practice. The knowledge acquired from practice and experience and can be shared through conversation, is commonly referred to in the literature as tacit knowledge (Nonaka, 1994; McAdam et al., 2007).

Although we did not set out to explicitly investigate the use of tacit knowledge to guide community participation practice in CHCs, participants repeatedly emphasized the role played by their professional and community-based knowledge over the use of explicit (research-based) knowledge. In doing so, our findings reveal that tacit knowledge, in the form of professional and personal experience and community contextualized knowledge, exerted a greater influence on guiding participation activities in Ontario CHCs than frameworks informed by research evidence. Focus group participants expressed a reliance on their own situations and experiences to inform the approach, methods and tools for engaging...
marginalized populations. A number of scholars have asserted that the knowledge of local people and communities is highly relevant to community participation processes (Eversole and Routh, 2005; Gaventa, 1993; Sillitoe, 2002; Warren et al., 1995). Eversole (2010) contends that “there is a broad agreement in the literature that the knowledge and insights of ‘local people’ and ‘local communities’ potentially complement, correct and/or provide alternative perspectives to the mainstream ‘scientific’ or ‘professional’ expert knowledge that typically informs [participation] practice.” (p. 33) This finding also supports Nonaka’s concept of tacit knowledge as knowledge that can be articulated using metaphors or analogies. One participant used the analogy of a broccoli and cauliflower to describe the complexity and multi-faceted nature of community participation.

Based on our analysis, there could be two explanations to explain the preferences of CHC staff for using tacit knowledge over research evidence alone to inform their community participation practices. First, there is limited research evidence that evaluates community participation efforts with marginalized populations and that can provide CHCs with valuable knowledge on the outcome(s) for particular methods of participation with different marginalized populations. Second, there is a stated preference for relying on the knowledge of staff who carry out community participation initiatives, as they are experts in their fields. Our findings on tacit knowledge support previous research on the use of evidence in the community-based health sector. Kothari and Armstrong (2011) found that public health practitioners in Ontario Public Health Units used explicit and tacit forms of knowledge in several ways. For instance, both forms of knowledge were used to decide such issues as: what direction public health practitioners would take in program planning, who should be involved on the planning team, and working out program details, such as funding.

The community development approach is used in facilitating engagement with marginalized populations within CHCs, yet participants did not refer to the community development approach as a framework for guiding their community participation practice. Their limited support for the use of frameworks, despite the important role of the community development approach to participation within their CHC, warrants consideration about how frameworks are conceptualized by CHC staff and providers.

In light of the limited support for community participation frameworks to guide CHCs’ participation initiatives, future research should identify and assess the use of alternative knowledge translation mechanisms for translating and sharing knowledge about community participation practice that can be applied within the CHC context. We suggest that different outputs of the framework that was presented to them (such as planning community participation initiatives) could be used, instead, to design a community participation toolkit or guidebook for engaging marginalized populations for each CHC (acknowledging the differences with their local context). There are many community participation toolkits that have been successfully used in health organizations outside of CHCs. These toolkits have been targeted to a specific geographical region and health sector (Coyne and Cox, 2004) or more broadly to guide any health organization or agency in the local health system (Ardal et al., 2006; Health Canada, 2006), or for a specific population (Community Futures, 2008; Ortiz and Broad, 2006). There are also some well-known international examples. (e.g., Queensland Community Engagement Model, 2005). Toolkits or guidebooks provide greater flexibility in specifying the strategies for enabling the participation of marginalized populations, and identifying varying participation methods that have been tried with marginalized populations. To ensure its relevance to CHCs, the toolkit or guidebook would be adapted to the local context of the CHC and could be developed in collaboration with marginalized populations.

Our findings suggest further discussion on the role of tacit knowledge in the community participation field. Further exploratory work is needed to identify the role of tacit knowledge to guide community participation practice in CHCs. Evaluations of community participation initiatives of CHCs—shaped by the experience of staff and providers and their interactions with members of relevant populations—could explain how tacit knowledge is used and the extent to which it facilitates community participation processes with marginalized populations. Further research is needed to explore how CHCs can be supported to use research evidence (in combination with their own research activities such as, needs assessments, focus groups, surveys) in their community participation practice, and to evaluate different knowledge translation mechanisms (whether toolkits, guidebooks, or practice guidelines) that combine research evidence and tacit knowledge on community participation practice. Our findings also point to the many contextual factors faced by CHC staff when engaging diverse marginalized populations. The diversity within marginalized groups suggests that a “one-size-fits-all” approach is not appropriate (Draper et al., 2010). This creates an interesting challenge in the integration of explicit and tacit knowledge that is distinct from the literature which assumes a common organizational context and a coherent approach to community participation across different organizations. While we have positioned tacit knowledge as an important feature of community practice with marginalized populations, some tacit knowledge might lead to ineffective community participation practice. It is important, therefore, to consider the negative implications of tacit knowledge in future studies on community participation practice with marginalized populations. Furthermore, future studies are called for to determine which types of knowledge are drawn upon in other health services organizations outside of CHCs and beyond Canada with an interest in engaging marginalized populations. We might ask: are tacit and explicit knowledge viewed differently in other health services organizations outside of CHCs?

Our findings provide a nuanced understanding of the limitations of community participation frameworks for informing the community participation efforts within Ontario CHCs. Our findings also demonstrate that a generic community participation framework that could be used by all CHCs is likely inappropriate, given the varying contexts and diverse populations that CHCs serve. Participants provided relevant insights about the key components that are missing from generic community participation frameworks, that could enhance their applicability to the CHC context. Other scholars have also noted that lack of conceptual clarity of the core elements that make up a framework, and limited rigorous evaluation of the framework in different practice settings can pose challenges to the successful use and implementation of evidence-based practice frameworks (Gagliardi et al., 2011; Kitson et al., 2008).

Despite the significant insights from this study, our findings should be considered in light of several limitations. Since the study did not set out to examine the use of tacit knowledge explicitly, the findings might underrepresent the level of tacit knowledge used in CHCs for the planning and implementation of community participation initiatives. Kothari and Armstrong (2011) stated that a participant observation method would reveal a skill-based asset of tacit knowledge not described by respondents. We concur that direct observation of CHCs staff or providers who are involved in community participation with marginalized populations would provide valuable insight on how tacit knowledge is actually used in practice.
7. Conclusion

Community participation lies at the core of most CHC activities in Ontario; it is an implicit goal of most of their programs, services and initiatives. The communities that are served by CHCs have the right to be active and equal participants with staff in the planning and decision-making of health services. For CHCs, community participation serves not only practical and strategic ends, it is also a principled undertaking that is part of the organizational culture. Although CHCs live and breathe community participation in so many ways, they do not have a framework in place that guides their community participation activities with marginalized populations. There are strong statements of principle and commitment towards community participation that are not supported by procedural and evaluation frameworks for assessing the robustness and impacts from their participation initiatives.

Our findings suggest that tacit knowledge is an essential feature of community participation practice and requires further exploration regarding its role in the community participation field. Finding an appropriate place for tacit knowledge alongside the traditional elements of knowledge translation which emphasizes acquiring, assessing and applying research evidence seems like a promising way forward to promote the value of community participation frameworks as knowledge translation mechanisms.

Acknowledgments

Research underpinning this paper was supported by a Population Health Intervention Research Network (PHIRN) Doctoral Award. We are grateful for the insights provided by the participants from the Community Health Centres (CHCs) who took time out of their busy schedule to participate in the focus groups. We are also grateful to Dr. Melanie Rock for her helpful suggestions to improve this manuscript.

Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.socscimed.2015.08.02.

References


